

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of  
Laurie Adams, RN**

**) STIPULATED ORDER FOR  
) WITHDRAWAL OF REGISTERED  
) NURSE LICENSE APPLICATION  
) Reference No. 20-01109**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Laurie Adams submitted an application for a Registered Nurse to the Board of Nursing on or about **May 15, 2020**.

On or about May 15, 2020, the Board received information that applicant had left her job in 2017 for a disability.

In the application, Applicant disclosed she had a substance abuse issue in 2017.

On or around June 24, 2020, Applicant requested to withdraw her application.

By the above actions, Applicant is subject to discipline pursuant to ORS 678.111(1)(f), (g) and OAR 851-045-0070, which read as follows:

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

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

(f) Conduct derogatory to the standards of nursing.

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

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

7(c) The use of a prescription or non-prescription medication, alcohol, or a mind-altering substance, to an extent or in a manner dangerous or injurious to the licensee or others or to an extent that such use impairs the ability to conduct safely the practice of nursing.

Applicant 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 Applicant:

That Laurie Adams's application for Registered Nurse License be withdrawn.

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

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

Applicant understands that this Stipulated Order is a document of public record.

Applicant has read this Stipulated Order, understands this Stipulated Order completely, and freely signs this Stipulated Order for Withdrawal of Registered Nurse Application.

IT IS SO AGREED:

\_\_\_\_\_  
Laurie Adams, RN

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Kathleen Chinn, FNP-BC  
Board President

\_\_\_\_\_  
Date

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Star Bilberry, RN** ) **REPRIMAND OF LICENSE**  
)  
**License No. 078041695RN** ) **Reference No. 20-00536**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Star Bilberry (Licensee) was issued a Registered Nurse License by the Board on September 15, 1978.

On or about November 18, 2019, the Board received information that Licensee failed to follow up on a resident's critical lab value and failed to complete nursing documentation related to the critical lab values.

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

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

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

**OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined**

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

- (2) Conduct related to achieving and maintaining clinical competency:
- (a) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established.
- (3) Conduct related to the client's safety and integrity:
- (b) Failing to take action to preserve or promote the client's safety based on nursing assessment and judgment.
- (4) Conduct related to communication:

- (a) Failure to accurately document nursing interventions and nursing practice implementation;
- (f) Failure to communicate information regarding the client's status to members of the healthcare team in an ongoing and timely manner as appropriate to the context of care.

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

**That the Registered Nurse License of Star Bilberry 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 she engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against her license, up to and including revocation of her license to practice as a Registered Nurse.

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

Licensee understands that by signing this Stipulated Order, she 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 her to sign this Order.

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

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

\_\_\_\_\_  
Star Bilberry, RN

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Kathleen Chinn, FNP-BC  
Board President

\_\_\_\_\_  
Date

PLEASE RETURN ALL PAGES OF THIS STIPULATED ORDER AFTER SIGNING

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **FINAL ORDER OF SUSPENSION**  
**Stacey Boeholt, RN** ) **BY DEFAULT FOR**  
 ) **FAILURE TO COOPERATE**  
 )  
**License No. 201242364RN** ) **Reference No. 20-01185**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Stacey Boeholt (Licensee) was issued a Registered Nurse License by the Board on July 24, 2012.

This matter was considered by the Board at its meeting on September 09, 2020.

On July 27, 2020, a Notice stating that the Board intended to suspend the Registered Nurse License of Licensee was sent via certified and first-class mail to Licensee's address of record. The Notice alleged that Stacey Boeholt failed to cooperate with the Board during the course of an investigation.

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

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

-I-

**FINDINGS OF FACT**

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

1. Licensee was issued a Registered Nurse License in the state of Oregon on July 24, 2012.
2. On or about June 09, 2020, Licensee was reported to the Board for allegations that licensee was terminated from employment for impairment in the workplace with a measured BAC of 0.226. The Board opened an investigation into the matter.
3. On June 17, 2020 Board staff mailed a letter to Licensee's address of record and her email address requesting that Licensee schedule an interview to discuss the allegations.

Licensee was further instructed to send a written statement regarding the allegations and a current work history. Licensee failed to schedule an interview and did not provide any documents to the Board.

4. On July 20, 2020, a second letter was sent to Licensee's address of record and her email address, requesting that she contact the Board within five (5) business days to schedule an interview to discuss the allegations. Licensee was also asked to provide a current work history and a written statement regarding the allegations. Licensee failed to schedule an interview and did not provide any documents to the Board.
5. On August 05, 2020, Board staff mailed a Notice of Proposed Suspension to Licensee via first-class and certified mail. The Notice granted Licensee twenty (20) days from the date of the mailing of the Notice to request a hearing. The Notice also designated that the agency file would be the record for purposes of default.
6. Licensee failed to respond to the Notice of Proposed Suspension within the required twenty (20) days. Consequently, Licensee's opportunity to request a hearing has expired and is in default.

-II-

#### CONCLUSIONS OF LAW

1. That the Board has jurisdiction over the Licensee, Stacey Boeholt, and over the subject matter of this proceeding.
2. That Licensee's failure to cooperate with the Board during the course of an investigation is grounds for disciplinary action pursuant to ORS 678.111(1)(f), OAR 851-045-0070(10) (a) and (c), which read as follows:

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

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

(f) Conduct derogatory to the standards of nursing.

**OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined.**

Conduct that adversely affects the health, safety, and welfare of the public, fails to conform to legal nursing standards, or fails to conform to accepted standards of the

nursing profession, is conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:

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

(a) Failing to fully cooperate with the Board during the course of an investigation, including but not limited to, waiver of confidentiality privileges, except client-attorney privilege.

(c) Failing to provide the Board with any documents requested by the Board.

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

SIGNATURES & DATED COPY ON FILE IN BOARD OFFICE

-III-

**ORDER**

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

ORDERED that the Registered Nurse License of Stacey Boeholt is SUSPENDED for a minimum of two weeks, commencing five business days from the date this Order is signed, and shall continue until such time as Stacey Boeholt has fully cooperated with the Board's investigation. Should the Board reinstate the Registered Nurse License of Stacey Boeholt, the Licensee would be subject to whatever terms and conditions the Board may impose.

DATED this 09<sup>th</sup> day of September, 2020

**FOR THE BOARD OF NURSING OF THE STATE OF OREGON**

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Kathleen Chinn, FNP-BC  
Board President

TO: STACEY BOEHOLT:

You may file a petition for reconsideration or rehearing of this Order. Reconsideration or rehearing may be obtained by filing a petition with the Board of Nursing within (sixty) 60 days from the service of this Order. Your petition shall set forth the specific grounds for reconsideration. Reconsideration or rehearing is pursuant to the provisions in ORS 183.482.

As an alternative to filing a Petition for Reconsideration of this Order, you are entitled to judicial review of this Order. Judicial review may be obtained by filing a petition with the Oregon Court of Appeals for review within sixty (60) days from the date of service of this Order. Judicial review is pursuant to the provisions of ORS 183.482.

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Jade Brannan** ) **PROBATION**  
)  
**License No. 200342113RN** ) **Reference No. 20-00895**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Jade Brannan (Applicant) was issued a Registered Nurse license by the Oregon State Board of Nursing on October 7, 2003 which was put on probation in October 2012 and voluntarily surrendered in November 2016.

In 2016, Applicant diverted and abused controlled substances. Board staff reviewed various records regarding Applicant's conduct and subsequent actions. Applicant agrees that a period of probation is appropriate.

By the above actions, Applicant is subject to discipline pursuant to ORS 678.111(1)(f)(g) and OAR 851-045-0070(7)(c), (8)(k) which provide as follows:

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

- (1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:
- (f) Conduct derogatory to the standards of nursing.
- (g) Violation of any provision of ORS 678.010 to 678.448 or rules adopted thereunder.

**OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined**

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

- (7) Conduct related to impaired function:
  - (c) The use of a prescription or non-prescription medication, alcohol, or a mind-altering substance, to an extent or in a manner dangerous or injurious to the licensee or others or to an extent that such use impairs the ability to conduct safely the practice of nursing.
- (8) Conduct related to other federal or state statute or rule violations:
  - (k) Possessing, obtaining, attempting to obtain, furnishing, or administering prescription or controlled medications to any person, including self, except as directed by a person authorized by law to prescribe medications;

Applicant admits that the above allegations occurred and constitute violations of the Nurse Practice Act. Applicant 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 Applicant:

**That the Registered Nurse license of Jade Brannan be placed on Probation. The Applicant's compliance with this agreement will be monitored by the Oregon State Board of Nursing from date of signature on the Stipulated Order. Applicant must complete a twenty-four (24) month period of probation to begin upon Applicant's return to supervised nursing practice at the level of a Registered Nurse. Applicant must practice a minimum of sixteen (16) hours per week and no more than one (1.0) FTE in a setting where Applicant is able to exercise the full extent of scope of duties in order to demonstrate whether Applicant is competent. Limited overtime may be approved on occasion.**

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

- 1) Applicant shall not violate the Nurse Practice Act (ORS 678) or the rules adopted thereunder.
- 2) Applicant shall have thirty-six (36) months from Board's acceptance of this Order to complete twenty-four (24) months of monitored practice.
- 3) Applicant shall notify Board staff, in writing, prior to any change of address or employment setting during the probation period.
- 4) Applicant shall maintain an active license.
- 5) Applicant shall inform Board staff in advance of any absences from Oregon and/or any move from Oregon to another licensing jurisdiction. If Applicant leaves the state and is unable to practice in the state of Oregon, Applicant's probationary status will be re-evaluated.
- 6) Applicant shall appear in person or by phone, to designated Board staff for interviews on a monthly basis during the probationary period. Frequency of contact may be reviewed and revised periodically at the discretion of Board staff.
- 7) Applicant shall notify Board staff of any citations, arrests, or convictions for any offense, whether felony, misdemeanor, violation, or citation within seven (7) days of the occurrence.
- 8) Applicant will not look for, accept, or begin a new nursing position without prior approval of Board staff. This includes changes of the employer itself or changes within the facility or institution.
- 9) Applicant shall inform current and prospective employers of the probationary status of

Applicant's license, the reasons for Applicant's probation, and terms and conditions of probation. If there is a Nurse Executive, that person is to be informed of Applicant's probationary status. The Nurse Executive will receive a copy of the Stipulated Order for Probation when Applicant is employed.

10) Applicant 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 Applicant's practice and provide assistance and who has taken the required Board approved Monitor/Supervisor training. Applicant shall be employed in a setting where Applicant'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, Applicant may be restricted from practicing as a nurse.

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

12) Applicant shall notify Board staff when there is a change in status of employment, including resignations and terminations.

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

14) Applicant shall not work in any practice setting when on-site monitoring is not available. This generally includes home health agencies, traveling agencies, float pools, temporary agencies, assisted living facilities, adult foster care, independent consulting contracts, home hospice, and night shifts outside of acute care settings.

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

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

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

Board staff to communicate with Applicant's treatment provider and release Applicant's treatment records to the Board.

18) Applicant shall participate in the Board's random urine drug testing program. Failure to comply with random urine 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. Applicant shall sign any release of information necessary to ensure the Board will receive the results of such testing. The presence of unauthorized substances may be considered a violation of the terms and conditions of this Stipulated Order. Upon request of Board staff, Applicant shall obtain an evaluation by a Board approved chemical abuse or dependence evaluator. Applicant understands that Applicant is financially responsible for any and all costs related to testing and evaluating. Applicant's failure to maintain an account in good standing with the Board's laboratory vendor shall be considered a violation of this Stipulated Order.

19) 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 20** below. Applicant shall avoid any over-the-counter products and food items containing alcohol, marijuana and poppy seeds.

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

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

22) Applicant shall notify any and all healthcare providers of the nature of Applicant's chemical dependency to ensure that Applicant's health history is complete before receiving any treatment, including medical and dental. 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. Applicant is financially responsible for any costs incurred for compliance with the terms and conditions of this Stipulated Order.

23) 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.

24) 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.

Applicant understands that in the event Applicant engages in future conduct resulting in violations the terms of this Stipulated Order and/or the Nurse Practice Act, the Board may take further disciplinary action against Applicant's license, up to and including revocation of Applicant's license to practice as a Registered Nurse.

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

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

Applicant understands that this Stipulated Order is a document of public record.

IT IS SO AGREED:

\_\_\_\_\_  
Jade Brannan

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Kathleen Chinn, FNP-BC  
Board President

\_\_\_\_\_  
Date

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Joel Brown, RN** ) **VOLUNTARY SURRENDER**  
)  
**License No. 201041730RN** ) **Reference No. 20-01177**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Joel Brown (Licensee) was issued a Registered Nurse License by the Board on July 12, 2010.

On February 12, 2020, the Board accepted a Stipulated Order for a 6 month Suspension followed by 24 months of Probation after Licensee was reported for numerous narcotic discrepancies as well as accessing the PYXIS while on administrative leave on three occasions. Licensee entered substance use disorder treatment.

Since beginning probation, Licensee has had difficulty maintaining compliance with the Board's random toxicology program including missed testing and one positive test due to incidental exposure. Due to family circumstances, Licensee has decided not to return to nursing at this time; therefore Licensee will not be able to comply with the monitored practice requirement.

By the above actions, Licensee is subject to discipline pursuant to ORS 678.111 (1) (f) and OAR 851-045-0070 (10) (d) which read as follows:

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

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

(f) Conduct derogatory to the standards of nursing;

OAR 851-045-0070

Conduct Derogatory to the Standards of Nursing Defined

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

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

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

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

**That the voluntary surrender of the Registered Nurse license of Joel Brown be accepted. If, after a minimum of three years, Mr. Brown wishes to reinstate their Registered Nurse license, Joel Brown may submit an application to the Board to request reinstatement.**

Licensee agrees that they will not practice as a Registered Nurse 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, **Joel Brown** 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 has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Voluntary Surrender.

---

Joel Brown, RN

---

Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

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Kathleen Chinn, FNP-BC  
Board President

---

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**  
**Santiago Campos Brambila, CNA** ) **VOLUNTARY SURRENDER**  
)  
**Certificate No. 202001438CNA** ) **Reference No. 21-00120**

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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. Santiago Campos Brambila (Certificate Holder) was issued a Nursing Assistant Certificate by the Board on February 12, 2020.

On or about August 06, 2020, the Board received information that Certificate Holder had engaged in non-consensual sexual behavior toward a resident while under his care on or about August 03, 2020.

On August 06, 2020 Board staff interviewed Certificate Holder who admitted he had engaged in non-consensual sexual contact with the resident while she was under his care.

By the above actions, CNA is subject to discipline pursuant to ORS 678.442(2)(f), OAR 851-063-0090(1)(a), (2)(a), (3)(d)(g)(i)(j)(k) and (8)(d), which read as follows:

**ORS 678.442 Certification of nursing assistants; rules.**

(2) In the manner prescribed in ORS chapter 183, the board may revoke or suspend a certificate issued under this section or may reprimand a nursing assistant for the following reasons:

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

**OAR 851-063-0090 Conduct Unbecoming a Nursing Assistant.** A CNA, regardless of job location, responsibilities, or use of the title "CNA," whose behavior fails to conform to the legal standard and accepted standards of the nursing assistant profession, or who may adversely affect the health, safety or welfare of the public, may be found guilty of conduct unbecoming a nursing assistant. Such conduct includes but is not limited to:

(1) Conduct, regardless of setting, related to general fitness to perform nursing assistant authorized duties:

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

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

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

(3) Conduct related to client safety and integrity:

(d) Jeopardizing the safety of a person under the CNA's care;

(g) Failing to respect the dignity and rights of the person receiving nursing services, regardless of social or economic status, age, race, religion, sex, sexual orientation, national origin, nature of health needs, other physical attributes, or disability;

(i) Engaging in or attempting to engage in sexual misconduct with a client in any setting;

(j) Engaging in sexual misconduct in the workplace; or

(k) Failing to maintain professional boundaries.

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

(d) Abusing a person.

CNA wishes to cooperate with the Board in this matter and voluntarily surrender his Certified Nursing Assistant certificate.

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

**That the voluntary surrender of the Certified Nursing Assistant certificate of Santiago Campos Brambila be accepted. Mr. Campos Brambila agrees to never reapply for a CNA certificate or any other nursing license in the State of Oregon.**

CNA agrees that they will not practice as a Certified Nursing Assistant from the date the Order is signed.

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

CNA understands that by signing this Stipulated Order, **Santiago Campos Brambila** waives 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 the signing of this Order.

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

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

\_\_\_\_\_  
Santiago Campos Brambila, CNA

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Kathleen Chinn, FNP-BC  
Board President

\_\_\_\_\_  
Date

PLEASE RETURN ALL PAGES OF THIS STIPULATED ORDER AFTER SIGNING

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of  
Irena Chernish, RN**

)  
) **FINAL ORDER OF REVOCATION**  
) **BY DEFAULT**

**License No. 201609883RN**

) **Reference No. 21-00029**

---

The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Irena Chernish (Licensee) was issued a Registered Nurse License/Certificate by the Board on December 09, 2016.

This matter was considered by the Board at its meeting on September 09, 2020.

