

**BEFORE THE OREGON
STATE BOARD OF NURSING**

In the Matter of Michael Cloutier, CNA	)	STIPULATED ORDER FOR
	)	REPRIMAND
	)	Reference No. 2025010259
Certificate No. 10037702		

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

Michael Cloutier (CNA) was issued a Nursing Assistant certificate by the Board on January 9, 2025.

On or about 01/18/2025, CNA spoke in an intimidating manner toward residents and co-workers.

By the above actions, CNA is subject to discipline pursuant to the following statutes and rules:

ORS 678.442 Certification of nursing assistants; discipline; rules.

(2) In the manner prescribed in ORS chapter 183, the board may revoke, suspend, deny or impose conditions on a certificate issued by the board and reprimand or place on probation, subject to terms imposed by the board, a person certified by the board for any of the reasons described in this section, including the following:

(d) Violation of any provisions of ORS 678.010 to 678.448 or rules adopted under ORS 678.010 to 678.448.

(f) Conduct unbecoming a nursing assistant in the performance of duties.

***Former OAR 851-063-0090 Conduct Unbecoming a Nursing Assistant
(effective 08/01/2021 through 06/30/2025)***

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:

(1) Conduct related to general fitness to perform nursing assistant authorized duties:

(a) Demonstrated incidents of violent, abusive, intimidating, neglectful or reckless behavior;

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

That the Nursing Assistant Certificate of Michael Cloutier be reprimanded.

CNA 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.

CNA 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 Certified Nursing Assistant.

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

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

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

CNA 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.

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

[Redacted Signature]

Michael Cloutier, CNA

02/27/26

Date

ORDER

IT IS SO ORDERED:

~~BOARD OF NURSING FOR THE STATE OF OREGON~~

[Redacted Signature]

Olanike Towobola, DNP, RN
Board President

4/15/28

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
Whitney Galvin, RN	) PROBATION
)
License No. 202107174RN	) Reference No. 2025090140

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

Whitney Galvin (Licensee) was issued a Registered Nurse license by the Board on July 20, 2021.

On 2/17/2025, medical records noted that Licensee pulled two tablets of oxycodone for a client; however, Licensee did not document what they did with tablets.

On 6/8/2025, medical records noted that Licensee pulled a 5mg tablet of oxycodone; however, it was unaccounted for until 6/26/2025 when Licensee documented it as administered.

On 6/9/2025, medical records noted that Licensee pulled a 5mg tablet of oxycodone; however, it was unaccounted for until 6/26/2025 when Licensee documented it as administered.

On 6/10/2025, medical records noted that Licensee pulled liquid Dilaudid for a client, wasted part of it, and documented administering the remaining amount two minutes later. Licensee then documented wasting that same “remaining amount” two hours and 20 minutes later.

On 6/18/2025, at 0805 hrs, medical records noted that Licensee documented administering oxycodone to a client; however, the medication was documented as pulled at 0807 hrs.

By the above actions, Licensee is subject to discipline pursuant to the following statutes and rules:

ORS 678.111 Denial, revocation or suspension of license or probation or reprimand. In the manner prescribed in ORS chapter 183 for a contested case, and except as provided in ORS 678.138, the Oregon State Board of Nursing may revoke, suspend, deny or impose conditions on a license issued by the board, or on an inactive or retired status granted by the board, and reprimand or place on probation, subject to terms imposed by the board, a person licensed by the board for any of the reasons described in this section, including the following:

- (6) Conduct derogatory to the standards of nursing.
- (7) Violation of any provision of ORS 678.010 to 678.448 or rules adopted under ORS 678.010 to 678.448.

Former OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined (effective 7/1/2024 through 11/19/2025)

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:

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

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

(4) Conduct related to communication:

(a) Failure to document the practice of nursing in a timely, accurate, thorough, and clear manner;

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 Board and is agreed to by Licensee:

That the Registered Nurse license of Whitney Galvin be placed on Probation. Licensee's compliance with this agreement will be monitored by the Board 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 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 complete the following two courses:

<https://www.elitelearning.com/nursing/courses/documentation-for-nurses-5th-edition/?state=OR>

(Documentation for Nurses, 5th Edition)

<https://www.nursingce.com/ceu-courses/pain-management-nursing-ce-course-for-rns-and-lpns>

(Pain Management Nursing CE Course for RNs and LPNs)

All courses shall be pre-approved by Board staff, and Licensee shall provide proof of completion of each course either through certificates of completion or transcripts. Should Licensee fail to complete these courses within the required time of 30 days from date this Order is signed by the Board President, Licensee shall be referred back to the Board for consideration of further disciplinary action.

6) 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 Board 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 licensee's Oregon probation if the position meets the monitoring requirements per line ten (10) of this stipulated order.

7) 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.

8) 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.

9) 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.

10) 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.

11) 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.

12) 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.

13) Licensee shall notify Board staff when there is a change in status of employment including resignations, disciplinary actions, and terminations.

14) Licensee shall not work in any practice setting in which on-site monitoring is not available. This generally includes home health agencies, travel nurse 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 cooperate fully with the Board in the supervision and investigation of Licensee's compliance with the terms and conditions of this Stipulated Order.

19) At the Board staff's request, upon reasonable concern that Licensee may be demonstrating signs of impairment, the Licensee shall provide a drug test. Failure to comply with quantitative 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.

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 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 Signature]

Whitney Galvin, RN

03/16/26

Date

ORDER

IT IS SO ORDERED:

~~BOARD OF NURSING FOR THE STATE OF OREGON~~

[Redacted Signature]

Olanike Towobola, DNP, RN
Board President

4/15/26

Date

PLEASE RETURN ALL PAGES OF THIS STIPULATED ORDER AFTER SIGNING

On July 3, 2025, the Board requested a postponement of the hearing. On July 10, 2025, ALJ Jarry granted the unopposed request and set a prehearing conference for August 18, 2025.

On August 18, 2025, ALJ Jarry held a prehearing conference by telephone. Ms. Koenig appeared without counsel. Ms. Rauch represented the Board, and Ms. Primus appeared for the Board. ALJ Jarry reset the hearing for January 21 and 22, 2026.

On December 18, 2025, the Board issued an Amended Notice of Proposed Revocation of Registered Nurse License (Amended Notice), which included additional alleged violations.

A hearing was held on January 21, 2026, in Portland, Oregon. Ms. Koenig appeared without counsel and testified on her own behalf. Ms. Rauch represented the Board, and Heather Johnson, RN, Nurse Investigator/Advisor appeared for the Board. The Board called the following witnesses to testify: Margo Waltz, RN; Brianne Poland, RN; Joyce Moule, RN; Angela Hall, RN; and Ms. Johnson. The record closed at the conclusion of the hearing on January 21, 2026.

CORRECTIONS TO AMENDED NOTICE

At the hearing, the Board requested correction by interlineation of scrivener's errors in the Amended Notice. ALJ Jarry granted the unopposed request.

In the second paragraph on page 2 of the Amended Notice, any reference to "2022" is changed to 2021, and any reference to "December 8" is changed to December 2.

ISSUES

Conduct during Employment at Asante Hospital

1. Whether Ms. Koenig engaged in conduct derogatory to the standards of nursing by delaying medication barcode scanning and documentation of controlled medications. OAR 851-045-0070(2)(a) and (4)(a) (August 1, 2017).¹
2. Whether Ms. Koenig engaged in conduct derogatory to the standards of nursing by dispensing controlled medications and wasting the entire dose without documenting an explanation. OAR 851-045-0070(2)(a) and (4)(a) (August 1, 2017).
3. Whether Ms. Koenig engaged in conduct derogatory to the standards of nursing by delaying the wasting of controlled medications after dispensing the medications. OAR 851-045-0070(2)(a) (August 1, 2017).
4. Whether Ms. Koenig engaged in conduct derogatory to the standards of nursing by failing to document patient assessments when administering controlled medications. OAR 851-

¹ OAR 851-045-0070 has been amended multiple times since the earliest conduct at issue occurred. The version of the rule in effect at the time of the conduct applies to each violation. The general meaning of the pertinent sections of the rule has remained consistent.

045-0070(2)(a) and (4)(a) (August 1, 2017).

Conduct during Employment at Grants Pass Surgery Center

5. Whether Ms. Koenig engaged in conduct derogatory to the standards of nursing by removing controlled medication from the medication safe without documenting the removal. OAR 851-045-0070(2)(a) and (4)(a) (August 1, 2017).

6. Whether Ms. Koenig engaged in conduct derogatory to the standards of nursing by removing controlled medication from the medication safe without an order to do so. OAR 851-045-0070(2)(a), (2)(b), and (4)(a) (August 1, 2017).

Conduct during Employment at Hearthstone Nursing and Rehabilitation Center

7. Whether Ms. Koenig engaged in conduct derogatory to the standards of nursing by wasting controlled medication without allowing the witness to the wasting to verify the type of medication. OAR 851-045-0070(2)(a) (July 1, 2024).

Conduct during Employment at Bay Area Hospital

8. Whether Ms. Koenig engaged in conduct derogatory to the standards of nursing by failing to document either the wasting or administration of controlled medication. OAR 851-045-0070(2)(a) and (4)(a) (July 1, 2024).

9. Whether Ms. Koenig engaged in conduct derogatory to the standards of nursing by delaying the wasting of controlled medication after dispensing the medication. OAR 851-045-0070(2)(a) and (4)(a) (July 1, 2024).

Sanction²

10. Whether Ms. Koenig's Registered Nurse license should be revoked. ORS 678.111(6).³

EVIDENTIARY RULINGS

Exhibits A1 through A38, offered by the Board, were admitted into the record without objection.

FINDINGS OF FACT

² The Board modified the Issue 10 and its related footnote to clarify that this Final Order cites to the version of the statute in effect at the time of the Final Order.

³ ORS 678.111 was amended in 2025, including a numbering change for the pertinent section of the statute. Prior to 2022, ORS 678.111(1) contained somewhat different language. Throughout the aforementioned amendments, the authority of the Board to revoke or otherwise sanction a license for conduct derogatory to the standards of nursing has remained unchanged. All statutory citations in this Final Order are to the version of the statute in effect at the time of the Final Order.

1. Ms. Koenig graduated from nursing school in 2019. (Ex. A3 at 6; test. of Koenig.) She became licensed as a registered nurse in the State of Oregon on August 22, 2019. Her license will expire on July 17, 2026. (Ex. A1 at 1.)

Asante Hospital

2. Asante Hospital (Asante) hired Ms. Koenig as a registered nurse in September 2019. Asante assigned her to the medical-surgical unit. (Ex. A3 at 6.)

3. Asante's Standards for Pain Management policy, in effect during Ms. Koenig's employment, provided, in part:

FOCUSED ASSESSMENT

A focused assessment is completed by the RN or LPN at the beginning of every shift, upon assuming care of the patient and PRN procedure or other change in condition. * * * .

* * * * *

POST-INTERVENTION REASSESSMENT

Post-intervention reassessment is completed by the RN or LPN within 1 hour of each pain-relieving intervention and includes the efficacy and side effects.

(Ex. A9 at 3-4; emphasis in original.)

4. Physicians typically include orders for different pain levels patients might experience. The purpose of the focused assessment for pain is to determine what medical interventions are needed to treat a patient's pain level. The post-intervention reassessment is used to determine whether the intervention was effective and to ensure that the patient has no adverse reactions. The focused assessment must be entered into the electronic charting system. (Test. of Poland.)

5. Asante's Medication Handling and Administration policy, in effect during Ms. Koenig's employment, provided, in part:

ACCESSING MEDICATIONS

* * * * *

Medications removed from the [automatic dispensing unit] or medication storage area must be taken directly to and administered to the patient, one patient at a time.

* * * * *

BARCODE SCANNING MEDICATION ADMINISTRATION

Barcode scanning technology is the standard and will be used with all medication administration unless necessary elements are not available.

* * * * *

C. Scan each medication prior to opening the package.

* * * * *

E. Any time scanning is bypassed, an administration comment explaining why the safety technology was not used must be documented. **Exception:** One-Step or Narrator driven medication administration.

- a) If the bypass is due to non-functioning scanner, this should be reported to ITS as soon as possible.
- b) If the bypass is due to unreadable barcode, pharmacy should be notified via [medication administration record] message. If the barcode was torn, please indicate that for clarification.

(Ex. A10 at 3, 5; emphasis in original.)

6. The purpose of requiring nurses to take dispensed medications directly to the patient and administer them is to ensure that the correct medication is administered. (Test. of Poland.)

7. At Asante, nurses log into and dispense medications from a medication dispensing machine. A portable rolling electronic medication chart is kept in each patient's room. Nurses must first scan the patient's wristband to confirm their identity and then scan the medication into the medication administration record, noting the dose, before administering the medication. (Test. of Poland.)

8. Ms. Koenig completed the following pain care and medication safety training during her employment with Asante:

- Asante Medication Handling and Administration Policy Module on September 18, 2019;
- Asante Pain Management and Opioid Safety on September 18, 2019;
- Asante Ortho Pain Management, Complications and Emergencies on October 29, 2019;
- Asante Opioid and Pain Management Class on November 19, 2019;
- Asante Patient Medication History Review on August 15, 2020; and

- Asante Care for Patients with Opioid Use Disorder in the Hospital on October 4, 2020.

(Ex. A5 at 3.)

9. On January 10, 2020, Ms. Koenig received verbal coaching for two unreconciled medication discrepancies for controlled substances on January 5, 2020. (Ex. A4 at 3.)

10. Ms. Koenig had the following delays in scanning the medication barcode and documenting the administration of controlled medications⁴ after they were dispensed:

- On May 26, 2020, she dispensed one hydrocodone tablet at 2021 and another at 2030.⁵ She administered one tablet at 2031 and returned the second tablet at 0732 on May 27, 2020. (Exs. A4 at 1; A6 at 24.)
- On May 27, 2020, she dispensed hydrocodone at 0040 and documented the administration of the medication at 0411, indicating she administered it at 0011. (Exs. A4 at 1; A6 at 25.)
- On May 27, 2020, she dispensed hydromorphone at 0039 and documented the administration of the medication at 0413, indicating she administered it at 0011. (Exs. A4 at 1; A6 at 26.)
- On May 27, 2020, she dispensed Dilaudid⁶ at 2314 and administered the medication at 0249 on May 28, 2020. (Exs. A4 at 1; A6 at 23.)
- On May 27, 2020, she dispensed Dilaudid at 0227 and administered the medication at 0420. (Exs. A4 at 1; A6 at 16.)
- On May 27, 2020, she dispensed hydrocodone at 0213 and documented the administration of the medication at 0447, indicating she administered it at 0012. (Ex. A6 at 24.)

11. Ms. Koenig administered controlled medication without completing a corresponding patient assessment on five occasions during the period May 14, 2020, to May 28, 2020. (Exs. A4 at 2; A6 at 14, 16-18, 21, 25.)

12. On May 26, 2020, Ms. Koenig wasted a full dose of a controlled medication an hour and a half after dispensing it. (Exs. A4 at 2; A6 at 21.)

⁴ The terms “controlled medications,” “controlled substances,” and “narcotic medications” are used interchangeably throughout this Proposed Order.

⁵ For consistency with the exhibits, the 24-hour format is used for time.

⁶ The generic version of the medication is hydromorphone. (Test. of Poland.)

13. On June 11, 2020, Asante issued a final warning to Ms. Koenig⁷ for a pattern of violating the Asante Medication Handling and Administration and the Asante Standards for Pain Management policies. (Ex. A4 at 1-4.) Ms. Koenig reviewed both policies. (*Id.* at 5-6.)

14. Ms. Koenig dispensed controlled medication and wasted the full amount without documenting the reason on the following dates: December 2, 2021; December 6, 2021; December 7, 2021; December 8, 2021; December 17, 2021; December 18, 2021; December 19, 2021; two instances on December 20, 2021; and December 22, 2021. (Exs. A5 at 2; A7 at 1.)

15. Ms. Koenig had the following delays before wasting controlled medication after dispensing the medication:

- On December 2, 2021, medication dispensed at 1942 and wasted at 2040;
- On December 17, 2021, medication dispensed at 2053 and wasted at 0552 on December 18, 2021;
- On December 18, 2021, medication dispensed at 2333 and wasted at 0541 on December 19, 2021;
- On December 20, 2021, medication dispensed at 2146 and wasted at 0517 on December 21, 2021; and
- On December 22, 2021, medication dispensed at 0327 and wasted at 0535.