On August 11, 2020, a Notice stating that the Board intended to Revoke the Registered Nurse License of Irena Chernish was sent to Licensee via certified and first-class mail to the address of record.

The Notice alleged that Licensee violated a Board Order.

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

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

-I-

**FINDINGS OF FACT**

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

1. Licensee was issued a Registered Nurse License in the state of Oregon on December 09, 2016.
2. On March 17, 2017, Licensee was reported to the Board by a physician alleging that Licensee was doctor shopping for prescriptions, using multiple providers and pharmacies for high doses of medications and refills for her own personal use. The Board opened an investigation into the matter.
3. On August 8, 2018, the Board issued Licensee a Notice of Proposed Revocation of her Registered Nurse License. A Notice of Proposed Revocation was mailed to Licensee at

her address of record. The Notice granted Licensee an opportunity for hearing if it was requested within twenty (20) days of mailing the Notice. A timely request for hearing was received by the Board.

4. On May 30, 2019 a hearing took place convened by Administrative Law Judge (ALJ) Rick Barber.
5. On July 23, 2019, ALJ Barber issued a Proposed Order affirming the Board's Notice in part and reversing the Board's Notice in part.
6. On February 19, 2020, the Board placed the Registered Nurse License of Irene Chernish on Suspension for 90 days, followed by 24 months of Probation. Per the Stipulated Order, Licensee shall maintain monthly contact with Board staff, participate in the Board's random urine drug testing program, and notify Board staff of any change of address.
7. On May 19, 2020, Licensee's 90 day suspension was completed and she was placed on 24 months of Probation. On May 22, 2020 Board staff mailed Licensee an initial probation packet, which included a letter requesting she schedule her first probation meeting with Board staff by June 3, 2020. That date passed without contact to Board staff. On July 2, 2020, Board staff sent another letter again to address of record and by email requesting contact by July 7, 2020. Phone number of record stated it was no longer in service. Despite repeated efforts to contact Licensee, no contact has ever been made. Licensee has also failed to activate her account with the Board's random urine drug testing program.
8. On August 11, 2020, Board staff mailed a Notice of Proposed Revocation to Licensee via first-class and certified mail. The Notice granted Licensee twenty (20) days from the date of the mailing of the Notice to request a hearing. The Notice also designated that the agency file would be the record for purposes of default.

-II-

### CONCLUSIONS OF LAW

1. That the Board has jurisdiction over the Licensee, Irena Chernish, and over the subject matter of this proceeding.
2. That Licensee's conduct is in violation of ORS 678.111 (1) (f) and OAR 851-045-0070 (10) (d) which read as follows:

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

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

(f) Conduct derogatory to the standards of nursing.

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

- (10) Conduct related to the licensee's relationship with the Board.
- (d) Violating the terms and conditions of a Board order.

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

**-III-**

**ORDER**

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

ORDERED that the Registered Nurse License/Certificate of Irena Chernish is REVOKED.

DATED this \_\_\_\_ day of September, 2020

**FOR THE BOARD OF NURSING OF THE STATE OF OREGON**

\_\_\_\_\_  
Kathleen Chinn, FNP-BC  
Board President

TO: IRENA CHERNISH:

You may file a petition for reconsideration or rehearing of this Order. Reconsideration or rehearing may be obtained by filing a petition with the Board of Nursing within (sixty) 60 days from the service of this Order. Your petition shall set forth the specific grounds for reconsideration. Reconsideration or rehearing is pursuant to the provisions in ORS 183.482.

As an alternative to filing a Petition for Reconsideration of this Order, you are entitled to judicial review of this Order. Judicial review may be obtained by filing a petition with the Oregon Court of Appeals for review within sixty (60) days from the date of service of this Order. Judicial review is pursuant to the provisions of ORS 183.482.

If, after a minimum of three (3) years, you wish to reinstate your Registered Nurse License/Certificate, you may submit an application to the Board to request reinstatement.

SIGNATURES & DATED COPY ON FILE IN BOARD OFFICE

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Cory Churner-Tisdale, LPN** ) **PROBATION**  
)  
**License No. 201608584LPN** ) **Reference No. 19-01461**

---

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. Cory Churner-Tisdale (Licensee) was issued a Practical Nurse license by the Board on October 19, 2016.

The Board alleges that while working at a long term care facility, Licensee was responsible for numerous discrepancies regarding the withdrawal, administration and documentation of opiate medications. An audit of the records of twenty-five facility residents uncovered a pattern of narcotics handling indicative of narcotics diversion or alternatively of poor nursing practice which failed to meet accepted standards.

The Board alleges that on 180 occasions between April 1, 2019, and September 1, 2019, Licensee signed out narcotic medications for residents without documenting the narcotic as administered to the corresponding resident in the electronic medication administration record. This resulted in a total of 281 pills that were unaccounted for.

The Board alleges that on at least 27 separate occasions between April 1, 2019, and September 1, 2019, Licensee signed out narcotics on two different narcotic logs for the same time and the same resident.

The Board alleges that on at least 38 separate occasions between April 1, 2019, and September 1, 2019, Licensee pulled medication from the Cubex medication dispensing system when the medication was already available in the resident's medication cart or had already been signed out of the medication cart for the resident for the same date and time.

On or about August 2, 2019, Licensee attended an interview with Board staff during which Licensee stated to Board staff that he did not use marijuana or other illegal drugs. On August 9, 2019, upon further questioning, Licensee admitted to Board staff that he had not been truthful about his own drug use and the results of the drug screen, and that a for-cause drug test result by his employer was positive for marijuana. Licensee agreed to undergo an additional drug test at a Board-approved testing site, but failed to attend the test.

During Licensee's previous employment at another nursing facility, the Oregon Department of Human Services (DHS) investigated an allegation of narcotics discrepancies by Licensee and issued a finding on August 23, 2018, that Licensee met the DHS standard for financial exploitation of two residents by narcotics diversion.

The Washington State Nursing Care Quality Assurance Commission denied Licensee's application for Practical Nurse license on March 16, 2020, based on the DHS finding as well as Licensee's failure to timely produce a requested evaluation.

Licensee underwent an evaluation by a qualified drug and alcohol evaluator and does not meet the criteria for a substance use disorder or treatment for substance use disorder.

The Board alleges that the above conduct is in violation of ORS 678.111(1)(f)(h) and OAR 851-045-0070 (2)(a), (3)(c), (4)(a)(c)(A)(E), (8)(k), (10)(a)(b) which read as follows:

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

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

(f) Conduct derogatory to the standards of nursing.

(h) Revocation or suspension of a license to practice nursing by any state or territory of the United States, or any foreign jurisdiction authorized to issue nursing credentials whether or not that license or credential was relied upon in issuing that license in this state. A certified copy of the order of revocation or suspension shall be conclusive evidence of such revocation or suspension.

**OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined**

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

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

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

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

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

(4) Conduct related to communication:

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

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

(A) Documenting nursing practice implementation that did not occur;

(E) Falsifying data;

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

(k) Possessing, obtaining, attempting to obtain, furnishing, or administering prescription or controlled medications to any person, including self, except as directed by a person authorized by law to prescribe medications;

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

- (a) Failing to fully cooperate with the Board during the course of an investigation, including but not limited to, waiver of confidentiality privileges, except client-attorney privilege;
- (b) Failing to answer truthfully and completely any question asked by the Board on an application for licensure or during the course of an investigation or any other question asked by the Board[.]

Licensee admits that the above conduct occurred and constitute violations of the referenced statutes and rules. 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 Nurse License of Cory Churner-Tisdale 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 thirty-six (36) 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 forty-eight (48) months from Board's acceptance of this Order to complete thirty-six (36) months of monitored practice.
- 3) Licensee shall notify Board staff, in writing, prior to any change of address or employment setting, during the probation period.
- 4) Licensee shall maintain an active license.
- 5) Licensee shall complete the following courses: *Professional Accountability & Legal Liability for Nurses* and *Righting a Wrong - Ethics & Professionalism in Nursing*. 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, Licensee shall be referred back to the Board for consideration of further disciplinary action.
- 6) Licensee shall inform Board staff in advance of any absences from Oregon and/or move from Oregon to another licensing jurisdiction. If Licensee leaves the State and is unable to practice in the State of Oregon, Licensee's probationary status will be re-evaluated.
- 7) Licensee shall appear in person or by phone, to designated Board staff for interviews on a monthly basis during the probationary period. Frequency of contact may be reviewed and revised periodically at the discretion of Board staff.

8) Licensee shall notify Board staff of any citations, arrests, or convictions for any offense, whether a felony, misdemeanor, violation, or citation within seven (7) 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 or terminations.