(Exs. A5 at 2; A7 at 1.)

16. Ms. Koenig dispensed controlled medication without documenting a corresponding patient assessment on the following dates: December 2, 2021; December 6, 2021; December 7, 2021; December 8, 2021; December 17, 2021; December 18, 2021; December 19, 2021; twice on December 20, 2021; and December 22, 2021. (Exs. A5 at 2-3; A7 at 1.)

17. On January 7, 2022, Asante terminated Ms. Koenig's employment for a pattern of violating the Asante Medication Handling and Administration Policy.

18. When Ms. Koenig started working for Asante, the hospital introduced a new medication scanning system. The system did not always work and caused some problems with Ms. Koenig's charting. (Ex. A2 at 3.)

19. The COVID-19 pandemic began during Ms. Koenig's employment at Asante. Some of the hospital's policies changed frequently, especially in the COVID unit. The hospital was understaffed and employed multiple travel nurses, who could not dispense medications. Ms. Koenig dispensed medications for them, and she had trouble keeping up with her workload. (Test. of Koenig; Ex. A2 at 3-5.)

⁷ Ms. Koenig's surname was Ramsey at that time. (Test. of Johnson.)

20. During her employment at Asante, Ms. Koenig experienced many personal difficulties, including an abusive marriage and various legal issues. (Ex. A2 at 3-4.)

Grants Pass Surgery Center

21. In May 2023, Grants Pass Surgery Center (Surgery Center) hired Ms. Koenig as a registered nurse. She initially worked as a post-anesthesia care unit nurse and later as a sedation nurse. (Ex. A3 at 27; test. of Waltz.)

22. Physicians at the Surgery Center performed a variety of outpatient surgeries and procedures, such as endoscopies and colonoscopies. The medication, propofol, is typically used for sedation. If propofol is contraindicated for a patient, usually due to an allergy, the physicians either order an alternative sedation medication (versed or fentanyl) or send the patient to another facility for the procedure. If the physician consents to performing the procedure using an alternative sedation medication, the physician will either verbally order the medication or enter the order into the Surgery Center's electronic system. For verbal orders, the nurse will enter the order, and the physician will sign the order when they come into the Surgery Center. (Test. of Waltz.)

23. During nurse orientation, the Surgery Center provided computer-based education on a variety of topics, including narcotic medication, and the newly hired nurses were assigned a preceptor (*i.e.*, teaching nurse) for approximately two to four weeks. Sedation nurses received additional orientation, including an online course and training with a sedation nurse. The training addressed proper handling of the sedation medications, including dispensing and wasting the medications. (Test. of Waltz.)

24. The Surgery Center stored controlled medications in a safe located in the nurses' station. When a controlled medication was needed, the Surgery Center's procedure required nurses to print out the physician's order, bring the order to the medication safe, and complete an entry in the narcotic record that included the date, the patient's name, the ordering physician, the registered nurse, the medication and amount, and time removed. (Test. of Waltz; *see* Ex. A12.)

25. Ms. Koenig removed fentanyl from the medication safe without a written order for the medication and without completing entries in the narcotics record on the following dates: October 27, 2023; November 8, 2023; November 10, 2023; November 14, 2023; November 16, 2023; November 28, 2023; and November 30, 2023. (Exs. A12 at 1-7; A13 at 1; A14-A30.)

26. On December 8, 2023, the Surgery Center terminated Ms. Koenig's employment for violations of its policies regarding the management and handling of controlled medications. (Ex. A11 at 1.)

27. During Ms. Koenig's employment at the Surgery Center, she continued to experience intimate partner violence and felt "scattered" as a result. (Test. of Koenig.)

28. Ms. Koenig believed that the Surgery Center's training regarding its policies was

inadequate, and she had difficulty using the Surgery Center's patient charting system. She felt unsupported by management. (Test. of Koenig; Ex. A2 at 6.)

Hearthstone Nursing and Rehabilitation Center

29. On June 8, 2024, Hearthstone Nursing and Rehabilitation Center (Hearthstone) hired Ms. Koenig as a registered nurse. (Ex. A31 at 1.)

30. Hearthstone's policy regarding controlled medication administration and dose destruction required two staff members (one doing the wasting and the other observing) to witness the wasting of the medication in liquid drug buster.⁸ Both staff members had to sign the narcotics log, indicating what medication was wasted. Hearthstone informed Ms. Koenig of the policy, and she received education on controlled medications. (Ex. A32 at 10-12.)

31. On October 23, 2024, Ms. Koenig asked another registered nurse to sign the narcotics log as a witness to the wasting of a dose of oxycodone. Without bringing the medication to the other nurse to examine with either the narcotics book or the medication card,⁹ Ms. Koenig removed a round white tablet from a pill cup and placed the tablet in the drug buster. The other nurse refused to sign as a witness to the wasting because she was unable to verify that the tablet was oxycodone. The other nurse observed that the tablet appeared larger than typical oxycodone tablets. (Exs. A32 at 1, 5-6; A38 at 2.)

32. Hearthstone terminated Ms. Koenig in early November 2024. (Ex. A31 at 1.)

33. Ms. Koenig found her job at Hearthstone to be difficult. She felt overworked and unsupported. (Test. of Koenig.)

Bay Area Hospital

34. At the end of 2024, Bay Area Hospital hired Ms. Koenig as a travel nurse to float to different units based on staffing needs. (Test. of Hall.)

35. Bay Area Hospital's Medication-Administration and Documentation policy, in effect during Ms. Koenig's employment, required caregivers to complete the "seven rights of medication administration" for the administration of all medications. (Ex. A35 at 3; test. of Hall.) The "seven rights" included verifying the right patient, the right medication, right dose and dosage form, the right time, the right route, right reason, and the right documentation. (Ex. A35 at 3-7.) The "right documentation" required caregivers "to document all required elements in the [medication administration record] at the time of medication administration[.]" document

⁸ "Drug buster" is a bottle containing liquid used to destroy medications, including controlled medications. (Ex. A38 at 1.)

⁹ A medication card is a bubble pack of prescription medication prepared by a pharmacy on which each pill is enclosed in a clear "bubble." The medication card is specific to a particular medication and a particular resident. The card includes the resident's name and the order for the medication. (Ex. A38 at 2.)

the patient's response to the medication, and document the scheduled medications not administered and the reason the medication was not given. (*Id.* at 7-8.)

36. The Medication-Administration and Documentation policy also included a section regarding controlled substances. (Ex. A35 at 8-9.) The policy provided, in part:

B. Controlled substances taken from Pyxis:

1. That are not being titrated, are to be given or wasted within 15 minutes of the time the medication is removed but no later than 30 minutes from time of removal.
2. Partial doses will be wasted and witnessed prior to administration of the ordered amount or as soon as possible.

* * * * *

C. Controlled substances taken from Pyxis and contaminated or not administered to the patients after opening or removing from tamper-proof packaging are to be wasted.

(*Id.* at 8.)

37. Ms. Koenig delayed more than 30 minutes after dispensing controlled medication before the wasting medication on the following dates:

- On February 10, 2025, she wasted a full dose of tramadol 2.17 hours after dispensing;
- On February 15, 2025, she wasted a partial dose of hydromorphone 2.10 hours after dispensing;
- On February 15, 2025, she wasted a partial dose of hydromorphone 3.28 hours after dispensing;
- On February 16, 2025, she wasted a partial dose of hydromorphone 5.37 hours after dispensing;
- On February 16, 2025, she wasted a partial dose of hydromorphone 6.33 hours after dispensing;
- On February 18, 2025, she wasted a partial dose of hydromorphone 4.52 hours after dispensing;
- On February 18, 2025, she wasted a partial dose of hydromorphone 4.58 hours after dispensing; and

- On February 18, 2025, she wasted a partial dose of hydromorphone 3.40 hours after dispensing.

(Ex. A33 at 3, 5-7.)

38. Ms. Koenig dispensed controlled substances and failed to document the administration or wasting of the medications on the following dates:

- On February 2, 2025, she dispensed 1 mg of alprazolam and did not document whether she administered or wasted the medication.
- On March 2, 2025, she dispensed 1 mg of lorazepam and documented that she administered 0.5 mg. She did not document whether she administered or wasted the remaining 0.5 mg.
- On March 4, 2025, she dispensed 5 mg of oxycodone and did not document whether she administered or wasted the medication.
- On March 11, 2025, she dispensed 5 mg of oxycodone and did not document whether she administered or wasted the medication.

(Exs. A33 at 6, 8; A34 at 1, 2.)

39. In March 2025, Bay Area Hospital investigated Ms. Koenig after noting some unusual behavior regarding medical handling. Bay Area Hospital terminated her employment upon completion of the investigation. (Test. of Hall.)

40. Ms. Koenig felt the training was inadequate at Bay Area Hospital. (Test. of Koenig.)

Standards of Nursing Practice

41. Controlled substances such as fentanyl, hydromorphone, oxycodone, and tramadol, have a high risk of oversedation, overdose, diversion, abuse, misuse, and addiction. Standards of nursing practice have developed to mitigate those risks, and nurses receive training regarding those standards in nursing schools. (Test. of Johnson; Poland.)

42. Registered nurses must have a physician's order to dispense controlled substances from where they are stored. The standard of practice is to document the removal of the medication. (Test. of Johnson.)

43. Prior to administering controlled substances, the standard of practice is for nurses to assess the patient's pain and document the result. (Test. of Johnson.)

44. After a nurse dispenses a controlled substance for a patient, the standard of practice is to take the medication directly to the patient, administer the medication, and immediately document the administration in the patient's record. This ensures that other medical providers

know what medication has been administered. (Test. of Johnson.)

45. If a nurse dispenses a controlled substance and subsequently wastes or returns the entire dose, the standard of practice is to document the reason for wasting or returning. (Test. of Johnson.)

46. If a nurse needs to waste a controlled substance, the standard of practice is to have another nurse verify the type of medication and witness the wasting of the medication. The wasting of the medication should occur immediately or as soon as possible. (Test. of Johnson.)

47. For medication systems that use barcodes, the standard of practice is to scan the medication just prior to administration. If the barcode malfunctions, the best practice is to try scanning with another unit or do an override with a ticket to the information technology department or inform the charge nurse of the issue. (Test. of Johnson.)

CONCLUSIONS OF LAW

Conduct during Employment at Asante Hospital

1. Ms. Koenig engaged in conduct derogatory to the standards of nursing by delaying medication barcode scanning and documentation of controlled medication.

2. Ms. Koenig engaged in conduct derogatory to the standards of nursing by dispensing controlled medication and wasting the entire dose without documenting an explanation.

3. Ms. Koenig engaged in conduct derogatory to the standards of nursing by delaying the wasting of controlled medication after dispensing the medication.

4. Ms. Koenig engaged in conduct derogatory to the standards of nursing by failing to document patient assessments when administering controlled medications.

Conduct during Employment at Grants Pass Surgery Center

5. Ms. Koenig engaged in conduct derogatory to the standards of nursing by removing controlled medication from the medication safe without documenting the removal.

6. Ms. Koenig engaged in conduct derogatory to the standards of nursing by removing controlled medication from the medication safe without an order to do so.

Conduct during Employment at Hearthstone Nursing and Rehabilitation Center

7. Ms. Koenig engaged in conduct derogatory to the standards of nursing by wasting controlled medication without allowing the witness to the wasting to verify the medication.

Conduct during Employment at Bay Area Hospital

8. Ms. Koenig engaged in conduct derogatory to the standards of nursing by failing to document either the wasting or administration of controlled medication.

9. Ms. Koenig engaged in conduct derogatory to the standards of nursing by delaying the wasting of controlled medication after pulling the medication.

Sanction

10. Ms. Koenig’s Registered Nurse license should be revoked.

OPINION

The Board proposed¹⁰ to revoke Ms. Koenig’s license based on allegations that she engaged in conduct derogatory to the standards of nursing. ORS 678.111 provides the authority for the Board to take such action against a licensee and states, in pertinent part:

In the manner prescribed in ORS chapter 183 for a contested case, and except as provided in ORS 678.138, the Oregon State Board of Nursing may revoke, suspend, deny or impose conditions on a license issued by the board, or on an inactive or retired status granted by the board, and reprimand or place on probation, subject to terms imposed by the board, a person licensed by the board for any of the reasons described in this section, including the following:

* * * * *

(6) Conduct derogatory to the standards of nursing.¹¹

The Board must prove its allegations against Ms. Koenig by a preponderance of the evidence, and it must also establish that the proposed sanction is appropriate under the facts of the case. *See* 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”); *Harris v. SAIF*, 292 Or 683, 690 (1982) (general rule regarding allocation of burden of proof is that the burden is on the proponent of the fact or position); *Dixon v. Board of Nursing*, 291 Or App 207, 213 (2018) (the standard of proof that generally applies in agency proceedings is the preponderance standard). 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 Administrative Rules

¹⁰ The Board changed the tense of this verb for clarity.

¹¹ The Board modified the quoted statutory language to reflect the pertinent text of the version of ORS 678.111 in effect at the time of the Final Order.

OAR 851-045-0070 (August 1, 2017) provides, in pertinent part:

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[.]

* * * * *

(4) Conduct related to communication:

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

OAR 851-045-0070 (July 1, 2024) provides, in pertinent part:

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:

* * * * *

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

(a) Failing to recognize standards of acceptable and prevailing nursing practice. Actual injury need not be established[.]

* * * * *

(4) Conduct related to communication:

(a) Failure to document the practice of nursing in a timely, accurate, thorough, and clear manner[.]

Asante Hospital

The Board contended¹² that Ms. Koenig engaged in the following conduct derogatory to the standards of nursing while employed at Asante Hospital: delaying medication barcode scanning and documenting the administration of a controlled medication; dispensing controlled medications and wasting the entire dose without documentation; delaying between dispensing controlled medication and wasting the medication; and failing to document patient assessments when administering controlled medications. Ms. Koenig does not dispute the allegations.

The evidence establishes that Ms. Koenig delayed scanning the medication barcode and delayed documenting the administration of a controlled medication on six occasions during the period May 26 to 28, 2020. This conduct was contrary to the Asante Medication Handling and Administration policy, which follows the standards of acceptable and prevailing nursing conduct. Accordingly, Ms. Koenig engaged in conduct derogatory to the standards of nursing and failed to accurately document nursing interventions, pursuant to OAR 851-045-0070(2)(a) and (4)(a) (August 1, 2017).

The evidence establishes that Ms. Koenig dispensed controlled medications and wasted the entire dose without documenting an explanation 10 times during the period December 2 to 22, 2021. The standard of nursing practice requires documenting the reason for wasting controlled medication. Accordingly, Ms. Koenig engaged in conduct derogatory to the standards of nursing and failed to accurately document nursing interventions, pursuant to OAR 851-045-0070(2)(a) and (4)(a) (August 1, 2017).

The evidence establishes that Ms. Koenig delayed wasting medications between one to nine hours after dispensing controlled medication on five occasions during the period December 8 to 22, 2021. The standard of nursing practice requires wasting of controlled medication to occur immediately or as soon as possible. Accordingly, Ms. Koenig engaged in conduct derogatory to the standards of nursing, pursuant to OAR 851-045-0070(2)(a) (August 1, 2017).

The evidence establishes that Ms. Koenig failed to document patient assessments when administering controlled medications on five occasions during the period May 14 to 28, 2020, and on ten occasions during the period December 2 to 22, 2021.¹³ This conduct is contrary to Asante's Standards for Pain Management policy, which requires the RN to complete a focused assessment of a patient "at the beginning of every shift, upon assuming care of the patient and PRN procedure or other change in condition." Exhibit A9 at 3; emphasis omitted. This policy conforms with acceptable and prevailing standard nursing practice. Accordingly, Ms. Koenig engaged in conduct derogatory to the standards of nursing and failed to accurately document nursing interventions and nursing practice implementation, pursuant to OAR 851-045-0070(2)(a) and (4)(a) (August 1, 2017).

Grants Pass Surgery Center

¹² The Board changed the tense of this verb for clarity.

¹³ The Board modified this sentence to align with Finding of Fact 16.

The Board alleged¹⁴ that Ms. Koenig removed controlled medication from the medication safe without documenting the removal and without an order to do so. Ms. Koenig did not dispute this allegation.

The evidence establishes that Ms. Koenig removed the controlled medication fentanyl from the Surgery Center's medication safe on seven occasions between October 27, 2023, and November 30, 2023, without documenting the removal in the narcotics record and without having written orders for the removal. Ms. Koenig's conduct violated the Surgery Center's procedures regarding the removal of narcotic medication, which require a written order and an entry in the narcotic record. Those procedures are in accordance with the standards of nursing practice.

Accordingly, Ms. Koenig violated OAR 851-045-0070(2)(a) (August 1, 2017) by failing to conform her conduct to the essential standards of acceptable and prevailing nursing practice, and OAR 851-045-0070(4)(a) (August 1, 2017) by failing to accurately document a nursing practice implementation.

Hearthstone Nursing and Rehabilitation Center

The Board alleged¹⁵ that Ms. Koenig wasted a controlled medication without verifying the medication with the nurse who witnessed the wasting. Ms. Koenig did not dispute that she did not provide the other nurse with the opportunity to verify the medication using the narcotics book or the medication card.

On October 23, 2024, Ms. Koenig asked another registered nurse to witness the wasting of oxycodone, a narcotic medication. Before giving the other nurse an opportunity to verify that the tablet was oxycodone using the narcotics book or medication card, Ms. Koenig dropped the tablet in the drug buster. The other nurse believed the tablet was unusually large for oxycodone and subsequently refused to sign as a witness to the wasting because she was unable to verify the medication.

Hearthstone's policy required that if a controlled substance needed to be wasted, two staff members must witness the wasting in liquid drug buster and sign the narcotics log, indicating what medication was wasted. This policy is in accordance with the standard nursing practice requiring the witness to verify the type of medication being wasted by the other nurse. Accordingly, Ms. Koenig violated OAR 851-045-0070(2)(a) (July 1, 2024) by failing to recognize standards of acceptable and prevailing nursing practice when she wasted a controlled substance without permitting the witness to verify the medication.

Bay Area Hospital

The Board alleged¹⁶ that Ms. Koenig removed a controlled substance and failed to subsequently document the administration or wasting of the controlled substance on four

¹⁴ The Board changed the tense of this verb for clarity.

¹⁵ The Board changed the tense of this verb for clarity.

¹⁶ The Board changed the tense of this verb for clarity.

occasions and that she had delays of two to six hours between dispensing a controlled substance and wasting the medication on approximately five occasions. Ms. Koenig did not dispute the allegations.

During the period February 2, 2025, through March 11, 2025, Ms. Koenig dispensed controlled substances and failed to document the administration or wasting of the medications on four occasions. This conduct was contrary to Bay Area Hospital's Medication Administration and Documentation policy, which required caregivers "to document all required elements [of the "seven rights"] in the [medication administration record] at the time of medication administration." Exhibit A35 at 7. The required elements included the medication and dose administered and if the scheduled medicine was not administered, the reason for failing to give the medication. The conduct also violates the standards of nursing practice, which require the documentation of medication administration and wasting. Accordingly, the Board established that Ms. Koenig violated OAR 851-045-0070(2)(a) and (4)(a) (July 1, 2024) by failing to recognize standards of acceptable and prevailing nursing practice and failing to document the practice of nursing in a timely, accurate, thorough, and clear manner.

The evidence establishes that Ms. Koenig delayed two to six hours before wasting controlled medications on eight occasions during the period February 10 through 18, 2025.¹⁷ This conduct violated Bay Area Hospital's Medication-Administration and Documentation policy regarding the timing of wasting controlled medications. Moreover, this conduct was contrary to the accepted standards of nursing practice, which require nurses to waste controlled substances immediately or as soon as possible after dispensing. Accordingly, Ms. Koenig violated OAR 851-045-0070(2)(a) (July 1, 2024) by failing to recognize standards of acceptable and prevailing nursing practice regarding the timing of wasting controlled substances.

Sanction

Pursuant to ORS 678.111(6),¹⁸ the Board has the discretion to revoke a license or impose other sanctions for the violations committed by Ms. Koenig. The Board contends that license revocation is an appropriate sanction due to Ms. Koenig's repeated failure to conform her conduct to the accepted standards of nursing practice.

At the hearing, Ms. Koenig asserted that a lesser form of discipline would be appropriate because the violations were the result of errors and no patients were harmed by her actions. She also provided various explanations for the violations, including difficulties related to the COVID-19 pandemic, issues with medication scanning systems and charting systems, inadequate training provided by employers, understaffing, and personal difficulties.

The Board established that license revocation is an appropriate sanction in this matter. As previously discussed, Ms. Koenig engaged in numerous violations of the standards of nursing related to clinical competency and communication. Her inability to comply with the accepted

¹⁷ The Board modified this sentence to align with Finding of Fact 37.

¹⁸ The Board modified this citation to reflect the version of the statute in effect at the time of the Final Order.

standards of nursing practice regarding the handling of, and documentation related to, controlled substances was not an isolated occurrence. Her violations occurred during the period September 2019 to March 2025, when she worked for, and was terminated by, four different employers. Although there is no allegation that she harmed any patients, her conduct was contrary to fundamental nursing standards for which nursing school and her employers provided training. Controlled substances carry a high risk of oversedation, overdose, abuse, misuse, addiction, and diversion. The standards related to proper documentation, handling, and wasting of those medications are extremely important to follow – not just for the safety of patients but also for the safety of nurses. Ms. Koenig engaged in similar violations at each workplace, demonstrating a pattern of noncompliance over multiple years. Although Ms. Koenig may have had some difficulties that contributed to her performance issues, the ongoing nature of the violations causes serious concern regarding her ability to safely practice nursing.

Pursuant to ORS 678.111(6),¹⁹ Ms. Koenig's Registered Nurse license should be revoked for engaging in conduct derogatory to the standards of nursing.

FINAL ORDER

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

Connie Jean Koenig's Registered Nurse license is revoked.



4/15/28

Olanike Towobola, DNP, RN
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.*

¹⁹ The Board modified this citation to reflect the version of the statute in effect at the time of the Final Order.

**BEFORE THE OREGON
STATE BOARD OF NURSING**

In the Matter of	)	STIPULATED ORDER FOR
Damen Launius, RN	)	CIVIL PENALTY
)	
License No. 201606045RN	)	Reference No. 2024090174

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

Damen Launius (Licensee) was issued an RN license by the Board on August 3, 2016. On 10/7/2023, Licensee's RN license expired; on 9/17/2024, Licensee applied for reinstatement by reactivation, which was subsequently approved.

On or about September 19, 2024, the Board received information that between 10/7/2023 and 9/18/2024, Licensee worked as an instructor with an expired license for a total of 233 calendar days.

By the above actions, Licensee is subject to discipline pursuant to the following statutes and rules:

ORS 678.111 Denial, revocation or suspension of license or probation or reprimand. In the manner prescribed in ORS chapter 183 for a contested case, and except as provided in ORS 678.138, the Oregon State Board of Nursing may revoke, suspend, deny or impose conditions on a license issued by the board, or on an inactive or retired status granted by the board, and reprimand or place on probation, subject to terms imposed by the board, a person licensed by the board for any of the reasons described in this section, including the following:

(6) 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.

Former OAR 851-001-0009 Imposition of Civil Penalties (effective 12/1/2022)

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.

Former OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined
(effective 1/1/2023 – 3/1/2025)

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:

(9) Conduct related to licensure or certification violations:

(b) Practicing nursing without a current Oregon license or certificate;

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 a civil penalty against the RN License of Damen Launius in the amount of \$25 per day, totaling \$5,825.00 (233 incidents x \$25 per incident).

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 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 **36** monthly payments of **\$161.80**. The first payment is to be received by the Board no later than ten (10) days following the Boards acceptance of this Stipulation; for every month thereafter, a payment is due 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. 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.

COLLECTION NOTICE: Pursuant to ORS 293.231, the Board will refer delinquent accounts for collection by the Department of Revenue or a private collection agency within 90 days of delinquency. 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. The Board may record unpaid penalties or costs with the county clerk of any county in this state, pursuant to ORS 205.125 and 205.126. 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 Signature]

Damen Launius, RN

03/12/26

Date

ORDER

IT IS SO ORDERED:

BOARD OF NURSING FOR THE STATE OF OREGON

[Redacted Signature]

Olanike Towobola, DNP, RN
Board President

4/15/26

Date

PLEASE RETURN ALL PAGES OF THIS STIPULATED ORDER AFTER SIGNING

1
2
3
4

**BEFORE THE
STATE OF OREGON**

OREGON STATE BOARD OF NURSING

5 IN THE MATTER OF:) OAH Case No. 2025-ABC-07114
6) Agency Case No. 2024070252
7 **MARK SCOTT LOGUE**)
8) **FINAL ORDER**
9)

10 This matter came before the Oregon State Board of Nursing (Board) at its April 15, 2026,
11 meeting, to consider the Proposed Order issued by Senior Administrative Law Judge (ALJ)
12 Jennifer H. Rackstraw on December 15, 2025.

HISTORY OF THE CASE

13 On April 21, 2025, the Oregon State Board of Nursing (Board) issued a Notice of Proposed
14 Revocation of Registered Nurse License [and] Proposed Denial of Registered Nurse License
15 Application to Mark Scott Logue. On April 25, 2025, Mr. Logue requested a hearing. On May
16 12, 2025, the Board referred the hearing request to the Office of Administrative Hearings (OAH).
17 The OAH assigned ALJ Jennifer H. Rackstraw to preside over the matter.

18 On May 27, 2025 and June 2, 2025, Mr. Logue filed requests to dismiss the Board's case.
19 On June 11, 2025, ALJ Rackstraw denied the requests.

20 On June 24, 2025, ALJ Rackstraw convened a telephone prehearing conference. Mr.
21 Logue appeared on his own behalf. Assistant Attorney General Kristen Williams appeared as the
22 Board's counsel. Heather Primus also appeared for the Board. A telephone hearing was scheduled
23 for September 29 and 30, 2025, with a deadline of September 15, 2025, for the filing of witness
24 lists and hearing exhibits.

25 On June 25, 2025, the Board filed a Motion for Qualified Protective Order, and a proposed
26 Qualified Protective Order Limiting Use and Disclosure. Mr. Logue objected to the motion. On
27 July 18, 2025, over Mr. Logue's objections, ALJ Rackstraw issued a Qualified Protective Order
28 Limiting Use and Disclosure.

29 On September 10, 2025, the Board filed a Motion for Continuance. The September 15,
30 2025 deadline for the filing of witness lists and hearing exhibits was suspended, pending a ruling
31 on the motion. On September 15, 2025, ALJ Rackstraw convened a telephone conference to
32 discuss the Motion for Continuance, which Mr. Logue opposed. At the conference, Mr. Logue
33 appeared on his own behalf. Ms. Williams and Ms. Primus appeared for the Board. During the

1 conference, Ms. Williams withdrew the Motion for Continuance. A new deadline of September
18, 2025, was set for the filing of exhibits and witness lists.

2 On September 18, 2025, the Board issued an Amended Notice of Proposed Revocation of
3 Registered Nurse License [and] Proposed Denial of Registered Nurse License Application
4 (Amended Notice) to Mr. Logue. On September 25, 2025, Mr. Logue objected to the inclusion of
5 the Amended Notice in the record. On September 26, 2025, ALJ Rackstraw overruled the
6 objection and offered Mr. Logue the option of postponing the hearing if he required additional
time to prepare for it. On that same date, Mr. Logue elected to go forward with the hearing, as
scheduled, on September 29, 2025.

7 On September 29, 2025, ALJ Rackstraw held a telephone hearing. Mr. Logue represented
8 himself and testified. Ms. Williams represented the Board. Heather Johnson and Maria Parish
testified for the Board. The record closed at the conclusion of the hearing.

9 On December 15, 2025, ALJ Rackstraw issued the Proposed Order recommending the
10 revocation of the nurse license and denial of the March 1, 2024 application to reactivate the license.
The Proposed Order notified Mr. Logue of the timing requirements for filing of exceptions. On
11 December 25, 2025 Mr. Logue emailed exceptions to the Board. On December 26, 2026, Mr.
12 Logue mailed a copy of those exceptions to the Board. On December 30, 2025 and January 1,
2026, Mr. Logue submitted additional correspondence to the Board. To the extent Mr. Logue
13 intended that correspondence to be additional exceptions and argument, the Board cannot consider
14 them as they were not timely filed. The Board reviewed the timely submitted exceptions and
arguments and to the extent they contain facts presented at the hearing or additional argument not
15 presented at the hearing, the Board has considered the exceptions and finds them unpersuasive.
After considering the exceptions and the record, the Board adopts the ALJ's proposed statement
16 of the issues, evidentiary rulings, factual findings, conclusions of law, opinion and proposed order
without substantial modification and adopts the following Final Order.

17 ISSUES

18 1. Whether Mr. Logue failed to complete a Board-ordered neuropsychiatric evaluation and
19 therefore engaged in conduct derogatory to the standards of nursing pursuant to *former* OAR 851-
20 045-0070(10)(d) (effective August 1, 2017 through June 30, 2024) and *current* OAR 851-045-
0070(10)(d) and (e).

21 2. Whether the Board may revoke Mr. Logue's registered nurse (RN) license and deny his
22 application for reactivation of his RN license. *See* ORS 678.111(1)(f) and (g), ORS 678.158, and
23 ORS 676.205(2).

24 EVIDENTIARY RULINGS

25 The Board's Exhibits A1 through A44 were admitted into the record without objection.
26 Pleadings P1 through P61 were also made a part of the record. Mr. Logue did not offer any
exhibits.

1 **FINDINGS OF FACT**

2 1. The Board first licensed Mr. Logue as an RN in July 1997. (See Ex. A3 at 2.)

3
4 2. In October 2008, Mr. Logue was reported to the Board for allegations of exceeding his
5 scope of practice, using poor judgment, and violating professional boundaries. On May 15, 2009,
6 the Board adopted a Stipulation for Reprimand with Conditions of Registered Nurse License. (Ex.
7 A3 at 1-5.)

8 3. In January 2019, Mr. Logue was reported to the Board for allegations of practicing
9 outside of his scope, violating professional boundaries, and assisting a client to violate their parole.
10 (Ex. A5 at 6.) The Board opened an investigation into the matter. (See Ex. A1 at 1.) As part of
11 its investigation, on June 19, 2019, the Board issued an Order for Neuropsychiatric Evaluation (the
12 Order) to Mr. Logue.¹ (See A5 at 1-12.) The Order stated, in part:

13 **You are hereby ordered** to undergo a neuropsychiatric evaluation with an
14 evaluator approved by the Board. If you would like to undergo an
15 evaluation by an evaluator who is not on the list of approved evaluators, you
16 must submit that name along with the professional's curriculum vitae to the
17 Board, requesting approval, see OAR 851-070-0060(1) for qualifications.²
18 The evaluator must use the DSM-V diagnostic criteria.

19 _____
20 ¹ ORS 678.113 provides, in part:

21 (1) During the course of an investigation into the performance or conduct of an applicant
22 * * * or licensee, the [Board] may order mental health, physical condition or chemical
23 dependency evaluations of the applicant * * * or licensee upon reasonable belief that the
24 applicant * * * or licensee is unable to practice nursing with reasonable skill and safety to
25 patients.

26 * * * * *

(3) A licensee or certificate holder by practicing nursing, or an applicant by applying to
practice nursing in Oregon, gives consent to submit to mental health * * * evaluations when
ordered by the board[.]

² OAR 851-070-0060(1) states, in relevant part:

To be approved by the Board as an independent third-party evaluator, an evaluator must
be:

(a) Licensed as required by the jurisdiction in which the evaluator works; [and]

1 You are required to contact a Board-approved evaluator to schedule an
2 appointment with the evaluator within 10 days of the date that this Order is
3 mailed to you. You are required to notify the Board of the name of the
4 evaluator you have selected, along with the date and time of your
5 appointment at least 7 days prior to your evaluation. Your neuropsychiatric
6 evaluation must be completed within 30 days of the date that this Order is
7 mailed to you.

8 In the written report of the evaluation, the evaluator will directly respond to
9 specific questions submitted by the Board. You must sign a release of
10 information with the evaluator. This permits the evaluator to send the
11 evaluation report directly to the Board, with a copy provided to you. You
12 are responsible for paying for the ordered evaluation.