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

15) 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.

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

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

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

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

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

21) 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.

22) Licensee shall sign any release of information necessary to allow Board staff to communicate with Licensee's healthcare providers and release Licensee's medical and treatment records to the Board. Licensee is financially responsible for any costs incurred for compliance with the terms and conditions of this Stipulated Order.

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

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

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

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

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

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

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

Licensee understands that this Stipulated Order is a public record.

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

IT IS SO AGREED:

\_\_\_\_\_  
Cory Churner-Tisdale, LPN

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Kathleen Chinn, FNP-BC  
Board President

\_\_\_\_\_  
Date

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of  
Amanda Ciraulo**

) **STIPULATED ORDER FOR**  
) **WITHDRAWAL OF REGISTERED**  
) **NURSE LICENSE APPLICATION**  
)  
) **Reference No. 20-00958**

**License No. 201242934RN**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Amanda Ciraulo (Licensee) was issued a Registered Nurse License by the Oregon State Board of Nursing on September 10, 2012.

In March of 2016, Licensee entered into a stipulated agreement, suspending her Registered Nurse license for 4 months followed by 24 months of probation, for administering medication in a manner inconsistent with prescriber orders, documenting administration of more medication than prescribed, withdrawing incorrect doses of medication and failing to follow proper procedures for wasting medications with a witness.

On July 13, 2015, the Board learned that Licensee had violated her probation by using non-prescribed controlled substances.

On or about December 20, 2016, Licensee surrendered her Registered Nurse license.

On or about February 20, 2020, Licensee submitted a reactivation application to the Board and disclosed a history of arrests and convictions, substance use and subsequent treatment. An investigation was opened into the matter.

Information reviewed during the Board's investigations shows that Licensee entered into substance use treatment in August 2019 and successfully completed in January 2020. Licensee has remained clean and sober since August 19, 2019.

On August 5, 2020, the Board reviewed the case and requested that Licensee reapply when Licensee has had at least two years of sobriety. Licensee agrees with the Board and therefore wishes to withdraw her reactivation application with the opportunity to reapply when Licensee has sustained two years of sobriety.

By the above actions, Licensee is subject to discipline pursuant to ORS 678.111(1)(f) and OAR 851-045-0070(7)(c) which reads as follows:

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

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

(f) Conduct derogatory to the standards of nursing.

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

(7) Conduct related to impaired function:

(c) The use of a prescription or non-prescription medication, alcohol, or a mind-altering substance, to an extent or in a manner dangerous or injurious to the licensee or others or to an extent that such use impairs the ability to conduct safely the practice of nursing.

Applicant 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 Applicant:

That Amanda Ciraulo's application for Registered Nurse License be withdrawn.

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

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

Applicant understands that this Stipulated Order is a document of public record.

Applicant has read this Stipulated Order, understands this Stipulated Order completely, and freely signs this Stipulated Order for Withdrawal of Registered Nurse Application.

IT IS SO AGREED:

\_\_\_\_\_  
Amanda Ciraulo, RN

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Kathleen Chinn, FNP-BC  
Board President

\_\_\_\_\_  
Date

PLEASE RETURN ALL PAGES OF THIS STIPULATED ORDER AFTER SIGNING

SIGNATURES & DATED COPY ON FILE IN BOARD OFFICE

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Melissa Davis, RN** ) **REPRIMAND OF LICENSE**  
)  
**License No. 201143136RN** ) **Reference No. 20-00908**

---

The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Melissa Davis (Licensee) was issued a Registered Nurse License by the Board on October 17, 2011.

On or about December 20, 2019, the Board received information that Licensee failed to perform an assessment and maintain an updated care plan for a client who required G-tube delegation living in a residential facility. Additionally it was reported that the delegation documentation was confusing.

Licensee stated she completed an initial assessment of the client and developed a care plan but because this was her first private pay client without a case manager to submit the documents to, she kept them in her electronic file. According to Licensee, she was hired for G-tube delegation only and her understanding was this private client did not have the same documentation requirements as all other previous clients who had been contracted through the state.

While Licensee maintained current delegation documentation of unlicensed staff but the forms did not differentiate between initial and reassessment of the unlicensed staff. Additionally, Licensee used a generic protocol she developed for G-tube as a “procedural guidance”, which did not contain specific outline of G-tube care/feeding task to be performed, step by step.

By the above actions, Licensee is subject to discipline pursuant to **ORS 678.111(1)(f)**, **OAR 851-045-0070(2)(a)(3)(c)(g)**, and **851-047-0030(2)(a)(3)(i)(A)(j)(F)(4)(a)(d)(g)**:

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

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

(f) Conduct derogatory to the standards of nursing.

**OAR 851-045-0070** Conduct Derogatory to the Standards of Nursing Defined

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

- (2) Conduct related to achieving and maintain clinical competency:
  - (a) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established;
- (3) Conduct related to the client's safety and integrity:
  - (c) Failing to develop, implement or modify the plan of care;
  - (g) Improperly delegating the performance of a nursing procedure to a UAP

**851-047-0030 Delegation of Special Tasks of Client/Nursing Care**

These rules for delegation of tasks of nursing care, in particular the process for initial direction described in OAR 851-047-0030(3)(g), the first supervisory visit within at least 60 days described in OAR 851-047-0030(4)(d) and the documentation requirements described in OAR 851-047-0030(3)(k), apply only to those tasks of nursing care delegated after the date these rules are adopted and in effect. Any new delegation of a task of nursing care undertaken after the effective date of these rules shall be in accordance with OAR 851-047-0030(2) and (3). After the effective date of these rules, the next scheduled periodic inspection, supervision and re-evaluation shall be in accordance with OAR 851-047-0030(4).

(2) The Registered Nurse may delegate a task of nursing care to unlicensed persons, specific to one client, under the following conditions:

(a) The client's condition is stable and predictable.

(3) The Registered Nurse shall use the following process to delegate a task of nursing care:

(i) Leave procedural guidance for performance of the task for the unlicensed persons to use as a reference. These written instructions shall be appropriate to the level of care, based on the previous training of the unlicensed persons and shall include:

(A) A specific outline of how the task of nursing care is to be performed, step by step;

(j) Instruct the unlicensed persons that the task being taught and delegated is specific to this client only and is not transferable to other clients or taught to other care providers.

(F) Evidence that the unlicensed person(s) were instructed that the task is client specific and not transferable to other clients or providers;

(4) The Registered Nurse shall provide periodic inspection, supervision and re-evaluation of a delegated task of nursing care by using the following process and under the following conditions:

(a) Assess the condition of the client and determine that it remains stable and predictable;

(d) Evaluate whether or not to continue delegation of the task of nursing care based on the Registered Nurse's assessment of the caregiver and the condition of the client within at least 60 days from the initial date of delegation.

(g) The less likely the client's condition will change and/or the greater the skill of the caregiver(s), the greater the interval between assessment/supervisory visits may be. In any case, the interval between assessment/supervisory visits may be no greater than every 180 days.

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 Registered Nurse License of Melissa Davis 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 she engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against her license, up to and including revocation of her license to practice as a Registered Nurse License/Certificate.

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, she 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 her to sign this Order.

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

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

---

Melissa Davis, RN

---

Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

---

Kathleen Chinn, FNP-BC  
Board President

---

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**  
**Yvonne Elkins, RN** ) **REPRIMAND OF LICENSE**  
)  
**License No. 087003076RN** ) **Reference No. 20-01002**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Yvonne Elkins (Licensee) was issued a Registered Nurse License by the Board on June 25, 1987.

On or about April 3, 2020, the Board received information that Licensee removed a medication belonging to a resident from the workplace, without authorization, to distribute to a family member for personal use.

By the above actions, Licensee is subject to discipline pursuant to **ORS 678.111(1)(f) and OAR 851-045-0070(2)(a)(8)(j)(l)**.

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

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

(f) Conduct derogatory to the standards of nursing.

**OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined**

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

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

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

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

(j) Stealing money, property, services or supplies from the client;

(l) Unauthorized removal or attempted removal of medications, supplies, property, or money from anyone in the work place.

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 Registered Nurse License of Yvonne Elkins 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 she engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against her license, up to and including revocation of her license to practice as a Registered Nurse.

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

Licensee understands that by signing this Stipulated Order, she 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 her to sign this Order.

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

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

\_\_\_\_\_  
Yvonne Elkins, RN

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Kathleen Chinn, FNP-BC  
Board President

\_\_\_\_\_  
Date

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Linda Gruenwald, NP** ) **VOLUNTARY SURRENDER**  
)  
**License No. 200450037NP, 094000558RN** ) **Reference No. 20-01203**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses and Nurse Practitioners. Linda Gruenwald (Licensee) was issued a Registered Nurse license on July 28, 1994 and a Nurse Practitioner License by the Board on June 02, 2004.