13 (*Id.* at 4; emphasis in original.) A letter from Board Nurse Investigator Heather Johnson, dated
14 June 19, 2019, accompanied the Order. The letter reiterated the deadlines set forth in the Order
15 and repeated the instructions for requesting an evaluation by an evaluator not on the Board's
16 approved list. (*Id.* at 1.) Ms. Johnson provided a list of Board-approved evaluators, along with
17 her letter and the Order. (*See id.* at 1, 7-12.)

18 4. A neuropsychiatric evaluation is an in-depth assessment that typically lasts between
19 four and eight hours, and it is sometimes split between two appointments. It evaluates both the
20 cognitive and psychiatric functioning of an individual. (Test. of Johnson; *see* Exs. A27 at 1 and
21 A30 at 3.)

22 5. On July 1, 2019, Mr. Logue's attorney at the time, Kevin Keaney, informed Ms. Johnson
23 that Mr. Logue had an evaluation appointment scheduled for July 8, 2019, with Michael Dellinger,
24 M.D., an internal medicine physician. (Ex. A6 at 1.) As an internal medicine physician, Dr.
25 Dellinger is not qualified to perform a neuropsychiatric evaluation. (Test. of Johnson.)

26 6. On July 2, 2019, Ms. Johnson sent a letter to Mr. Logue and Mr. Keaney via email. (Ex.
A8 at 1-3.) The letter stated, in part:

Please be advised that your upcoming appointment scheduled with Dr.
Michael Dellinger at OHSU on July 8, 2019, does not meet the requirements
of the Board Order to obtain a neuropsychiatric evaluation.

* * * * *

(b) Able to provide a comprehensive assessment of and written report describing a
certificate holder or licensee's diagnosis, degree of impairment, and treatment
recommendations[.]

1 [P]er the Board Order, you are required to select an evaluator approved by
2 the Board. If you are choosing to undergo an evaluation by an evaluator
3 who is not on the list that was provided to you, you must submit that name,
4 along with the professional's curriculum vitae to the Board, requesting
5 approval, BEFORE you schedule the appointment.

6 Please be aware that as of today, July 2, 2019, you are in violation of a
7 Board Order. You have failed to schedule an evaluation with a Board
8 approved evaluator by the default date of June 29, 2019.

9 Your case will be presented at the next Board meeting, at which time the
10 Board will determine if further discipline is warranted.

11 (*Id.* at 3.) In response, on July 2, 2019, Mr. Logue sent a fax to Ms. Johnson, reporting that he
12 planned to schedule an evaluation appointment with Leeza Maron, Ph.D., Clinical Professor of
13 Psychology. Mr. Logue explained that before he could schedule that evaluation, he first had to see
14 an internist for a referral. Mr. Logue provided biographical information for Dr. Maron to Ms.
15 Johnson. (Ex. A9 at 1-4.) Ms. Johnson never received confirmation that Mr. Logue had an
16 evaluation appointment with Dr. Maron. (Test. of Johnson.)

17 7. On July 3, 2019, Ms. Johnson sent a letter to Mr. Keaney, stating in part:

18 I received a fax directly from licensee, Mark Logue, dated July 2, 2019 *
19 * * [which] indicates that the licensee is attempting to schedule an
20 appointment with Leeza Maron, Ph.D. I have included this information in
21 the licensee's file, however, the licensee is still in violation of a Board order.
22 The order specifically states that the licensee must schedule an appointment
23 with a Board approved evaluator within ten days of the date the order was
24 mailed to him. The licensee was required to provide an appointment date
25 for a Board approved evaluator by June 29, 2019, as the original order was
26 mailed to the licensee on June 19, 2019.

The licensee's case is scheduled to be presented at the July 2019, Board
meeting for violation of a Board order. I will follow up with you after that
meeting.

(Ex. A10 at 1.) By letter to Ms. Johnson dated July 3, 2019, Mr. Keaney stated, in part,

Mr. Logue contacted his health-care provider to schedule the
neuropsychiatric evaluation. Evidently, OHSU requires that Mr. Logue
obtain the evaluation appointment through referral from his PCP (or
equivalent). Mr. Logue scheduled the PCP appointment. If the PCP
believes the referral appropriate, Mr. Logue will attend the evaluation with
Dr. Maron.

1 (Ex. A11 at 1.) In the letter, Mr. Keaney asserted that the Board had to date “behaved
2 unreasonably” towards Mr. Logue by threatening action against his RN license before he had the
3 opportunity to be evaluated by a health-care provider. Mr. Keaney also challenged the Board’s
4 alleged basis for requiring the neuropsychiatric evaluation. (*Id.* at 2.)

5 8. By letter to Ms. Johnson dated July 8, 2019, Mr. Keaney wrote, in part:

6 Mr. Logue asked me to relay, before my representation ends at 5 pm today,
7 the following:

8 * * * * *

9 Mr. Logue attended the evaluation today at OHSU. My understanding is
10 there was no finding of neurocognitive impairment, but Mr. Logue will be
11 evaluated by another physician.

12 (Ex. A12 at 1.)

13 9. By July 18, 2019, the Board had not received from Mr. Logue either a completed
14 neuropsychiatric evaluation or the name of a Board-approved evaluator with whom Mr. Logue had
15 a confirmed appointment for a neuropsychiatric evaluation. (Test. of Johnson.) Therefore, on July
16 18, 2019, the Board issued a Notice of Proposed Revocation of Registered Nurse License to Mr.
17 Logue, alleging that he failed to comply with the Order for a Neuropsychiatric Evaluation by
18 failing to schedule an appointment for a neuropsychiatric evaluation by the deadline specified in
19 the order. (Ex. A13 at 1-2; test. of Johnson.)

20 10. On July 21, 2019, Mr. Logue provided Ms. Johnson with three pages of progress notes
21 from his July 8, 2019 visit with Dr. Dellinger and verification of a 20-minute appointment
22 scheduled with Leah Kalin, M.D., on August 12, 2019. (Ex. A14 at 1-11; test. of Johnson.) Dr.
23 Dellinger’s progress notes state, in part:

24 Need more info on what nursing board wants us to assess. Sounds like may
25 include psych and cognitive – which I am unable to do today. I paged PCP
26 and she agrees would be better for him to come back with more info and see
27 her.

28 [P]lease ask nursing board for a form or something in writing to guide Dr.
29 Kalin’s evaluation and bring that to [the] appointment with her.

30 * * * * *

31 Board of nursing says he needs a return to work letter to stay
32 certified/active[.]

33 [N]othing in writing from them, but they need something from his physician
34 saying he is able to work as [an] RN[.]

1 (Id. at 7; emphasis omitted.)

2 11. On September 10, 2019, Mr. Logue sent an email to the Board's counsel at the time,
3 Thomas Cowan, stating in part:

4 I am requesting Leah Kalin, M.D. from Internal Medicine, and M. Dean
5 Dellinger, M.D. Adjunct Assistant Professor of Medicine OHSU Medical
6 School and Internist Medicine, as choice of evaluators.

7 Please note, and consider, that both MDs are **HIGHLY** qualified, with
8 **outstanding** reputations in Medicine.

9 Both MDs have stated they have no issues with me practicing as a RN, and
10 should the Oregon State Board of Nursing object, please have the Board
11 state in writing why the Board under (ORS) has the authority to **over-rule**
12 the medical evaluation results of two licensed Medical Doctors of Internal
13 Medicine.

14 Should this fail, I will request an evaluation from a psychiatrist at OHSU
15 Internal Medicine.

16 (Ex. A15 at 1; emphasis in original.)

17 12. On October 12, 2019, Mr. Logue sent an email to Mr. Cowan that stated, in part:

18 [T]he Board Letter, dated June 19, 2019, does allow for me to submit to the
19 [Board] a **list of providers of my own choice** for consideration[.] * * *
20 [O]n Sept 3, 2019, a request for Michael D[.] Dellinger, MD OHSU, was
21 submitted for consideration.

22 Thirty days has [*sic*] passed, with no detailed information, as to reasons for
23 objection to Dellinger * * * and Leah Kalin, MD, given that two MD[.]s
24 have stated, I have **no neurological or psychological issues**, that would
25 interfere, with the practice of Nursing[.] I respectfully wish to have the
26 issue closed.

27 In conclusion: The State of Oregon, Board of Nursing, has had thirty 30
28 days, to state a detailed medical objection, to the qualifications, of the two
29 Medical Doctors offered to the Board for evaluations.

30 (Ex. A16 at 1; emphasis in original.)

31 13. By email to Mr. Cowan, dated October 25, 2019, Mr. Logue provided a list of contacts
32 he had made thus far to schedule a neuropsychological evaluation. The contacts included the
33 following: Hazelden Springbrook; Serenity Lane; Lifeworks Northwest; Western Psychological;

1 De Paul Treatment Centers; Dr. Dellinger; and Dr. Kalin. All except for Drs. Dellinger and Kalin
2 appeared on the Board's approved evaluator list. (Ex. A17 at 1.) Western Psychological, De Paul
3 Treatment Centers, and Serenity Lane each informed Mr. Logue that they did not provide one-
4 time evaluations. (*Id.* at 4, 8, 10.) Lifeworks Northwest similarly informed Mr. Logue that they
5 were no longer providing mental health evaluations for the Board. (*Id.* at 6.) Hazelden
6 Springbrook informed Mr. Logue that they only provide drug and alcohol evaluations. (*Id.* at 12.)

7 14. Also on October 25, 2019, Mr. Logue informed Mr. Cowan via email that he attempted
8 to contact the phone number for Gorge Counseling (which appeared on the approved evaluator
9 list), and there was no such evaluator at that phone number. (Ex. A18 at 1.) On October 29, 2019,
10 Mr. Logue sent another email to Mr. Cowan, stating that he had contacted Kaiser Permanente
11 (which appeared on the list of approved evaluators) and learned that Kaiser is no longer providing
12 mental health evaluation services at the number provided by the Board. (Ex. A19 at 1.)

13 15. On November 1, 2019, Mr. Logue sent an email to Mr. Cowan that included an excerpt
14 of a progress note from his August 12, 2019 visit with Dr. Kalin. In a portion of that excerpt, Dr.
15 Kalin noted that Mr. Logue's mental status was "[a]lert and oriented x 4, mood and affect
16 congruent," and there were "[n]o focal neurological defects appreciated." (Ex. A20 at 1.) In his
17 email, Mr. Logue asserted that Dr. Kalin found "no mental health issues" and "[no] neurological
18 deficits," and the Board should therefore close the case against him. (*Id.* at 2.) By email to Mr.
19 Cowan dated November 2, 2019, Mr. Logue provided several arguments as to why the Board
20 should close its case against him. (*See id.* at 3-4.)

21 16. On November 18, 2020, the Board adopted a Stipulated Order for Suspension of
22 License.³ (Ex. A23 at 1-5.) The Stipulated Order states that Mr. Logue agreed to the following:

23 That the Registered Nurse license of Mark Logue be SUSPENDED until
24 [he] completes and the Board reviews the Board ordered neuro-psychiatric
25 evaluation. The terms of the evaluation have been outlined in the Board's
26 previously issued Order dated June 19, 2019. The suspension will begin the
date this Order is signed by the Oregon State Board of Nursing.

(*Id.* at 4.)

17. In an email to Mr. Logue dated December 7, 2020, Ms. Johnson stated, in part:

If you are ready to complete the Board ordered Neuro-Psychiatric
evaluation please find a specific provider and provide their name and
credentials to me for approval prior to scheduling your appointment. I am
unable to approve OHSU as a group, I will need a specific provider that you
intend to schedule with[.]

³ Mr. Logue had requested a contested case hearing on that notice, but ultimately reached a settlement with the Board.
(*See* Ex. A21; test. of Johnson.)

1 (Ex. A24 at 1.) In an email to Mr. Logue dated December 11, 2020, Ms. Johnson reiterated that
2 Mr. Logue was required to provide her with the name and credentials of a specific provider who
would be completing the Board-ordered neuropsychiatric evaluation. (Ex. A25 at 1.)

3 18. On January 7, 2021, Mr. Logue informed Ms. Johnson via email that Dr. Kalin had
4 placed a referral for Mr. Logue to have a mental health evaluation for depression at OHSU's Center
5 for Healing. In an email response, Ms. Johnson informed Mr. Logue that the Board required him
to have a neuropsychiatric evaluation, which is more in-depth than an office visit for an evaluation
of depression. (Ex. A27 at 1-2; test. of Johnson.)

6 19. On January 11, 2021, Mr. Logue informed Ms. Johnson via email that Monique M.
7 Jones, Assistant Professor of Psychiatry, School of Medicine, OHSU, had availability to see Mr.
8 Logue in late February or March of 2021. In a responsive email on January 12, 2021, Ms. Johnson
9 instructed Mr. Logue to confirm with the provider that they perform full neuropsychiatric
evaluations, and if so, to schedule such an evaluation and provide her with the date and time of the
appointment. (Ex. A28 at 1-2.)

10 20. On January 28, 2021, Mr. Logue informed Ms. Johnson via email that he left a message
11 for one provider (Paul Conti, M.D., of Pacific Premier Group); he tried to contact another provider
12 (Steve Saeks, Ph.D.), but the phone number was no longer in service;⁴ and he tried to contact
13 another provider (Larry Friedman, Ph.D.), and learned that he was not taking clients. All three
providers were on the Board's approved evaluator list. (Ex. A29 at 1.)

14 21. On January 29, Mr. Logue informed Ms. Johnson via email that he had an evaluation
15 appointment scheduled for 10:00 a.m. on May 6, 2021, with Pacific Premier Group. (Ex. A30 at
16 1.) In response, Ms. Johnson requested that Mr. Logue confirm that his scheduled appointment
17 was for a full neuropsychiatric evaluation, which is typically lengthy (six to eight hours) and may
be split between two appointments. On that same date, Mr. Logue informed Ms. Johnson that
there would be "several hours for testing" at his scheduled appointment. (*Id.* at 3.)

18 22. On February 1, 2021, Mr. Logue informed Ms. Johnson via email that Katy Powell, at
19 Pacific Premier Group, performs evaluations for the Board. (Ex. A31 at 3.) Ms. Johnson
20 subsequently contacted Ms. Powell, a psychiatric mental health nurse practitioner, to inquire
21 whether Ms. Powell performs neuropsychiatric evaluations. In response, Ms. Powell informed
Ms. Johnson that she does not perform such evaluations, that an appointment with her would not
satisfy the Board's requirements of Mr. Logue, and that she would ask the clinic to cancel Mr.
Logue's appointment with her. (*Id.* at 5.)

22 23. On March 5, 2021, Mr. Logue informed Ms. Johnson via email that he was attempting
23 to schedule an appointment for a neuropsychiatric evaluation with Norman Gregory Hamilton,
24 M.D. (Ex. A32 at 1.) On March 9, 2021, Mr. Logue informed Ms. Johnson that he was having
25 difficulty reaching Dr. Hamilton's office to make an appointment because of limited office hours
due to the Covid-19 pandemic. (*Id.* at 3.)

26 ⁴ See also Exhibit A33 at 4 (Mr. Logue confirming that Dr. Saeks' office was closed after trying to reach him again
on March 13, 2021).

1 24. On March 11, 2021, Mr. Logue informed Ms. Johnson via email that he had contacted
2 Larry Friedman, Ph.D., (who is on the Board’s approved evaluator list), and Dr. Friedman had
3 recently retired due to the pandemic. In the email, Mr. Logue lamented that it was “almost
4 impossible” to follow the Board’s Order for a neuropsychiatric evaluation because the Board’s list
5 of approved evaluators was so out-of-date. (Ex. A33 at 1; emphasis omitted.)

6 25. On March 12, 2021, Mr. Logue informed Ms. Johnson via email that he was attempting
7 to schedule a neuropsychiatric evaluation with Thomas Dodson, M.D., a forensic psychiatrist. (Ex.
8 A33 at 3.)

9 26. On March 20, 2021, Mr. Logue sent an email to Ms. Johnson, which stated in part:

10 All the people I have contacted in the past few weeks have either closed
11 their Office or refuse to return phone calls * * *.

12 Pacific Premier Group Mental Health, located in Portland, stated, “At this
13 time in Oregon no provider can offer the Mental Health Services the BON
14 is demanding due to the COVID-19 Pandemic, the Board is placing those
15 Nurses in an impossible situation[.]”