On or about June 15, 2020, the Board received information that Licensee had violated a Board Order by practicing as a Nurse Practitioner while her license was suspended by the Board.

By the above actions, Licensee is subject to discipline pursuant to **ORS 678.111(1)(f) and OAR 851-045-0070(10)(d)**.

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

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

(f) Conduct derogatory to the standards of nursing.

**OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined**

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

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

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

Licensee wishes to cooperate with the Board in this matter and voluntarily surrender their Registered Nurse and Nurse Practitioner licenses.

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

**That the voluntary surrender of the Registered Nurse and Nurse Practitioner licenses of**

**Linda Gruenwald be accepted. If, after a minimum of three years, Ms. Gruenwald wishes to reinstate their Registered Nurse and Nurse Practitioner licenses, Linda Gruenwald may submit an application to the Board to request reinstatement.**

Licensee agrees that they will not practice as a Registered Nurse or a Nurse Practitioner 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, 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 signing of this Order.

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

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

---

Linda Gruenwald, NP

---

Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

---

Kathleen Chinn, FNP-BC  
Board President

---

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**  
**Debora Halstead, RN** ) **REPRIMAND OF LICENSE**  
)  
**License No. 084060670RN** ) **Reference No. 20-01053**

---

The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Debora Halstead (Licensee) was issued a Registered Nurse License by the Board on August 25, 1986.

On or about April 22, 2020, the Board received information that Licensee failed to properly delegate insulin administration and tube feeding to unlicensed staff for a private pay resident in an adult foster home. Additionally it was alleged that Licensee failed to ensure that the unlicensed staff could perform the tasks safely and accurately initially and failed to reassess the caregiver and condition of the client within at least 60 days from the initial date of delegation.

According to Licensee, she did not have complete order information for the insulin order initially but Licensee failed to obtain clarification. Other concerns with delegations include failure to provide resident specific, step by step instructions for the delegation of insulin administration, CBG monitoring, and tube feeding. These delegation documents were updated on or about April 24, 2020, in addition to retraining of the unlicensed staff when brought to Licensee's attention during an adult foster home licensing survey. There was no reported negative harm to the resident.

By the above actions, Licensee is subject to discipline pursuant to **ORS 678.111(1)(f)**, **OAR 851-045-0070(2)(a)(3)(g)**, and **851-047-0030(3)(a)(b)(d)(e)(f)(i)(A)(B)(C)(j)(4)(d)**:

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

(f) Conduct derogatory to the standards of nursing.

**OAR 851-045-0070** Conduct Derogatory to the Standards of Nursing Defined

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

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

(a) Failing to conform to the essential standards of acceptable and prevailing nursing practice.

Actual injury need not be established;

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

(g) Improperly delegating the performance of a nursing procedure to a UAP

### **851-047-0030 Delegation of Special Tasks of Client/Nursing Care**

These rules for delegation of tasks of nursing care, in particular the process for initial direction described in OAR 851-047-0030(3)(g), the first supervisory visit within at least 60 days described in OAR 851-047-0030(4)(d) and the documentation requirements described in OAR 851-047-0030(3)(k), apply only to those tasks of nursing care delegated after the date these rules are adopted and in effect. Any new delegation of a task of nursing care undertaken after the effective date of these rules shall be in accordance with OAR 851-047-0030(2) and (3). After the effective date of these rules, the next scheduled periodic inspection, supervision and re-evaluation shall be in accordance with OAR 851-047-0030(4).

(3) The Registered Nurse shall use the following process to delegate a task of nursing care:

(a) Perform a nursing assessment of the client's condition;

(b) Determine that the client's condition is stable and predictable prior to deciding to delegate;

(d) Determine whether or not an unlicensed person can perform the task safely without the direct supervision of a Registered Nurse;

(e) Determine how often the client's condition needs to be reassessed to determine the appropriateness of continued delegation of the task to the unlicensed persons; and

(f) Evaluate the skills, ability and willingness of the unlicensed persons.

(i) Leave procedural guidance for performance of the task for the unlicensed persons to use as a reference. These written instructions shall be appropriate to the level of care, based on the previous training of the unlicensed persons and shall include:

(A) A specific outline of how the task of nursing care is to be performed, step by step;

(B) Signs and symptoms to be observed; and

(C) Guidelines for what to do if signs and symptoms occur.

(j) Instruct the unlicensed persons that the task being taught and delegated is specific to this client only and is not transferable to other clients or taught to other care providers.

(4) The Registered Nurse shall provide periodic inspection, supervision and re-evaluation of a delegated task of nursing care

(d) Evaluate whether or not to continue delegation of the task of nursing care based on the Registered Nurse's assessment of the caregiver and the condition of the client within at least 60 days from the initial date of delegation.

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 Registered Nurse License of Debora Halstead 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 she engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against her

license, up to and including revocation of her license to practice as a Registered Nurse License/Certificate.

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, she 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 her to sign this Order.

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

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

\_\_\_\_\_  
Debora Halstead, RN

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Kathleen Chinn, FNP-BC  
Board President

\_\_\_\_\_  
Date

PLEASE RETURN ALL PAGES OF THIS STIPULATED ORDER AFTER SIGNING

**OREGON STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Amanda Hammond, RN** ) **PROBATION**  
)  
**License No. 201505186RN** ) **Reference No. 20-00348**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Amanda Hammond (Licensee) was issued a Registered Nurse License by the Oregon State Board of Nursing on July 28, 2015.

On or about December 27, 2016, the Board received a complaint regarding Licensee. As part of the investigation, Licensee reported a conviction for DUII. Licensee was evaluated and given a diagnosis that meets the Board's requirements for Monitoring by the Board.

On September 13, 2017, the Board approved Licensee entrance into the Health Professional Services Program (HPSP). Licensee has been reported Non-Compliant for three positive Toxicology tests.

Licensee has been unable to meet the requirements of the HPSP.

By the above actions, Licensee is subject to discipline pursuant to:

ORS 676.200 Board participation in program; rules.

(1)(a) A health profession licensing board that is authorized by law to take disciplinary action against licensees may adopt rules opting to participate in the impaired health professional program established under ORS 676.190 and may contract with or designate one or more programs to deliver therapeutic services to its licensees.

(c) A board may adopt rules establishing additional requirements for licensees referred to the impaired health professional program established under ORS 676.190 or a program with which the board has entered into a contract or designated to deliver therapeutic services under subsection (1) of this section.

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

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

(e) Impairment as defined in ORS 676.303.

(f) Conduct derogatory to the standards of nursing.

ORS 678.112 Impaired health professional program. Persons licensed to practice nursing who elect not to participate in the impaired health professional program established under

ORS 676.190 or who fail to comply with the terms of participation shall be reported to the Oregon State Board of Nursing for formal disciplinary action under ORS 678.111. [1991 c.193 §2; 2007 c.335 §1; 2009 c.697 §7; 2009 c.756 §§32,94]

OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined  
Conduct that adversely affects the health, safety, and welfare of the public, fails to conform to legal nursing standards, or fails to conform to accepted standards of the nursing profession, is conduct derogatory to the standards of nursing. Such conduct includes, but is not limited to:  
(10) Conduct related to the licensee's relationship with the Board:  
(e) Failing to comply with the terms and conditions of Health Professionals' Services Program agreements.

#### 851-070-0100 Substantial Non-Compliance Criteria

(1) The HPSP will report substantial non-compliance to the Board within one business day after the HPSP learns of non-compliance, including but not limited to information that a licensee:  
(d) Received a positive toxicology test result as determined by federal regulations pertaining to drug testing or self report of unauthorized substance use;  
(2) The Board, upon being notified of a licensee's substantial non-compliance will investigate and determine the appropriate sanction, which may include a limitation of licensee's practice and any other sanction, up to and including termination from the HPSP and formal discipline. Licensee admits that the above allegations occurred and constitute violations of the Nurse Practice Act. Licensee wishes to cooperate with the Board in resolving the present disciplinary matter. The following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

That the Registered Nurse License/Certificate license of Amanda Hammond 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's acceptance of this Order to complete twenty-four (24) months of monitored practice.
- 3) Licensee shall notify Board staff, in writing, prior to any change of address or employment setting during the probation period.
- 4) Licensee shall maintain an active license.
- 5) Licensee shall inform Board staff in advance of any absences from Oregon and/or any move

from Oregon to another licensing jurisdiction. If Licensee leaves the state and is unable to practice in the state of Oregon, Licensee's probationary status will be re-evaluated.

6) Licensee shall appear in person or by phone, to designated Board staff for interviews on a monthly basis during the probationary period. Frequency of contact may be reviewed and revised periodically at the discretion of Board staff.

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

8) Licensee will not look for, accept, or begin a new nursing position without prior 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 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 perform the duties of a nurse.

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

13) Licensee shall not work in any practice setting when on-site monitoring is not available. This generally includes home health agencies, traveling agencies, 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 participate in and comply with any treatment recommendations set forth by a third party evaluator approved by the Board. Within fourteen (14) days of completing treatment, Licensee shall submit to Board staff a copy of Licensee's completion certificate or discharge summary. Licensee shall attend Narcotics Anonymous (NA), Alcoholics Anonymous (AA) or similar recovery program on a weekly basis and provide proof of attendance to Board staff. Licensee shall sign any release of information necessary to allow Board staff to communicate with Licensee's treatment provider and release Licensee's treatment records to the Board.

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

18) Licensee shall abstain from using alcohol and/or other intoxicating, mind altering, or potentially addictive drugs, including over-the-counter or prescription drugs while participating in the Board's random urine drug testing program, except as provided in **Section 19** below. Licensee shall avoid any over-the-counter products and food items containing alcohol, marijuana and poppy seeds.

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

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

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

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

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

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

Licensee understands that in the event Licensee engages in future conduct resulting in violations the terms of this Stipulated Order and/or the Nurse Practice Act, 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 its approval and is subject to the Board's confirmation.

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

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

IT IS SO AGREED:

\_\_\_\_\_  
Amanda Hammond, RN

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Barbara Turnipseed, RN  
Board President

\_\_\_\_\_  
Date

SIGNATURES & DATED COPY ON FILE IN BOARD OFFICE

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **FINAL ORDER OF SUSPENSION**  
**Krystle Herrera, CMA CNA** ) **OF NURSING ASSISTANT**  
 ) **CERTIFICATE AND MEDICATION AIDE**  
 ) **CERTIFICATE BY DEFAULT FOR**  
 ) **FAILURE TO COOPERATE**  
**Certificate No. 200720025CMA,** ) **Reference No. 20-01195**  
**200510386CNA**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Certified Medication Aides. Krystle Herrera (Certificate Holder) was issued a Nursing Assistant Certificate by the Board on February 15, 2005, and Certified Medication Aide Certificate by the Board on March 05, 2007.

This matter was considered by the Board at its meeting on September 9, 2020.

On July 20, 2020, a Notice stating that the Board intended to suspend the Nursing Assistant Certificate of Certificate Holder was sent to the address of record via certified and first-class mail. The Notice alleged that Krystle Herrera failed to cooperate with the Board during the course of an investigation.

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

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

-I-

**FINDINGS OF FACT**

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

1. Certificate Holder was issued a Nursing Assistant Certificate in the state of Oregon on March 05, 2007.
2. On or about June 10, 2020, Certificate Holder was reported to the Board for diversion

of patient narcotics. The Board opened an investigation into the matter.

3. On June 11, 2020, Board staff mailed a letter to Certificate Holders' address of record requesting that an interview be scheduled to discuss the allegations. Certificate Holder was further instructed to send a written statement regarding the allegations and a current work history. Certificate Holder failed to schedule an interview and did not provide any documents to the Board.
4. On July 01, 2020, a second letter was sent to Certificate Holder's address of record, requesting that the Board be contacted within five (5) business days to schedule an interview to discuss the allegations. Certificate Holder was also asked to provide a current work history and a written statement regarding the allegations. Certificate Holder failed to schedule an interview and did not provide any documents to the Board.
5. On July 20, 2020, Board staff mailed a Notice of Proposed Suspension to Certificate Holder via first-class and certified mail. The Notice granted Certificate Holder twenty (20) days from the date of the mailing of the Notice to request a hearing. The Notice also designated that the agency file would be the record for purposes of default.
6. Certificate Holder failed to respond to the Notice of Proposed Suspension within the required twenty (20) days. Consequently, Certificate Holder's opportunity to request a hearing has expired resulting in default.

-II-

### CONCLUSIONS OF LAW

1. That the Board has jurisdiction over the Certificate Holder, Krystle Herrera, and over the subject matter of this proceeding.
2. That Certificate Holder's failure to cooperate with the Board during the course of an investigation is grounds for disciplinary action pursuant to ORS 678.442(2)(f) and OAR 851-063-0090(10)(a) and (c), which read as follows:

**ORS 678.442(2)(f) Certification of nursing assistants; rules:**

(2) In the manner prescribed in ORS chapter 183, the board may revoke or suspend a certificate issued under this section or may reprimand a nursing assistant for the following reasons:

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

**OAR 851-063-0090(10)(a)(c) Conduct Unbecoming a Nursing Assistant:**

A CNA, regardless of job location, responsibilities, or use of the title "CNA," whose behavior fails to conform to the legal standard and accepted standards of the nursing assistant profession, or who may adversely affect the health, safety or welfare of the public, may be found guilty of conduct unbecoming a nursing

assistant. Such conduct includes but is not limited to:

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

(a) Failing to fully cooperate with the Board during the course of an investigation, including but not limited to waiver of confidentiality, except attorney-client privilege.

(c) Failing to provide the Board with any documents requested by the Board; or

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

**-III-**

**ORDER**

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

ORDERED that the Nursing Assistant Certificate of Krystle Herrera is **SUSPENDED** for a minimum of two weeks, commencing five business days from the date this Order is signed, and shall continue until such time as Krystle Herrera has fully cooperated with the Board's investigation. Should the Board reinstate the Nursing Assistant Certificate of Krystle Herrera, the Certificate Holder would be subject to whatever terms and conditions the Board may impose.

DATED this \_\_\_\_ day of September, 2020

**FOR THE BOARD OF NURSING OF THE STATE OF OREGON**

\_\_\_\_\_  
Kathleen Chinn, FNP-BC  
Board President

TO: **KRYSTLE HERRERA:**

You may file a petition for reconsideration or rehearing of this Order. Reconsideration or rehearing may be obtained by filing a petition with the Board of Nursing within (sixty) 60 days from the service of this Order. Your petition shall set forth the specific grounds for

reconsideration. Reconsideration or rehearing is pursuant to the provisions in ORS 183.482.

As an alternative to filing a Petition for Reconsideration of this Order, you are entitled to judicial review of this Order. Judicial review may be obtained by filing a petition with the Oregon Court of Appeals for review within sixty (60) days from the date of service of this Order. Judicial review is pursuant to the provisions of ORS 183.482.

SIGNATURES & DATED COPY ON FILE IN BOARD OFFICE

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Kjersti Johnston, RN** ) **REPRIMAND OF LICENSE**  
)  
**License No. 201704386RN** ) **Reference No. 20-00997**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Kjersti Johnston (Licensee) was issued a Registered Nurse License by the Board on June 17, 2017.

On or about April 2, 2020, the Board received information that Licensee resigned in lieu of termination from her employer for multiple practice concerns. On or about February 2020, Licensee failed to monitor, intervene appropriately the following changes in patient condition and notify provider: elevated temperature, high MEW score, and increased drainage from surgical site.

By the above actions, Licensee is subject to discipline pursuant to **ORS 678.111(1)(f)** and **OAR 851-045-0070(2)(a)(3)(b)(4)(f)**, and **OAR 851-045-0060(3)(a)(G)**:

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

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

**OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined**

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

- (2) Conduct related to achieving and maintaining clinical competency:
  - (a) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established;
  - (3) Conduct related to the client's safety and integrity:
    - (b) Failing to take action to preserve or promote the client's safety based on nursing assessment and judgment;
    - (4) Conduct related to communication:
      - (f) Failing to communicate information regarding the client's status to members of the health care team in an ongoing and timely manner as appropriate to the context of care;

**851-045-0060 Scope of Practice Standards for Registered Nurses**

(3) Standards related to the RN’s responsibility for nursing practice. Through the application of scientific evidence, practice experience, and nursing judgment, the RN shall:

- (a) Conduct comprehensive assessments by:
- (G) Evaluating the data to identify problems or risks presented by the client.

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 Registered Nurse License of Kjersti Johnston 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 she engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against her license, up to and including revocation of her license to practice as a Registered Nurse License/Certificate.

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, she 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 her to sign this Order.

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

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

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Kjersti Johnston, RN

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Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Kathleen Chinn, FNP-BC  
Board President

\_\_\_\_\_  
Date

PLEASE RETURN ALL PAGES OF THIS STIPULATED ORDER AFTER SIGNING

SIGNATURES & DATED COPY ON FILE IN BOARD OFFICE

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Peter Jones, RN** ) **VOLUNTARY SURRENDER**  
)  
**License No. 201040419RN** ) **Reference No. 20-00820**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Peter Jones (Licensee) was issued a Registered Nurse License by the Board on March 02, 2010.