16 The BON should allow the evaluation from two MDs of Internal Medicine
17 at OHSU and allow me to continue the practice of Nursing in Oregon, the
18 evaluation of two outstanding MDs of Internal Medicine at OHSU should
19 be sufficient to resolve this situation.

20 The ORDER placed on me failed to take into consideration the impact of
21 the COVID-19 Pandemic on the Mental Health Community to evaluate
22 clients which are not currently in a mental health crisis.

23 (Ex. A33 at 5.)

24 27. On April 1, 2021, Mr. Logue informed Ms. Johnson via email that he had contacted
25 Acumen Assessments (who was on the Board’s approved evaluator list) and learned that an
26 evaluation with that provider would require travel and lodging, which made the total cost of the
27 evaluation prohibitively expensive for him. (Ex. A34 at 1.)

28 28. In a June 9, 2021, email to Ms. Johnson, Mr. Logue requested that the Board allow
29 Mr. Logue to be evaluated by Thomas Patrick Welch, M.D., a psychiatry and neurology
30 practitioner. (Ex. A35 at 1-2.) However, on June 15, 2021, Mr. Logue informed Ms. Johnson that
31 he subsequently learned from Dr. Welch’s office that the provider did not have any availability to
32 perform an evaluation of Mr. Logue. (*Id.* at 4.)

33 29. On August 9, 2021, Mr. Logue provided the Board with written documentation of
34 some of his attempts to contact providers and schedule the Board-ordered neuropsychological
35 evaluation. (*See* Ex. A36 at 1-2.) The document states, in part, “Paul Conti Pacific Premier Group

1 * * * interview cancelled by Heather Johnson[.]” (*Id.* at 2.) Ms. Johnson never received
2 confirmation that Mr. Logue had an appointment scheduled with Dr. Conti. Ms. Johnson did not
cancel an evaluation appointment regarding Mr. Logue. (Test. of Johnson.)

3 30. On February 15, 2022, Mr. Logue provided the Board with a copy of a Department of
4 Veterans Affairs (VA) Central Nervous System and Neuromuscular Diseases Disability Benefits
5 Questionnaire. (Ex. A37 at 1-9.) The questionnaire was based on an in-person examination of
6 Mr. Logue and a records review by Robert D. Barriatua, M.D., an emergency medicine specialist.
(*See id.* at 3, 9.) This documentation does not constitute evidence of a neuropsychiatric evaluation.
(Test. of Johnson and Parish.)

7 31. On May 17, 2022, Mr. Logue requested that Ms. Johnson provide him with an updated
8 Board-approved evaluator list. On May 18, 2022, Ms. Johnson provided an updated list to Mr.
Logue.⁵ (Ex. A38 at 1-6.)

9 32. On May 25, 2022, Mr. Logue informed Ms. Johnson via email that Michael Schwartz,
10 M.D., agreed to perform a “Mental Health Evaluation” on Mr. Logue, and that the provider
11 requested a phone call from Ms. Johnson. (Ex. A39 at 1.) A mental health evaluation is different
than a neuropsychiatric evaluation. (Test. of Johnson.)

12 33. On January 21, 2024, Mr. Logue’s RN license expired (*i.e.*, lapsed). (Ex. A41 at 1-2;
13 test. of Parish.) On March 1, 2024, he submitted an application to reactivate the license.⁶ (Ex.
A40 at 1-10.)

14 34. By letter to Mr. Logue dated September 18, 2024, the Board’s Investigations
15 Department acknowledged receipt of Mr. Logue’s application to reactivate his RN license and
16 requested that Mr. Logue provide certain information to the Board no later than October 3, 2024.
17 That information included whether Mr. Logue had obtained a neuropsychological evaluation, and,
18 if so, the date of the evaluation, the name and credentials of the evaluator, and contact information
19 for the evaluator. The letter also requested that Mr. Logue fill out and sign a release of information
form for any such evaluation, if it existed. (Ex. A42 at 1.) At the time of the hearing, the Board
had not received any of the requested information from Mr. Logue (or anyone on his behalf). (Test.
of Parish.)

20 35. On December 20, 2024, Board Investigator Maria Parish informed Mr. Logue, in
21 writing, that the Board would be reviewing his case at an upcoming Board meeting. Ms. Parish
22 invited Mr. Logue to submit any information he wished the Board to consider no later than January
3, 2025. (Ex. A43 at 1.)

23 36. On April 1, 2025, the Board received a written message from Mr. Logue that stated as
24 follows:

25 ⁵ At hearing, Ms. Johnson testified that the list gets updated periodically. (Test. of Johnson.)

26 ⁶ OAR 851-031-0051(1) provides that reactivation of a license is required “if the license has been expired more than
30 calendar days.”

1 Heather Johnson RN cancelled the neuropsychiatric eval after payment was
2 made and the date was set for evaluation. The Nurse Practice Act allows
3 the evaluation to be performed by two providers. My attorney stated the
4 Board has no jurisdiction in a Federal Case, advocating for a federal inmate
5 being abused is not a violation of the Nurse Practice Act. Drop the case and
6 return my RN license. The Board stated Heather Johnson RN abused all
7 her clients, the case has no merit.

8 (Ex. A44 at 1.)

9 37. The Board's investigation that began in 2019 remained open at the time of the hearing.
10 (Test. of Johnson.) As of the date of the hearing, Mr. Logue had not completed the Board-ordered
11 neuropsychiatric evaluation. (Test. of Parish and Johnson.)

12 38. It is not the Board's practice to recommend a specific provider to a licensee who needs
13 to complete a Board-ordered evaluation or to set up an evaluation appointment for the licensee.
14 (Test. of Johnson.)

15 CONCLUSIONS OF LAW

16 1. Mr. Logue failed to complete a Board-ordered neuropsychiatric evaluation and therefore
17 engaged in conduct derogatory to the standards of nursing pursuant to *former* OAR 851-045-
18 0070(10)(d) and *current* OAR 851-045-0070(10)(d) and (e).

19 2. The Board may revoke Mr. Logue's RN license and deny his application for reactivation
20 of his RN license.

21 OPINION

22 The Board has proposed revocation of Mr. Logue's RN license and denial of his application
23 to reactivate his license on the ground that he engaged in conduct derogatory to the standards of
24 nursing. Regarding the proposed license revocation, the Board must prove its allegations against
25 Mr. Logue by a preponderance of the evidence, and it must establish that revocation is warranted
26 under the facts of the case. *See* 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"); *Harris v.*
SAIF, 292 Or 683, 690 (1982) (general rule regarding allocation of burden of proof is that the
burden is on the proponent of the fact or position); *Dixon v. Board of Nursing*, 291 Or App 207,
213 (2018) (the standard of proof that generally applies in agency proceedings is the preponderance
standard). 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). With regard to Mr. Logue's application for license reactivation, he bears the
burden of establishing his fitness for licensure. *See Sobel v. Board of Pharmacy*, 130 Or App 374,
380 (1994), *rev den* 320 Or 588 (1995) ("In an application proceeding, it is the applicant who has
the burden of establishing eligibility, qualifications, and fitness").

1 ORS 678.111(1)(f) and (g) provide, in relevant part:

2 (1) The Oregon State Board of Nursing may refuse to issue a license to
3 practice nursing * * * or may revoke or suspend a license, issue a limited
4 license, censure or reprimand or place on probation, subject to any
5 conditions imposed by the board, a person issued a license, for any of the
6 following causes:

7 * * * * *

8 (f) Conduct derogatory to the standards of nursing.

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

11 **1. Conduct derogatory to the standards of nursing**

12 As relevant to this matter, the version of OAR 851-045-0070 in effect from August 1, 2017
13 through June 30, 2024, defined “conduct derogatory to the standards of nursing” as follows:

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

18 * * * * *

19 (10) Conduct related to the licensee’s relationship with the Board:

20 * * * * *

21 (d) Violating the terms and conditions of a Board order[.]

22 The current version of OAR 851-045-0070 similarly provides, in relevant part:

23 Conduct derogatory to the practice of nursing is conduct that adversely
24 affects the health, safety, and welfare of the public; that fails to conform to
25 OAR 851-045 scope and standards of practice; or that fails to conform to
26 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:

* * * * *

1 (d) Violating the terms and conditions of a Board order; or

2 (e) Failing to comply with the terms and conditions of a Board order or
3 stipulated agreement.

4 On June 19, 2019, as part of an investigation into allegations that Mr. Logue practiced
5 outside of his scope, violated professional boundaries, and assisted a client to violate their parole,
6 the Board issued an Order for Neuropsychiatric Evaluation. The Order required Mr. Logue to
7 undergo a neuropsychiatric evaluation with a Board-approved evaluator. The Board provided Mr.
8 Logue with a list of approved evaluators, and advised that if he wanted to use an evaluator not on
9 the list, he had to submit the evaluator's name and curriculum vitae to the Board for its approval.
10 The Order provided deadlines for Mr. Logue to schedule an evaluation with a Board-approved
11 evaluator (*e.g.*, within 10 days of the Order being issued to him), notify the Board of the name of
12 the evaluator and the date and time of the evaluation, and complete the evaluation. *See* Exhibit
13 A5 at 4.

14 Although the record shows that Mr. Logue made some efforts to find an approved evaluator
15 with whom he could schedule an evaluation, he failed to fulfill the requirement to schedule an
16 evaluation with a Board-approved evaluator within 10 days of the issuance of the Order (*i.e.*, by
17 June 29, 2019). Therefore, on July 18, 2019, the Board issued a Notice of Proposed Revocation
18 of Registered Nurse License to Mr. Logue. *See* Exhibit A13 at 1-2.

19 Subsequently, Mr. Logue entered into a Stipulated Order for Suspension of License. The
20 Board approved the Stipulated Order on November 18, 2020. Under the terms of the Stipulated
21 Order, Mr. Logue's RN license was placed in suspended status pending his completion of the
22 Board-ordered evaluation (under the terms set forth in the June 19, 2019, Order) and the Board's
23 review of that evaluation.

24 The record shows that after entering into the Stipulated Order, Mr. Logue again made some
25 efforts to find an approved evaluator with whom he could schedule an evaluation. Unfortunately,
26 he encountered difficulties, at least in part, related to a scarcity of available providers due to the
Covid-19 pandemic and the fact that the Board's approved evaluator list did not contain the most
accurate, up-to-date information.

Although Mr. Logue still had not completed the required evaluation (and did not have a
scheduled appointment with an approved evaluator), he nonetheless remained in contact with the
Board and kept Ms. Johnson, in particular, apprised of his efforts through May 25, 2022. However,
after that date, there is no evidence that Mr. Logue made further efforts to comply with the Board's
order to schedule and complete the neuropsychiatric evaluation.

At the time of the September 29, 2025 hearing, the Board's investigation remained open,
and Mr. Logue had still not completed the Board-ordered neuropsychiatric evaluation.

The record persuasively establishes that Mr. Logue has failed to comply with the terms and
conditions of the June 19, 2019, Order for Neuropsychiatric Evaluation and the November 18,

1 2020, Stipulated Order of Suspension. This constitutes “conduct derogatory to the standards of
2 nursing” under *former* OAR 851-045-0070(10)(d) and *current* OAR 851-045-0070(10)(d) and (e).
3 Mr. Logue is therefore subject to discipline under ORS 678.111(1)(f) and (g).

3 **2. License revocation and denial of application to reactivate license**

4 Pursuant to ORS 678.111(1)(f) and (g), the Board seeks to revoke Mr. Logue’s RN license
5 and deny his application for license reactivation. ORS 678.158 pertains to the Board’s continuing
6 authority to act against a license in lapsed status and states, in part:

7 The lapse, suspension or revocation of a license * * * by the operation of
8 law or by order of the [Board] or by the decision of a court of law, or the
9 voluntary surrender of a license by a licensee * * *, shall not deprive the
10 board of jurisdiction to proceed with any investigation of or any action or
11 disciplinary proceeding against the licensee * * *.

12 *See also* ORS 676.205(2).⁷

13 Although Mr. Logue initially made efforts to comply with the Board’s orders to schedule
14 and complete a neuropsychiatric evaluation with a Board-approved evaluator, he fell short of
15 completing the requirement. After May 2022, there is no evidence that he made any additional
16 efforts. As the Board pointed out in its closing argument, Mr. Logue was first licensed as an RN
17 in Oregon in 1997, and he therefore has the education and experience to navigate the Board’s
18 requirement that he schedule and complete a neuropsychiatric evaluation with a Board-approved
19 evaluator. Despite the difficulties he encountered regarding a lack of available providers and the
20 Board’s out-of-date evaluator list, the fact remains that Mr. Logue has now had more than five
21 years to complete the Board-ordered evaluation. The record does not demonstrate that Mr. Logue
22 has any continuing desire or intention to schedule and complete the evaluation, and thereby comply
23 with the Board’s orders.

24 The Board is authorized under ORS 678.111(1)(f) and (g) to revoke Mr. Logue’s RN
25 license and deny his reactivation application and, on this record, there is sufficient justification to
26 do so.

///

///

⁷ ORS 676.205 provides:

A health professional regulatory board continues to have jurisdiction for licensing,
regulatory and disciplinary purposes related to acts and omissions that occur while
a person is licensed or required to be licensed, regardless of any changes in the
licensing status of the person.

The Board of Nursing is a health professional regulatory board. *See* ORS 676.160(9).

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26

FINAL ORDER

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

Mark Scott Logue’s registered nurse license is revoked, and his application to reactivate his registered nurse license, submitted on March 1, 2024, is denied.

DATED this 15th day of April, 2026.

FOR THE BOARD OF NURSING OF THE STATE OF OREGON



Olanike Towobola, DNP, RN
Board President

APPEAL

NOTICE: You are entitled to judicial review of this order pursuant to ORS 183.480 *et seq.* If you wish to appeal the final order, you must file a petition for judicial review with the Oregon Court of Appeals within sixty (60) days of the date this final order is served on you.

**BEFORE THE
STATE OF OREGON
OREGON STATE BOARD OF NURSING**

IN THE MATTER OF:) **FINAL ORDER**
)
ANNE MEEKS) OAH Case No. 2025-ABC-07122
) Agency Case No. 2025030079
)

This matter came before the Oregon State Board of Nursing (Board) at its April 15, 2026, meeting to consider the Proposed Order issued by Senior Administrative Law Judge (ALJ) Samantha A. Fair on March 24, 2026.

The Proposed Order provided Anne Meeks (Licensee) with information on filing exceptions. The exceptions deadline was April 3, 2026. The Board did not receive exceptions to the Proposed Order.

After considering the record, the Board adopts the ALJ's History of the Case, Issues, Conclusions of Law, and Opinion with minor modifications as explained below. The Board adopts the Evidentiary Rulings, Findings of Fact, and proposed sanction without modification and adopts the following Final Order.

HISTORY OF THE CASE¹

On May 1, 2025, the Oregon State Board of Nursing (Board) issued Anne Meeks a Notice of Proposed Revocation of Registered Nurse License. On May 19, 2025, Ms. Meeks requested a hearing.

On May 21, 2025, the Board referred the matter to the Office of Administrative Hearings (OAH). The OAH assigned the matter to Administrative Law Judge (ALJ) Elizabeth Jarry and scheduled the matter for a prehearing conference on June 16, 2025. On June 6, 2025, Ms. Meeks requested a postponement of the prehearing conference. The ALJ granted the unopposed request and scheduled the prehearing conference for July 15, 2025. On July 3, 2025, Ms. Meeks requested a postponement of the prehearing conference. The ALJ granted the unopposed request and scheduled the prehearing conference for July 29, 2025.

On July 29, 2025, ALJ Jarry convened a prehearing conference. Ms. Meeks appeared. Senior Assistant Attorney General (AAG) Kristen Williams appeared on the Board's behalf. Heather Primus also appeared on behalf of the Board. ALJ Jarry scheduled a hearing for October 30, 2025, and set deadlines for the submission of witness lists and exhibits.

On September 2, 2025, the Board filed a Motion for Protective Order and a proposed Protective Order Limiting Use and Disclosure. On September 2, 2025, ALJ Jarry granted the

¹ The Board modified History of the Case to clarify that the postponement requests were not opposed.

unopposed motion, and the OAH issued the Protective Order Limiting Use and Disclosure.

On September 11, 2025, the OAH reassigned the matter to ALJ Samantha Fair.