On or about January 31, 2020 the Board received information that Licensee failed to supervise clinical staff. On March 12, 2020, the Board received information that Licensee had failed to meet the standards of nursing care while practicing in a clinic setting. Licensee wishes to retire from nursing practice at this time.

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

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

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

**OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined**

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

- (2) Conduct related to achieving and maintaining clinical competency:
- (a) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established.
- (3) Conduct related to the client's safety and integrity:
- (b) Failing to take action to preserve or promote the client's safety based on nursing assessment and judgement;
- (3) Failing to clinically supervise persons to whom an assignment has been made.

4) Conduct related to communication:

- (a) Failure to accurately document nursing interventions and nursing practice implementation;
- (f) Failing to communicate information regarding the client's status to members of the health care team in an ongoing and timely manner as appropriate to the context of care.

Licensee wishes to cooperate with the Board in this matter and voluntarily surrender their Registered Nurse license.

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

**That the voluntary surrender of the Registered Nurse license of Peter Jones be accepted. If, after a minimum of three years, Mr. Jones wishes to reinstate their Registered Nurse license, Peter Jones may submit an application to the Board to request reinstatement.**

Licensee agrees that they will not practice as a Registered Nurse 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, **Peter Jones** 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 has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Voluntary Surrender.

\_\_\_\_\_  
Peter Jones, RN

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Kathleen Chinn, FNP-BC  
Board President

\_\_\_\_\_  
Date

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of**

**Christine Laib, CNA**

**Certificate No. 201503030CNA**

)

) **FINAL ORDER OF REVOCATION**

) **BY DEFAULT**

)

) **Reference No. 20-01039**

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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. Christine Laib (Certificate Holder) was issued a Certified Nursing Assistant Certificate by the Board on May 21, 2015.

This matter was considered by the Board at its meeting on September 9, 2020.

On August 7, 2020, a Notice stating that the Board intended to Revoke the Nursing Assistant Certificate of Christine Laib was sent to Certificate Holder via certified and first-class mail to the address of record.

The Notice alleged that Certificate Holder financially exploited Resident A of the care facility where Certificate Holder was employed as administrator, and failed to cooperate with the Board's investigation.

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

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

**-I-**

**FINDINGS OF FACT**

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

1. Certificate Holder was issued a Certified Nursing Assistant Certificate in the State of Oregon on May 21, 2015.
2. In Fall of 2019 Certificate Holder began managing Resident A's personal finances by using Resident A's checkbook and obtaining access to Resident A's checking account online, without authorization to do so. Resident A suffers from dementia and requires extensive assistance with decision making.

3. On November 17, 2019, Certificate Holder made a cash withdrawal of \$500 from Resident A's checking account. Certificate Holder stated that she had used the cash to purchase personal items, including clothes for Resident A, but could not produce receipts for such items.
4. On December 3, 2019, Certificate Holder made a cash withdrawal of \$2,000 from Resident A's checking account. Certificate Holder stated that the money was used to buy a money order for \$2,000 to pay a pharmacy bill for Resident A, but she could not produce a receipt. Resident A's payee-representative confirmed the pharmacy bill was unpaid.
5. In fall 2019 Certificate Holder began using Resident A's 2017 Subaru for her personal use. Certificate Holder stated that she had an agreement with Resident A that she would buy the car from Resident A for \$15,000, making payments of \$200/month. As of February 5, 2020, she had not made any payments to Resident A or the payee-representative.
6. Certificate Holder sold Resident A's recreational vehicle to Certificate Holder's in-laws for \$1500.
7. On or about June 9, 2020, and June 24, 2020, Board staff mailed a letter to Certificate Holder's address of record requesting that Certificate Holder schedule an interview to discuss the allegations. Certificate Holder was further instructed to send a written statement regarding the allegations and a current work history. Certificate Holder failed to schedule an interview and did not provide the requested documents to the Board.
8. On August 7, 2020, Board staff mailed a Notice of Proposed Revocation to Certificate Holder via first-class and certified mail. The Notice granted Certificate Holder twenty (20) days from the date of the mailing of the Notice to request a hearing. The Notice also designated that the agency file would be the record for purposes of default.

-II-

### CONCLUSIONS OF LAW

1. That the Board has jurisdiction over the Certificate Holder, Christine Laib, and over the subject matter of this proceeding.
2. That Certificate Holder's conduct is in violation of ORS 678.442(2)(f) and OAR 851-063-0090 (1)(a)(b), (2)(a), (3)(g)(k), (8)(d)(l) and (10)(a)(c) which read as follows:

**ORS 678.442** Certification of nursing assistants; rules.

(2) In the manner prescribed in ORS chapter 183, the board may revoke or suspend a certificate issued under this section or may reprimand a nursing assistant for the following reasons:

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

**OAR 851-063-0090 Conduct Unbecoming a Nursing Assistant**

A CNA, regardless of job location, responsibilities, or use of the title "CNA," whose behavior fails to conform to the legal standard and accepted standards of the nursing assistant profession, or who may adversely affect the health, safety or welfare of the public, may be found guilty of conduct unbecoming a nursing assistant. Such conduct includes but is not limited to:

(1) Conduct, regardless of setting, related to general fitness to perform nursing assistant authorized duties:

- (a) Demonstrated incidents of violent, abusive, neglectful or reckless behavior; or
- (b) Demonstrated incidents of dishonesty, misrepresentation, or fraud.

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

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

(3) Conduct related to client safety and integrity:

- (g) Failing to respect the dignity and rights of the person receiving nursing services, regardless of social or economic status, age, race, religion, sex, sexual orientation, national origin, nature of health needs, other physical attributes, or disability;
- (k) Failing to maintain professional boundaries.

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

- (d) Abusing a person;
- (l) Using one's role or title as a nursing assistant to solicit or borrow money, materials, property or possessions from a client or the client's family for personal gain or sale;

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

- (a) Failing to fully cooperate with the Board during the course of an investigation, including but not limited to waiver of confidentiality, except attorney-client privilege.
- (c) Failing to provide the Board with any documents requested by the Board[.]

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

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**-III-**

**ORDER**

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

ORDERED that the Nursing Assistant Certificate of Christine Laib is REVOKED.

DATED this \_\_\_\_\_ day of September, 2020

**FOR THE BOARD OF NURSING OF THE STATE OF OREGON**

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Kathleen Chinn, FNP-BC  
Board President

TO: CHRISTINE LAIB:

You may file a petition for reconsideration or rehearing of this Order. Reconsideration or rehearing may be obtained by filing a petition with the Board of Nursing within (sixty) 60 days from the service of this Order. Your petition shall set forth the specific grounds for reconsideration. Reconsideration or rehearing is pursuant to the provisions in ORS 183.482.

As an alternative to filing a Petition for Reconsideration of this Order, you are entitled to judicial review of this Order. Judicial review may be obtained by filing a petition with the Oregon Court of Appeals for review within sixty (60) days from the date of service of this Order. Judicial review is pursuant to the provisions of ORS 183.482.

If, after a minimum of three (3) years, you wish to reinstate your Certified Nursing Assistant Certificate, you may submit an application to the Board to request reinstatement.

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **FINAL ORDER OF SUSPENSION**  
**Cayla Larkin, CNA** ) **OF NURSING ASSISTANT**  
 ) **CERTIFICATE BY DEFAULT FOR**  
 ) **FAILURE TO COOPERATE**  
**Certificate No. 201806881CNA** ) **Reference No. 20-01090**

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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. Cayla Larkin (Certificate Holder) was issued a Nursing Assistant Certificate by the Board on August 16, 2018.

This matter was considered by the Board at its meeting on September 09, 2020.

On August 12, 2020, a Notice stating that the Board intended to suspend the Nursing Assistant Certificate of Certificate Holder was sent to the address of record via certified and first-class mail. The Notice alleged that Cayla Larkin failed to cooperate with the Board during the course of an investigation.

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

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

-I-

**FINDINGS OF FACT**

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

1. Certificate Holder was issued a Nursing Assistant Certificate in the state of Oregon on August 16, 2018.
2. On or about May 7, 2020, Certificate Holder was reported to the Board for walking off the job one hour after her shift started without notifying any staff member and through a text to a co-worker one and a half hours after leaving the facility she was having a mental health crisis.. The Board opened an investigation into the matter.