On September 18, 2025, the Board issued Ms. Meeks an Amended Notice of Proposed Revocation of Registered Nurse License (Amended Notice).

On October 27, 2025, the Board requested a postponement of the hearing. The ALJ granted the unopposed request and scheduled a prehearing conference for October 30, 2025. On October 30, 2025, ALJ Fair convened a prehearing conference. Ms. Meeks and Ms. Williams appeared. ALJ Fair scheduled a hearing for December 19, 2025, and set deadlines for the submission of any supplemental witness lists and exhibits. On November 21, 2025, the Board requested a postponement of the hearing. The ALJ granted the unopposed request and scheduled a prehearing conference for December 19, 2025. On December 19, 2025, ALJ Fair convened a prehearing conference. Ms. Meeks, Ms. Williams, and Ms. Primus appeared. ALJ Fair scheduled a hearing for March 11, 2026, and set deadlines for the submission of any supplemental witness lists and exhibits.

On March 11, 2026, ALJ Fair convened a hearing at the Board's location in Portland, Oregon. Ms. Meeks appeared and testified. Ms. Williams represented the Board. Nikki Blomquist, the Board's lead compliance specialist, appeared as the Board's agency representative and testified. Also testifying on the Board's behalf were Kelly Nichols, Director of Nursing at the Pacific Cardiovascular Surgery Center (PCSC), and Dr. Penelope Ziegler, a consultant for Affinity eHealth (Affinity). The record closed on March 11, 2026, at the conclusion of the hearing.

ISSUES²

1. Whether Ms. Meeks engaged in conduct derogatory to the standards of nursing in the following manner:

- By violating conditions and/or failing to comply with conditions 1, 17, and 18 of the May 17, 2023 stipulated Board order; and
- By engaging in dishonesty and failing to answer truthfully questions asked by the Board.

ORS 678.111(6) and (7)³ and OAR 851-045-0070(1) and (10) (July 1, 2024).

² The Board modified Issue 1 to clarify the issue and modified its related footnote to clarify that this Final Order cites the version of the statute in effect at the time of the Final Order.

³ ORS 678.111 was amended with an effective date of January 1, 2026. The amendment made no substantive changes to the portions of the cited statute that would affect the outcome, but renumbered the cited statutory provisions. Throughout the aforementioned amendments, the authority of the Board to revoke or otherwise sanction a license for conduct derogatory to the standards of nursing has remained unchanged. All subsequent citations to the statute in this Final Order are to the version of the statute in effect at the time of the Final Order.

2. Whether the Board should revoke Ms. Meeks' registered nurse license. ORS 678.111(1).

EVIDENTIARY RULINGS

Exhibits A1 through A45, offered by the Board, were admitted into the record without objection. Exhibits R1 and R2, offered by Ms. Meeks, were admitted into the record without objection.

FINDINGS OF FACT

1. The Board issued Ms. Meeks a registered nurse (RN) license on February 2, 2009, with a current expiration date of December 22, 2026. (Ex. A1 at 1.)

2. In 2014, Ms. Meeks entered the Health Professionals' Services Program (HPSP), seeking help for her alcohol use. (Ex. A4 at 2.) In July 2015, Ms. Meeks attended a 28-day inpatient alcohol treatment program, during which she received a diagnosis of alcoholism. (Ex. A3 at 2.) On April 13, 2016, the Board placed Ms. Meeks on 36 months of probation for violating the terms of the HPSP by consuming alcohol. (Exs. A1 at 1; A4 at 2.)

3. In December 2018, Ms. Meeks significantly relapsed, resulting in multiple tests that were positive for alcohol consumption. (Ex. A3 at 1.) On April 29, 2019, Ms. Meeks signed a Stipulated Order for Voluntary Surrender of her RN license to avoid discipline for conduct derogatory to the standards of nursing for the multiple positive tests. (Ex. A2 at 1-2.) The order became effective on June 12, 2019. (Exs. A1 at 2; A2 at 2.) Ms. Meeks continued to heavily consume alcohol that resulted in a hospitalization in July 2019. She achieved sobriety from alcohol after the hospitalization stay. (Ex. A3 at 1.)

4. On June 29, 2022, Ms. Meeks filed an application for reinstatement of her RN license with the Board. (Ex. A3.) On April 24, 2023, Ms. Meeks signed a Stipulated Order for Probation (Re-Entry) (Stipulated Order) that required Ms. Meeks to complete 24 months of monitored probation within 36 months of the Board's acceptance of the Stipulated Order. (Ex. A4 at 2-4, 7.) Additional terms and conditions of her probation included the following:

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

* * * * *

17) Applicant shall participate in the Board's random testing program. Failure to comply with random urine, blood, hair, nail, or any other requested drug test shall result in Applicant's immediate removal from nursing practice. Applicant shall submit to observed tests to determine the presence of unauthorized substances immediately upon request by

Board staff or Applicant's employer. * * *. The presence of unauthorized substances may be considered a violation of the terms and conditions of this Stipulated Order. * * *. Applicant understands that Applicant is financially responsible for any and all costs related to testing and evaluating. * * *.

18) Applicant 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 19 below.⁴ Applicant shall avoid any over-the-counter products and food items containing alcohol, THC including CBD products, and poppy seeds.

* * * * *

20) Applicant shall cease practicing as a nurse upon the occurrence of a relapse, * * *.

21) * * *. Applicant shall provide Board staff with the names and contact information of any and all health care providers. Applicant shall sign any release of information necessary to allow Board staff to communicate with Applicant's healthcare providers and release Applicant's medical and treatment records to the Board. * * *.

22) Applicant 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.

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

Applicant 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.

(*Id.* at 4-6.) Directly above Ms. Meeks' signature, the Stipulated Order included the following statement:

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

(*Id.* at 7.) The Board accepted the Stipulated Order on May 17, 2023. (*Id.*)

⁴ Section 19 provides for the use of medications pursuant to a legal prescription with prior notice to the Board.

5. For its random testing program, the Board utilizes Affinity as the laboratory vendor. (Ex. A5 at 2.) Affinity does not collect and test the specimens. It utilizes a network of third-party collection sites that collect the specimens, these collection parties forward the specimens to third-party laboratories that perform the tests, and Affinity reviews and posts the results in its online database and communication system. (Test. of Zeigler.)

6. Laboratories test for the presence of cannabinoids, which is the metabolite made when a person ingests marijuana. If the cannabinoid presence is less than 20, then the test result is considered negative. If the cannabinoid presence is greater than 20, the laboratory will test for the presence of delta-9 THC, which is the psychoactive, mind-alternating substance in marijuana. (Test. of Zeigler.)

7. When testing a urine sample, laboratories also test two components of urine: the creatinine level (a natural secretion produced by humans) and the specific gravity. A normal creatinine level is between 20 and 30 mg/dL. A creatinine level below 20 is considered out of range and indicative of dilution, usually caused by drinking excessive amounts of fluids before a test, or the addition of a chemical substance. A creatinine level below 10 is highly likely caused by active efforts to dilute with excessive fluid ingestion or a chemical substance. When the creatinine level is below 20 and the specific gravity is below 1.010 mg/dL, the urine sample is deemed diluted. Dilution of urine specimen results in artificially low THC levels and the possibility of a negative test result if the dilution drives the level below the 20 cannabinoid cutoff. Urine samples with low creatinine can be normalized, which would result in higher THC levels. (Test. of Zeigler.) Normalizing THC levels when creatinine levels are abnormally low provides a more accurate view of whether a subject's THC levels are rising or falling. (Test. of Blomquist.)

8. CBD products will also contain THC even if in low amounts. A laboratory test cannot distinguish the source of the THC. (Test. of Zeigler.)

9. As part of the monitoring program, probationers must check in daily from Monday through Friday on the Affinity online system. At the check-in, the system will inform the probationer whether they have been selected for a test that must be taken that same day. (Test. of Blomquist.) Typically, a participant will be called for testing twice per month. (Ex. A38 at 3, 5.) There are multiple collection sites, including out-of-state but not out-of-country sites, with varying hours and fees. (Test. of Blomquist.) Collection fees are usually from \$20, \$50, to \$60 for a single collection. (Exs. A35 at 15; A38 at 7.) Probationers must post the fees to their accounts prior to testing and take photo identification to the collection site. If the probationer fails to appear for a test, it will be noted as a missed test unless Board staff excused it based upon the probationer's reason for missing the test. (Test. of Blomquist.)

10. On June 1, 2023, Board staff sent a letter to Ms. Meeks to schedule her first probation appointment. (Ex. A5 at 1.) The letter included a list of the "**MOST IMPORTANT THINGS**" for probation participants, one of which was the following: "Remember that alcohol and marijuana are drugs...and that your PROBATION agreement says you will abstain from both." (*Id.* at 2.) (Emphasis in original.) Within a week of the Board's letter, Affinity sent a

packet to Ms. Meeks with the instructions for her to begin the random testing program. (*Id.* at 1; test. of Blomquist.)

11. By August 2023, Ms. Meeks obtained new nursing employment with PCSC, providing onsite patient care. (Ex. A7 at 2; test. of Nichols.) Her pre-employment drug screen test for the job was positive for marijuana. Board staff excused Ms. Meeks' first Affinity-scheduled test because Ms. Meeks noted she lacked funds to pay for the test. On August 3, 2023, Ms. Meeks was again selected for a drug test through Affinity. Ms. Meeks again informed Board staff that she could not pay for a drug test. Board staff noted that, since her pre-employment drug screen was positive and the prior drug selection test was rescheduled for the same financial reason, Ms. Meeks' failure to test would be noted as a missed test. (Ex. A6 at 1-2.)

12. On August 29, 2023, Ms. Meeks took her first Affinity-scheduled drug test.⁵ (Ex. A39 at 3.) The result was positive for marijuana with a THC level of 274 nanograms per milliliter (ng/mL) and a creatinine level of 10.1 milligrams per deciliter (mg/dL). A normalized THC level would be 2,712 ng/mL. (Ex. A43 at 1.)

13. On September 8, 2023, Board staff advised Ms. Meeks that her prior sample was diluted, and she should not drink too much water or caffeinated beverages prior to testing. Board staff also warned her not to use anything with THC, including CBD. (Ex. A11 at 19.)

14. On September 11, 2023, Ms. Meeks was selected for a random test. She contacted Board staff, indicating that her wallet had been stolen and she had not yet replaced her driver license. Board staff rescheduled her test. On September 26, 2023, Ms. Meeks advised Board staff that she had obtained her replacement driver license. (Ex. A9 at 1.)

15. On October 3, 2023, Ms. Meeks provided a urine sample that tested positive for marijuana with a THC level of 239 ng/mL. The test sample had a creatinine level of 9.2 mg/dL and a specific gravity of 1.0022. (Ex. A8 at 1-2.) The normalized THC level would be 2,597 ng/mL. (Ex. A43 at 1.)

16. On October 11, 2023, Board staff warned Ms. Meeks that her urine samples continued to be diluted. (Ex. A11 at 16.)

17. On October 24, 2023, Ms. Meeks missed a test, informing Board staff that she did not have the funds to pay for the test. Board staff advised Ms. Meeks, because of her history of very few completed tests and multiple excused tests, that tests would no longer be excused for lack of funds unless she informed the Board of her funding issues in advance. Ms. Meeks responded that she would make sure to budget for the tests. (Ex. A9 at 2.)

18. On October 30, 2023, Ms. Meeks was selected for a test. Prior to taking the test, she informed Board staff that she had taken a CBD gummy the prior night to help her sleep. In response, Board staff reminded Ms. Meeks that a condition of her Stipulated Order was no use of

⁵ Ms. Meeks had completed one prior test that only tested for alcohol. (Ex. A39 at 3.)

marijuana and that prohibition included THC and CBD. (Ex. A10 at 1.) The test was positive for marijuana with a THC level of more than 300 ng/mL⁶ and a creatinine level of 14.8 mg/dL. (Ex. A43 at 1.)

19. By January 30, 2024, Ms. Meeks was still testing positive for THC, but the level was now 26 ng/mL, just above the cutoff of 20, with a creatinine level of 19.2 mg/dL. (Ex. A11 at 6.) On February 16, 2024, Ms. Meeks provided a urine sample that tested negative for marijuana with a creatinine level of 21.2 mg/dL. (Ex. A44 at 1.)

20. On March 25, 2024, Ms. Meeks informed Board staff that she ate a food item at a family event that made her feel “weird” and expressed concern that she may test positive at her next drug test. (Ex. A11 at 4.)

21. On April 8, 2024, Ms. Meeks provided a urine sample that tested positive for marijuana with a THC level of 960 ng/mL. Her creatinine level was 13.0 mg/dL with a specific gravity of 1.0037. (Ex. A12 at 1.) The normalized THC level would be 7,384 ng/mL. (Ex. A43 at 1.) Based on that high result, on April 18, 2024, Board staff informed Ms. Meeks that a report would be filed for the Board’s consideration. (Ex. A11 at 3.)

22. Ms. Meeks failed to take a scheduled test on April 25, 2024, and did not complete that test until April 30, 2024. (Ex. A11 at 1.) On April 30, 2024, she provided a urine sample that tested positive for marijuana with a THC level of more than 300 ng/mL. Her creatinine level was 29.9 mg/dL with a specific gravity of 1.004. (Ex. A13 at 1.)

23. On May 29 and July 10, 2024, Ms. Meeks provided urine samples that tested positive for marijuana with each having THC levels of more than 300 ng/mL. The May sample had a creatinine level of 32.9 mg/dL, and the July sample had a creatinine level of 7.2 mg/dL and a specific gravity of 1.0018. (Exs. A14 at 1-2; A43 at 1.)

24. On July 29, 2024, Ms. Meeks informed Board staff that she was being admitted to the hospital after passing out in the shower that morning. Board staff advised her to send them a copy of her medical documentation. (Ex. A17 at 2.) On July 31, 2024, Ms. Meeks was scheduled for a test. She informed Board staff that she remained hospitalized with the doctor inserting a heart monitoring implant. Board staff excused her test and rescheduled it. On August 15, 2024, Ms. Meeks reported that she was being discharged from the hospital that same day. (*Id.* at 1.)

25. Ms. Meeks worked her scheduled shifts at PCSC on August 1, 2, 5, 6, 8, 9, 12, 13, and 15. (Ex. A26 at 5-6.) All work performed by Ms. Meeks for PCSC is onsite work, and she never works from home. (Ex. A37 at 2.)

26. On August 16, 2024, Ms. Meeks provided a urine sample that tested positive for marijuana with a THC level of 253 ng/mL. Her creatinine level was 6.4 mg/dL and the specific gravity was 1.0046. (Ex. A18 at 1.) The normalized THC level would be 3,953 ng/mL. On

⁶ Some laboratories report exact THC levels while other laboratories report greater than noted cutoff levels. (Ex. A11 at 1; test. of Zeigler.)

August 27, 2024, Ms. Meeks provided a urine sample that tested positive for marijuana with a THC level of 250 ng/mL and a creatinine level of 8.9 mg/dL. The normalized THC level would be 2,808 ng/mL. (Ex. A43 at 1.)

27. On September 18, 2024, the Board voted to allow Ms. Meeks to continue her probation but with a last chance warning. On September 19, 2024, Board staff issued a letter to Ms. Meeks that informed her that any issues of non-compliance with the Stipulated Order, including increasing THC levels, would result in the Board considering further disciplinary action. (Ex. A19 at 1.)

28. On September 18, 2024, Ms. Meeks provided a urine sample that tested positive for marijuana with a THC level of 480 ng/mL. Her sample had a creatinine level of 8.3 mg/dL and a specific gravity of 1.0023. (Ex. A20 at 1-2.) The normalized THC level would be 5,783 ng/mL. (Ex. A43 at 1.) Because she provided the sample on the same date that the Board issued the last chance letter, the Board decided not to take any immediate action against Ms. Meeks. (Ex. A23 at 10.)

29. On September 23, 2024, Board staff sent Ms. Meeks a letter, warning her of the dilute urine samples with increasing THC levels. The letter included the warning that Ms. Meeks must abstain from the use of products that contain THC. (Ex. A21 at 1.) In response, Ms. Meeks acknowledged using products that contain THC and CBD for pain and asserted that she would avoid such products in the future. (Ex. A22 at 1.)

30. On October 9, 2024, Ms. Meeks informed Board staff that she took a CBD gummy or a combination CBD and THC gummy for pain prior to the September 18, 2024, test. (Ex. A23 at 3, 6.) Ms. Meeks and Board staff also discussed her July and August hospital stay, in which Ms. Meeks continued to assert that she was hospitalized and indicated she would provide the discharge paperwork to Board staff. (*Id.* at 12-13.)

31. On October 28, 2024, Ms. Meeks provided a urine sample that tested positive for marijuana with a THC level of more than 300 ng/mL and a creatinine level of 18.9 mg/dL.⁷ (Ex. A43 at 1.)

32. On November 13, 2024, Ms. Meeks failed to check in with Affinity. Affinity had her scheduled to perform a random drug test that day, and Ms. Meeks failed to show for the test. (Exs. 39 at 1; A40 at 1.)

33. On November 18, 2024, Ms. Meeks provided a urine sample that tested positive for marijuana with a THC level of 243 ng/mL and a creatinine level of 16.6 mg/dL. The normalized THC level would be 1,463 ng/mL. (Ex. A43 at 1.)

34. On November 24, 2024, Ms. Meeks informed Board staff that she was going to Canada for a few days because her sister-in-law had been hospitalized. On November 25, 2024, Ms. Meeks was selected for a random drug test that she missed. Board staff requested hospital

⁷ The THC level of a urine sample with a low creatinine level cannot be normalized when the exact THC level is unknown. (Test. of Blomquist.)

documentation to support Ms. Meeks' absence and missed drug test. On November 28, 2024, Ms. Meeks informed Board staff that she would not be returning home before the weekend as originally planned because her sister-in-law's discharge date had been postponed. On December 4, 2024, Ms. Meeks informed Board staff that she "ran into some weather" on the way home that might delay her return. (Ex. A25 at 1.) On December 5, 2024, she informed Board staff that she anticipated returning home late on December 6, 2024. (*Id.*)

35. Ms. Meeks worked her shifts at PCSC on November 25 and 26 and December 2, 3, 5, and 6, 2024. (Ex. A26 at 13-14.)

36. On December 9, 2024, Ms. Meeks provided a urine sample that tested positive for marijuana with a THC level of 204 ng/mL and a creatinine level of 25.9 mg/dL. The normalized THC level would be 787 mg/dL. (Ex. A43 at 1.)

37. On December 27, 2024, Ms. Meeks failed to check in with Affinity and failed to appear for the scheduled drug test for that day. On December 29, 2024, Ms. Meeks informed Board staff that she missed her drug test because someone broke into her car and stole her insurance, phone, and laboratory forms. (Exs. A27 at 1; A40 at 1.) When Board staff asked for a copy of the police report, Ms. Meeks advised that she did not file one. (Ex. A28 at 1-2.)

38. On January 30, 2025, Ms. Meeks provided a urine sample that tested positive for marijuana with a THC level of 169 ng/mL and a creatinine level of 25.1 mg/dL. The normalized THC level would be 673 ng/mL. (Ex. A43 at 1.)

39. On February 14, 2025, Ms. Meeks informed Board staff that snowy road conditions made her arrive too late at the lab for a test. Board staff instructed Ms. Meeks to take the test on February 18, 2025. On February 18, 2025, Ms. Meeks informed Board staff that she could not take the test because her bank had put a freeze on her bank account. In response, Board staff warned Ms. Meeks that continued missed tests may result in the submission of her case to the Board for review of her probation. (Ex. A30 at 2.) By the morning of February 20, 2025, Ms. Meeks had still not provided a urine sample. On February 21, 2025, Ms. Meeks provided a urine sample that tested positive for marijuana with a THC level of 111 ng/mL. Her sample had a creatinine level of 17.9 mg/dL and a specific gravity of 1.0022. (Ex. A31 at 5.) The normalized THC level would be 620 ng/mL. (Ex. A43 at 1.)

40. On March 3, 2025, Ms. Meeks failed to check in with Affinity and missed a test. On March 4, 2025, Ms. Meeks informed Board staff that she had been sick, had not been sleeping, slept all day the day before, and planned on seeing a doctor. On March 5, 2025, Ms. Meeks informed Board staff that she had seen a doctor and tested positive for strep and COVID. Board staff requested a copy of the report from her medical appointment. (Ex. A30 at 1.) On March 6, 2025, Ms. Meeks provided Board staff documentation purporting to be from The Doctor's Clinic and referencing a visit summary for Ms. Meeks on March 4, 2025 with Dr. Hoa Hoang. The visit summary noted complaints of sore throat and fatigue, a temperature of 101.3, positive test results for strep and COVID, and a prescription for Amoxicillin for five days. (Exs. A30 at 1; A32 at 1.) On March 9, 2025, Ms. Meeks informed the Board that she continued to experience fevers. On March 10, 2025, Ms. Meeks reported that, per the doctor, she was no longer

contagious. During her reported illness, Board staff had suspended her testing. (Ex. A34 at 2.)

41. Ms. Meeks worked her scheduled shifts at PCSC on March 3, 4, 6, and 7, 2025. (Ex. A26 at 20.)

42. On March 14, 2025, Board staff again requested Ms. Meeks to send medical records, including for the Canada trip, and sent her a release of information form to sign and return so that Board staff could directly obtain the records. Board staff also informed her that a report was being submitted to the Board regarding her missed tests. On March 16, 2025, Ms. Meeks still had not returned the release forms but sent documentation that purported to be medical records from Salem Hospital, listing an admission date of July 30, 2024, and a discharge date of August 15, 2024, for Ms. Meeks, and medical records from Vancouver (BC) General Hospital, showing a date of service of November 22, 2024, for KD (presumably the sister-in-law). (Exs. A33 at 1-6; A34 at 1.)

43. On March 14, 2025, Ms. Meeks provided a urine sample that tested positive for marijuana with a THC level of 207 ng/mL and a creatinine level of 110 mg/dL. (Ex. A36 at 2.)

44. After the Board's persistent attempts to obtain a release of information for her Salem Hospital records, on March 20, 2025, Ms. Meeks spoke with Board staff and informed them she was never in Salem Hospital in July and August of 2024. She informed them that, instead of being in the hospital, she was home sick with depression and suicidal feelings during that time. (Exs. A34 at 1; A35 at 2-3.) Board staff reminded Ms. Meeks of the importance of completing her scheduled tests. (*Id.* at 17.)

45. On April 9, 2025, Ms. Meeks provided a urine sample that tested negative for marijuana. (Ex. A39 at 1.)

46. On April 18, 2025, Board staff informed Ms. Meeks that the Board had voted to issue her a notice of revocation of her license. (Ex. A36 at 2.) In response to Board staff expressing concerns about Ms. Meeks working on days where she reported being too depressed to take a test, Ms. Meeks responded, "I was working from home some of the days." (*Id.* at 1.)

47. Ms. Meeks' urine samples collected on April 28, May 12, June 2, and June 18, 2025, were negative for marijuana. (Ex. A39 at 1.)

48. On June 30, 2025, Ms. Meeks was scheduled to test. She informed Board staff that she was \$60 short of having the money to pay for the test because she spent \$1,500 on putting her sick dog down and \$4,000 on her wedding. (Ex. A38 at 2-3.) She then missed her July 2 and July 11, 2025 check-ins. (Ex. A40 at 1.)

49. On August 6, 2025, Ms. Meeks provided a urine sample that tested negative for marijuana. The sample had a creatinine value of 9.0 mg/dL and a specific gravity of 1.0015. (Ex. A45 at 1.) The Board's probationary monitoring program for Ms. Meeks ended in August 2025. (Test. of Blomquist.)

50. From May 10, 2024, through July 11, 2025, Ms. Meeks failed to check in with Affinity on 25 occasions. Of those occasions, she was selected for testing five times and failed to take the drug tests. During that same period, she checked in but failed to take the drug test five additional times. On three additional occasions, she failed to take the drug test, but her failures were excused. (Exs. A39 at 1-2; A40 at 1.)

51. On March 11, 2026, Ms. Meeks informed Board staff that she made up various excuses for missing tests because she felt that she could not continuously use the same excuse of lack of funds. (Test. of Meeks.)

51. Ms. Meeks has wanted to be a nurse since childhood and enjoys caring for her patients. (Test. of Meeks.) Her colleagues are supportive and appreciative of her commitment to nursing, the nursing skills she demonstrates at work, and her care for the patients. (Exs. R1 and R2.) During her life, Ms. Meeks has struggled with her addictive personality and found herself on multiple occasions relapsing into her addictions. Her struggles were further complicated by an alcoholic spouse. She felt, what she now recognizes, an inappropriate resentment of the Board and its probation requirements. Although she was aware that Board staff were willing to work with her towards success, she found she could not be honest with Board staff and made various excuses for her conduct. Similarly, she was not honest with her therapist and failed to be open with her therapist regarding her conduct. She is apologetic about her conduct and hopes to be able to continue her nursing career. (Test. of Meeks.)

CONCLUSIONS OF LAW⁸

1. Ms. Meeks engaged in conduct derogatory to the standards of nursing in the following manner:

- By violating conditions and/or failing to comply with conditions 1, 17, and 18 of the May 17, 2023 stipulated Board order; and
- By engaging in dishonesty and failing to answer truthfully questions asked by the Board.

2. The Board should revoke Ms. Meeks' registered nurse license.

OPINION⁹

The Board proposed to revoke Ms. Meeks' registered nurse license, based on allegations that she engaged in conduct derogatory to the standards of nursing. As the proponent of the allegations, the Board has the burden to establish, by a preponderance of the evidence, that the allegations are correct and that it should impose the proposed discipline. 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"); *Reguero v. Teachers Standards and Practices Commission*, 312 Or 402, 418 (1991) (burden is on Commission in disciplinary action); *Dixon v. Board of*

⁸ The Board modified the Conclusions of Law to clarify the legal conclusions reached.

⁹ The Board modified the Opinion to clarify its rationale and to remove irrelevant or unnecessary findings.

Nursing, 291 Or App 207, 213 (2018) (in administrative actions, burden of proof is by a 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 true than not true. *Riley Hill General Contractor v. Tandy Corp.*, 303 Or 390, 402 (1987).

ORS 678.111 provides, in part:¹⁰

In the manner prescribed in ORS chapter 183 for a contested case, and except as provided in ORS 678.138, the Oregon State Board of Nursing may revoke, suspend, deny or impose conditions on a license issued by the board, or on an inactive or retired status granted by the board, and reprimand or place on probation, subject to terms imposed by the board, a person licensed by the board for any of the reasons described in this section, including the following:

* * * * *

(6) Conduct derogatory to the standards of nursing.

(7) Violation of any provision of ORS 678.010 to 678.448 or rules adopted under ORS 678.010 to 678.448[.]

OAR 851-045-0070 defines “conduct derogatory to the standards of nursing” and provides, in part:

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:

(1) Conduct related to general fitness in the practice of nursing:

* * * * *

(b) Demonstrated incidents of dishonesty, misrepresentation, or fraud.

* * * * *

(10) Conduct related to the licensee’s relationship with the Board:

* * * * *

(b) Failing to answer truthfully and completely any question asked by the

¹⁰ The Board modified the quoted statutory language to reflect the pertinent text of the version of ORS 678.111 in effect at the time of the Final Order.

Board. This includes:

* * * * *

(D) While under monitoring by the Board via Board order.

* * * * *

(d) Violating the terms and conditions of a Board order; or

(e) Failing to comply with the terms and conditions of a Board order or stipulated agreement[.]

Conduct Derogatory to the Standards of Nursing

(i) Dishonesty and Untruthful Statements

On April 24, 2023, Ms. Meeks signed the Stipulated Order, agreeing to the Stipulated Order and acknowledging her understanding of its terms and conditions, which included 24 months of monitored probation.

During the course of her Board-monitored probation, Ms. Meeks made numerous representations to Board staff in response to their inquiries. On July 29, 2024, Ms. Meeks informed Board staff that she was being admitted to the hospital when, in fact, she was never admitted to the hospital and continued to work for PCSC on multiple occasions in the following weeks. She informed Board staff on July 31, 2024, that she remained hospitalized and when she informed Board staff on August 15, 2024, that she was being discharged from the hospital. By doing so, Ms. Meeks delayed further drug tests for approximately two weeks. On March 16, 2025, after repeated requests from Board staff for medical records of this hospitalization, Ms. Meeks manufactured medical documentation that showed her purported stay at the Salem Hospital and provided the false documentation to Board staff. Ms. Meeks' representations to Board staff were dishonest, fraudulent, and untruthful.¹¹

On November 24, 2024, Ms. Meeks informed Board staff that she was traveling to Canada because her sister-in-law had been hospitalized. In fact, Ms. Meeks never traveled to Canada and remained at home, including working her PCSC shifts on numerous occasions during the following weeks. She continued her travel ruse when she informed Board staff as follows: (1) on November 28, 2024, that she would be returning by that weekend because her sister-in-law had not yet been discharged from the hospital; (2) on December 4, 2024, that she had run into bad weather that further delayed her return; and (3) on December 5, 2024, that she expected to return home the following day. Ms. Meeks' representations to Board staff were dishonest, fraudulent, and untruthful.¹²

¹¹ The Board modified this paragraph to remove unnecessary findings.

¹² The Board modified this paragraph to remove unnecessary findings.

On March 4, 2025, Ms. Meeks informed Board staff that she had been too sick to check in with Affinity and take the drug test scheduled for March 3, 2025. On March 5, 2025, she informed Board staff that she had seen a doctor and tested positive for strep and COVID. On March 6, 2024, in response to Board staff's request, she provided documentation that she purported to be from her doctor, showing positive test results for strep and COVID. In fact, Ms. Meeks did not have strep or COVID, never saw a doctor on these dates, and continued to report for work at PCSC during this week. She manufactured the medical documentation in an effort to delude Board staff into accepting her reason for failing to check in and take the drug test. She compounded her representations by continuing to maintain the charade when she informed Board staff on March 9, 2025, that she was still feverish, and on March 10, 2025, when she informed Board staff that her doctor had stated she was no longer contagious. As with her false representations involving her hospital stay and her trip to Canada, Ms. Meeks' representations to Board staff were dishonest, fraudulent, and untruthful.¹³

By making dishonest, fraudulent, and untruthful statements to Board staff and falsifying documentation that she provided to Board staff while under monitoring by the Board pursuant to a Board Order, Ms. Meeks repeatedly engaged in conduct derogatory to the standards of nursing. *See* OAR 851-045-0070(1)(b) and (10)(b)(D). By violating OAR 851-045-0070(1)(b),¹⁴ Ms. Meeks has also violated Condition 1 of the Stipulated Order that prohibits her from violating the Oregon State Board of Nursing administrative rules, which constitutes additional conduct derogatory to the standards of nursing.

(ii) Violation of Conditions of the Stipulated Order

Condition 17 of the Stipulated Order requires Ms. Meeks' participation in the Board's random testing program and provides that the presence of any unauthorized substance may be a violation of the Stipulated Order. Condition 18 prohibits Ms. Meeks' use of intoxicating, mind altering, or potentially addictive drugs, which would include THC, and specifically prohibits the use of THC and CBD products. Therefore, the presence of THC in Ms. Meeks' urine would be a violation of the conditions of the Stipulated Order.

On August 27, 2024, Ms. Meeks provided a urine sample that tested positive for THC with a level of 250 ng/mL and a normalized THC of 2,808 ng/mL, an amount slightly lower than her prior test on August 16, 2024. On September 18, 2024, Ms. Meeks provided a urine sample that tested positive for THC with a level of 480 ng/mL and a normalized THC of 5,783 ng/mL. Ms. Meeks acknowledged the use of a CBD product prior to providing the September 18, 2024 urine sample.¹⁵ By her use of a CBD product, Ms. Meeks engaged in conduct derogatory to the standards of nursing by violating Condition 18 of the Stipulated Order. *See* OAR 851-045-0070(10)(d) and (e).

Condition 17 of the Stipulated Order specifically requires Ms. Meeks to comply with any

¹³ The Board modified this paragraph to remove unnecessary findings and to clarify the Board's rationale.

¹⁴ The Board modified this citation to clarify the subsection.

¹⁵ Based on the substantial increase in her THC levels, Ms. Meeks, more likely than not, understated her usage of marijuana products to Board staff.

drug test and to take a drug test immediately upon request by Board staff. On November 13 and December 27, 2024, and March 3, 2025, Ms. Meeks failed to check in with Affinity and missed the drug tests that had been scheduled for those days. On November 25, 2024, Ms. Meeks failed to appear for the Affinity-scheduled drug test. After missing a scheduled drug test on February 14, 2025, Board staff instructed Ms. Meeks to take a drug test on February 18, 2025. Ms. Meeks again failed to take a drug test on that date. At hearing, Ms. Meeks asserted that she missed testing because of lack of funds. However, in light of her established history of false statements¹⁶ and the sheer volume of missed tests, her testimony is not credible. By missing drug tests scheduled by the Board's Affinity program and by Board staff, Ms. Meeks engaged in conduct derogatory to the standards of nursing by violating Condition 17 of the Stipulated Order. See OAR 851-045-0070(10)(d) and (e).¹⁷

Revocation of License

In the Amended Notice, the Board proposed to revoke Ms. Meeks' registered nurse license. Licensee opposed a revocation, wishing to continue her chosen and desired profession. However, despite Ms. Meeks' stated desire to continue a nursing practice and the support from her colleagues, the Board established that revocation is the appropriate sanction in this case. The Stipulated Order required 24 months of monitored practice. The evidence established that Ms. Meeks was aware of the conditions of the Stipulated Order and the requirements of the Board's random testing program, and Board staff regularly reminded her of these requirements. Despite this knowledge and reminders, during her probationary period, Ms. Meeks regularly failed to meet the testing requirements of the Board's random testing program. She frequently failed to check in with Affinity and failed to complete drug tests. In light of the persistence of her low creatinine levels, it is more likely than not, Ms. Meeks actively diluted her urine samples throughout her probation in an effort to disguise the level of her marijuana use. She also failed to abstain from marijuana products, despite the specific provision in the Stipulated Order and Board staff's warnings.¹⁸

Ms. Meeks compounded her failures to adhere to the conditions of the Stipulated Order and the Board's random testing program by her flagrantly dishonest conduct with the Board. On multiple occasions throughout this 24-month probation, Ms. Meeks made false statements to Board staff, seeking to excuse her failures to complete drug tests. When confronted by Board staff's requests for more information, she persisted in her lies even to the extent of manufacturing medical documentation. The persistence and sheer extent of her dishonest conduct throughout the course of her probation demonstrates that this licensee is untrustworthy.¹⁹

Finally, the Board has previously disciplined Ms. Meeks. Ms. Meeks' prior probation that resulted from her alcohol addiction was equally unsuccessful, culminating in the surrender of her license.

¹⁶ Her original excuses for the November 25, 2024, and March 3, 2025 failures (Canada and strep incidents) were proven false.

¹⁷ The Board modified this paragraph to remove unnecessary findings.

¹⁸ The Board modified this paragraph to remove unnecessary findings and to clarify its rationale.

¹⁹ The Board modified this paragraph to remove unnecessary findings and to clarify its rationale.

In sum, Ms. Meeks' disciplinary history, her multiple violations of the conditions of the Stipulated Order, despite her knowledge of those conditions and reminders from Board staff, and her flagrant dishonesty with Board staff while on probation establish that revocation is the appropriate sanction in this case. Ms. Meeks' license as a registered nurse should be revoked.

FINAL ORDER

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

Anne Meeks' registered nurse license is revoked.

DATED this 15th day of April, 2026.

FOR THE BOARD OF NURSING OF THE STATE OF OREGON



Olanike Towobola, DNP, RN
Board President

APPEAL

NOTICE: You are entitled to judicial review of this order pursuant to ORS 183.480 *et seq.* If you wish to appeal the final order, you must file a petition for judicial review with the Oregon Court of Appeals within sixty (60) days of the date this final order is served on you.

**BEFORE THE OREGON
STATE BOARD OF NURSING**

In the Matter of	) STIPULATED ORDER FOR
Thomas Mulcahy, LPN	) PROBATION
)
License No. 201505672LPN	) Reference No. 2024040082

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

Thomas Mulcahy (Licensee) was issued an LPN License by the Board on 08/07/2015.

On or about 04/09/2024, the Board received information that Licensee experienced a medical issue while working at a medical facility, which resulted in Licensee being sent home after being deemed unable to continue practicing safely by supervising staff. The Board learned that the medical issue was triggered by a change in medications being taken by Licensee. On or about 09/11/2025, the Board received information that Licensee had effected six (6) medication concerns within an approximate 3-hour timeframe, which included late documentation, missing administration, and documentation errors. Licensee acknowledged these medication concerns were due to a medical issue triggered by a change in medications being taken by Licensee. Licensee acknowledged that in each of these incidents, Licensee perceived that a medical issue was about to occur but declined to remove themselves from practice out of fear of leaving the facility short-staffed.

By the above actions, Licensee is subject to discipline pursuant to the following statutes and rules:

ORS 678.111 Denial, revocation or suspension of license or probation or reprimand. In the manner prescribed in ORS chapter 183 for a contested case, and except as provided in ORS 678.138, the Oregon State Board of Nursing may revoke, suspend, deny or impose conditions on a license issued by the board, or on an inactive or retired status granted by the board, and reprimand or place on probation, subject to terms imposed by the board, a person licensed by the board for any of the reasons described in this section, including the following:
(6) Conduct derogatory to the standards of nursing.

Former OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined (effective 07/01/2024 – 11/20/2025)

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:

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

- (a) Failing to recognize standards of acceptable and prevailing nursing practice. Actual injury need not be established;
- (e) Failure to remove oneself from practice when unable to practice with professional skill and safety.
- (7) Conduct related to impaired function:
 - (a) Practicing nursing when unable or unfit due to:
 - (A) Physical impairment as evidenced by documented deterioration of functioning in the practice setting or by the assessment of an LIP qualified to diagnose physical condition or status;
 - (b) Practicing nursing when physical or mental ability to practice is impaired by stress, illness, the use of any drug, prescription or non-prescription medication, alcohol, or a mind-altering substance;
- (8) Other conduct derogatory to the practice of nursing:
 - (r) Failing to administer medications in a manner consistent with state and federal law;
 - (s) Failing to dispense medications in a manner consistent with state and federal law;

Former OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined (effective 08/01/2017 – 06/30/2024)

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;
- (7) Conduct related to impaired function:
 - (a) Practicing nursing when unable or unfit due to:
 - (A) Physical impairment as evidenced by documented deterioration of functioning in the practice setting or by the assessment of an LIP qualified to diagnose physical condition or status;
- (8) Conduct related to other federal or state statute or rule violations:
 - (q) Failing to dispense or administer medications in a manner consistent with state and federal law;

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 Practical Nursing License of Thomas Mulcahy 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 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.

13) 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.

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

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

16) 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.

17) Licensee shall cooperate fully with the Board 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:



Thomas Mulcahy, LPN

02/26/26

Date

ORDER

IT IS SO ORDERED:

BOARD OF NURSING FOR THE STATE OF OREGON



Olanike Towobola DNP, RN
Board President

4/15/26

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
Dahndi Sivad, CNA RN	)	REPRIMAND
)	
License No. 201242368RN	)	Reference No. 2025010229

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

Dahndi Sivad (Licensee) was issued an RN license by the Board on July 24, 2012.

On or about January 22, 2025, the Board received information the Licensee administered sedation medication to a patient without a valid order or prior authorization from a physician. The Licensee subsequently acknowledged the error, admitting that they administered sedation instead of complying with the providers' order to administer local anesthetic.

By the above actions, Licensee is subject to discipline pursuant to the following statutes and rules:

ORS 678.111 Denial, revocation or suspension of license or probation or reprimand. In the manner prescribed in ORS chapter 183 for a contested case, and except as provided in ORS 678.138, the Oregon State Board of Nursing may revoke, suspend, deny or impose conditions on a license issued by the board, or on an inactive or retired status granted by the board, and reprimand or place on probation, subject to terms imposed by the board, a person licensed by the board for any of the reasons described in this section, including the following:

- (6) Conduct derogatory to the standards of nursing.
- (7) Violation of any provision of ORS 678.010 to 678.448 or rules adopted under ORS 678.010 to 678.448

Former OAR - 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined
(effective July 1, 2024 – June 30, 2025)

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:

- (1) Conduct related to general fitness in the practice of nursing:
 - (a) Demonstrated incidents of violent, abusive, intimidating, neglectful or reckless behavior;
- (2) Conduct related to achieving and maintaining clinical competency:
 - (a) Failing to conform to the recognized standards of acceptable and prevailing nursing practice. Actual injury need not be established;
 - (c) Performing activities, interventions, or roles within the practice of nursing that are not within one's individual scope of practice;
 - (l) Failing to honor the client's right to decline an intervention or medication;

- (8) Other conduct derogatory to the practice of nursing:
- (k) Except as authorized through a medical order written by a person authorized to prescribe the medication:
- (B) Furnishing or administering a prescription

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 RN License of Dahndi Sivad 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 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 a RN.

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, 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.



Dahndi Sivad, RN

03/30/26

Date

ORDER

IT IS SO ORDERED:

BOARD OF NURSING FOR THE STATE OF OREGON



Olanike Towobola, DNP, RN
Board President

4/15/28

Date

PLEASE RETURN ALL PAGES OF THIS STIPULATED ORDER AFTER SIGNING

**BEFORE THE OREGON
STATE BOARD OF NURSING**

In the Matter of Angela Southard, LPN License No. 201603683LPN) STIPULATED ORDER FOR) VOLUNTARY SURRENDER)) Reference No. 2026020280
--	--

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 through ORS 678.448.

Angela Southard (Licensee) was issued an LPN license by the Board on May 31, 2016.

On August 15, 2023, Licensee entered into a Consent Agreement for probation with the Arizona Board of Nursing.

On September 30, 2024, as part of the Arizona Board of Nursing consent agreement, Licensee was selected for a random Phosphatidyl ethanol (Peth) blood alcohol testing. The results were positive.

On October 8, 2024, Licensee notified the Arizona Board of Nursing that they had consumed alcohol, a violation of the consent agreement.

On October 19, 2024, Licensee voluntarily surrendered their Arizona LPN license.

On June 25, 2025, the Board reviewed the above matter and accepted Licensee's Stipulated Order for Probation of their LPN license.

On February 19, 2026, Licensee requested to surrender their LPN license to focus on personal matters.

By the above actions, Licensee is subject to discipline pursuant to the following statutes and rules:

ORS 678.111 Denial, revocation or suspension of license or probation or reprimand. In the manner prescribed in ORS chapter 183 for a contested case, and except as provided in ORS 678.138, the Oregon State Board of Nursing may revoke, suspend, deny or impose conditions on a license issued by the board, or on an inactive or retired status granted by the board, and reprimand or place on probation, subject to terms imposed by the board, a person licensed by the board for any of the reasons described in this section, including the following:

(6) Conduct derogatory to the standards of nursing.

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

OAR 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:

(10) Conduct related to the licensee's relationship with the Board:

(e) Failing to comply with the terms and conditions of a Board order or stipulated agreement.

Licensee wishes to cooperate with the Board in this matter and voluntarily surrender their LPN License.

Therefore, the following will be proposed to the Oregon State Board of Nursing and is agreed to by Angela Southard:

That the voluntary surrender of the LPN License of Angela Southard be accepted. If, after a minimum of three (3) years, they wish to reinstate their License, they may submit an application for reinstatement to the Board.

Licensee agrees that they will not practice as an LPN from the date the Order is signed.


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, Angela Southard 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 signing of 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 Voluntary Surrender.



Angela Southard, LPN

02/23/26

Date

ORDER

IT IS SO ORDERED:

BOARD OF NURSING FOR THE STATE OF OREGON



Olanike Fowobola, DNP, RN
Board President

4/15/26

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
Ryan Whitlow, RN	)	REPRIMAND
)	
License No. 202211856RN	)	Reference No. 2024020240

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

Ryan Whitlow (Licensee) was issued a RN license by the Board on August 4, 2022.

On or about February 22, 2024, the Board received information that Licensee administered the wrong medication to a patient and upon realizing the error, he failed to notify the provider and the patient. Instead, Licensee walked out and quit, abandoning his patients.

By the above actions, Licensee is subject to discipline pursuant to the following statutes and rules:

ORS 676.205 Continuing jurisdiction of boards; effect of expiration, lapse, surrender, suspension or revocation of license.

(1) As used in this section:

(a) "Health professional regulatory board" means the agencies listed in ORS 676.160 and the Health Licensing Office created in ORS 676.560.

(b) "License" means a license, registration, certification or other authorization to engage in a profession.

(2) A health professional regulatory board continues to have jurisdiction for licensing, regulatory and disciplinary purposes related to acts and omissions that occur while a person is licensed or required to be licensed, regardless of any changes in the licensing status of the person.

(3) A person who obtains, but is not required to obtain, a license to engage in a profession regulated by a health professional regulatory board, and whose license expires, lapses or is voluntarily surrendered while the person is under investigation by the board, or whose license is suspended or revoked, may not engage in that profession unless the person again obtains a license from the relevant health professional regulatory board to engage in the profession.

(4) Nothing in this section limits the jurisdictional, investigatory or other authority otherwise provided by law to a health professional regulatory board.

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

The lapse, suspension or revocation of a license or certificate by the operation of law or by order of the Oregon State Board of Nursing or by the decision of a court of law, or the voluntary surrender of a license by a licensee or of a certificate by a certificate holder, shall not deprive the board of jurisdiction to proceed with any investigation of or any action or disciplinary

proceeding against the licensee or certificate holder or to revise or render null and void an order of disciplinary action against the licensee or certificate holder.

ORS 678.111 Denial, revocation or suspension of license or probation or reprimand.

In the manner prescribed in ORS chapter 183 for a contested case, and except as provided in ORS 678.138, the Oregon State Board of Nursing may revoke, suspend, deny or impose conditions on a license issued by the board, or on an inactive or retired status granted by the board, and reprimand or place on probation, subject to terms imposed by the board, a person licensed by the board for any of the reasons described in this section, including the following:
(6) Conduct derogatory to the standards of nursing.

Former OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined (effective 1/1/23-7/1/24)

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:

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

(i) Leaving or failing to complete any nursing assignment, including a supervisory assignment, without notifying the appropriate personnel and confirming that nursing assignment responsibilities will be met;

(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.

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 RN License of Ryan Whitlow 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 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 a RN.

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, 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 Signature]

Ryan Whitlow, RN

03/24/26

Date

ORDER

IT IS SO ORDERED:

BOARD OF NURSING FOR THE STATE OF OREGON

[Redacted Signature]

Nikky Towobola, DNP, RN
Board President

4/15/26

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
Julia Young, LPN	)	REPRIMAND
)	
License No. 201706633LPN	)	Reference No. 2025010022

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 through ORS 678.448.

Julia Young (Licensee) was issued an LPN license by the Board on August 16, 2017.

On or about January 3, 2025, the Board received information that Licensee searched, accessed and viewed medical records of an individual without a business need. Licensee admitted to typing the patient's name in the medical database on at least two (2) occasions: once on February 6, 2024, and again on October 11, 2024.

By the above actions, Licensee is subject to discipline pursuant to the following statutes and rules:

ORS 678.111 Denial, revocation or suspension of license or probation or reprimand. In the manner prescribed in ORS chapter 183 for a contested case, and except as provided in ORS 678.138, the Oregon State Board of Nursing may revoke, suspend, deny or impose conditions on a license issued by the board, or on an inactive or retired status granted by the board, and reprimand or place on probation, subject to terms imposed by the board, a person licensed by the board for any of the reasons described in this section, including the following:

(6) Conduct derogatory to the standards of nursing.

Former 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined
(effective 08/01/2017 – 06/30/2024)

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:

(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;

Former 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined
(effective 07/01/2024 – 11/19/2025)

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:

(8) Other conduct derogatory to the practice of nursing:

- (a) Violating any law, rule, or regulation intended to guide the conduct of nurses;
- (c) Violating the rights of privacy, confidentiality of information, or disclosing knowledge concerning the client, unless required by law to disclose such information;

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 LPN License of Julia Young 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 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 LPN.

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, 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.



Julia Young, LPN

03/04/26

Date

ORDER

IT IS SO ORDERED:

BOARD OF NURSING FOR THE STATE OF OREGON



~~Olanike Towobola, DNP, RN~~
Board President

4/15/28
Date

PLEASE RETURN ALL PAGES OF THIS STIPULATED ORDER AFTER SIGNING