3. On July 22, 2020, Board staff mailed a letter to Certificate Holders' address of record requesting that an interview be scheduled to discuss the allegations. Certificate Holder was further instructed to send a written statement regarding the allegations and a current work history. Certificate Holder failed to schedule an interview and did not provide any documents to the Board.
4. On August 05, 2020, a second letter was sent to Certificate Holders's address of record, requesting that the Board be contacted within five (5) business days to schedule an interview to discuss the allegations. Certificate Holder was also asked to provide a current work history and a written statement regarding the allegations. Certificate Holder failed to schedule an interview and did not provide any documents to the Board.
5. On August 12, 2020, Board staff mailed a Notice of Proposed Suspension to Certificate Holder via first-class and certified mail. The Notice granted Certificate Holder twenty (20) days from the date of the mailing of the Notice to request a hearing. The Notice also designated that the agency file would be the record for purposes of default.
6. Certificate Holder failed to respond to the Notice of Proposed Suspension within the required twenty (20) days. Consequently, Certificate Holder's opportunity to request a hearing has expired resulting in default.

-II-

### CONCLUSIONS OF LAW

1. That the Board has jurisdiction over the Certificate Holder, Cayla Larkin, and over the subject matter of this proceeding.
2. That Certificate Holder's failure to cooperate with the Board during the course of an investigation is grounds for disciplinary action pursuant to ORS 678.442(2)(f) and OAR 851-063-0090(10)(a) and (c), which read as follows:

**ORS 678.442(2)(f) Certification of nursing assistants; rules:**

(2) In the manner prescribed in ORS chapter 183, the board may revoke or suspend a certificate issued under this section or may reprimand a nursing assistant for the following reasons:

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

**OAR 851-063-0090(10)(a)(c) Conduct Unbecoming a Nursing Assistant:**

A CNA, regardless of job location, responsibilities, or use of the title "CNA," whose behavior fails to conform to the legal standard and accepted standards of the nursing assistant profession, or who may adversely affect the health, safety or welfare of the public, may be found guilty of conduct unbecoming a nursing assistant. Such conduct includes but is not limited to:

- (10) Conduct related to the certificate holder's relationship with the Board:
- (a) Failing to fully cooperate with the Board during the course of an investigation, including but not limited to waiver of confidentiality, except attorney-client privilege.
  - (c) Failing to provide the Board with any documents requested by the Board; or

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

**-III-**

**ORDER**

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

ORDERED that the Nursing Assistant Certificate of Cayla Larkin is SUSPENDED for a minimum of two weeks, commencing five business days from the date this Order is signed, and shall continue until such time as Cayla Larkin has fully cooperated with the Board's investigation. Should the Board reinstate the Nursing Assistant Certificate of Cayla Larkin, the Certificate Holder would be subject to whatever terms and conditions the Board may impose.

DATED this \_\_\_\_\_ day of September, 2020

**FOR THE BOARD OF NURSING OF THE STATE OF OREGON**

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Kathleen Chinn, FNP-BC  
Board President

TO: CAYLA LARKIN:

You may file a petition for reconsideration or rehearing of this Order. Reconsideration or rehearing may be obtained by filing a petition with the Board of Nursing within (sixty) 60 days from the service of this Order. Your petition shall set forth the specific grounds for reconsideration. Reconsideration or rehearing is pursuant to the provisions in ORS 183.482.

As an alternative to filing a Petition for Reconsideration of this Order, you are entitled to judicial review of this Order. Judicial review may be obtained by filing a petition with the Oregon Court of Appeals for review within sixty (60) days from the date of service of this Order. Judicial review is pursuant to the provisions of ORS 183.482.

SIGNATURES & DATED COPY ON FILE IN BOARD OFFICE

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of  
Leah Leming**

)  
) **FINAL ORDER OF DENIAL OF**  
) **REGISTERED NURSE APPLICATION**  
) **BY DEFAULT**  
)  
) **Reference No. 20-00837**

**RN Applicant**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Nurses. Leah Leming, RN applied for a Registered Nurse in the state of Oregon on or about December 18, 2019.

This matter was considered by the Board at its meeting on June 10, 2020.

On June 12, 2020, a Notice stating that the Board intended to deny the application for Registered Nurse was sent to Applicant via certified and first-class mail to Applicant's address of record. The Notice alleged that Applicant failed to cooperate with the Board's investigation and was dishonest with the Board through the course of the Board's investigation.

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

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

**I  
FINDINGS OF FACT**

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

1. On or about December 28, 2019, Applicant was dishonest on her application to the Board. Applicant answered no to the question "*Have you ever been part of an investigation for any type of abuse or mistreatment, in any state or jurisdiction?*" In an interview with Board staff on April 22, 2020, Applicant disclosed that she had been involved in several investigations related to allegations of child abuse.
2. On or about March 16, 2020, Board staff sent a letter to Applicant's address of record requesting a copy of a police report. In an interview with Board staff on April 22, 2020, Applicant admitted that she had not yet requested the police report from the issuing agency. On this same date, Board staff requested that Applicant provide a copy of a police report. On May 18, 2020, and again on May 21, 2020, Board staff sent an email to Applicant requesting an

update on the police report. Applicant has failed to respond to the Board and has failed to provide a copy of the requested police report.

3. On June 10, 2020, the Board reviewed the facts of the case against Applicant and voted to issue a Notice of Proposed Denial of Registered Nurse.

4. On June 12, 2020, Board staff mailed a Notice of Proposed Denial of Registered Nurse to Applicant via first-class and certified mail. The Notice granted Applicant sixty (60) days from the date of the mailing of the Notice to request a hearing. The Notice also designated that the agency file would be the record for purposes of default.

## II CONCLUSIONS OF LAW

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

2. That Applicant's conduct is in violation of ORS 678.111(1)(f) and OAR 851-045-0070(10)(a)(b)(c) which reads as follows:

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

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

(f) Conduct derogatory to the standards of nursing.

**OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined**

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

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

(a) Failing to fully cooperate with the Board during the course of an investigation, including but not limited to, waiver of confidentiality privileges, except client-attorney privilege;

(b) Failing to answer truthfully and completely any question asked by the Board on an application for licensure or during the course of an investigation or any other question asked by the Board;

(c) Failing to provide the Board with any documents requested by the Board;

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

**III  
ORDER**

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

ORDERED that the Application for Registered Nurse is denied.

Dated this \_\_\_\_\_ day of September, 2020

FOR THE OREGON STATE BOARD OF NURSING

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Kathleen Chinn, FNP-BC  
Board President

You may file a petition for reconsideration or rehearing of this Order. Reconsideration or rehearing may be obtained by filing a petition with the Board of Nursing within 60 days from the service of this Order. Your petition shall set forth the specific grounds for reconsideration. Reconsideration or rehearing is pursuant to the provisions in ORS 183.482.

As an alternative to filing a Petition for Reconsideration of this Order, you are entitled to judicial review of this Order. Judicial review may be obtained by filing a petition with the Oregon Court of Appeals for review within 60 days from the date of service of this Order. Judicial review is pursuant to the provisions of ORS 183.482 to the Oregon Court of Appeals.

**BEFORE THE OFFICE OF ADMINISTRATIVE HEARINGS  
STATE OF OREGON  
for the  
OREGON STATE BOARD OF NURSING**

IN THE MATTER OF: ) **FINAL ORDER**  
)  
**JANET MATTHEWS** ) OAH Case No. 2019-ABC-02488  
) Agency Case No. 17-01923

**HISTORY OF THE CASE**

On September 18, 2018, the Oregon State Board of Nursing (Board) mailed a Notice of Proposed Revocation of License to Janet Matthews. The notice informed Ms. Matthews that she had 20 days from the date of the mailing in which to request a contested case hearing. On October 11, 2018, the Board received Ms. Matthews' request for hearing. On October 18, 2018, the Board mailed a Final Order of Revocation by Default to Ms. Matthews. On November 11, 2018, Ms. Matthews filed a Petition for Reconsideration with the Board, explaining the circumstances under which she had miscalculated the deadline for requesting a hearing. On December 12, 2018, the Board granted the Petition for Reconsideration, and on February 13, 2019, the Board referred the matter to the Office of Administrative Hearings (OAH) for a contested case hearing.

On March 8, 2019, Presiding Administrative Law Judge (ALJ) Monica A. Whitaker convened a telephone prehearing conference. Senior Assistant Attorney General Tom Cowan represented the Board. Ms. Matthews represented herself. A hearing was scheduled for February 6, 2020, before ALJ Jennifer H. Rackstraw, with a deadline of January 23, 2020 for the filing of witness lists and hearing exhibits.

On April 23, 2019, ALJ Rackstraw issued a Qualified Protective Order Limiting Use and Disclosure.

On November 1, 2019, the Board filed a notice of substitution of counsel, announcing that Senior Assistant Attorney General Lori Lindley would be representing the Board in Ms. Matthews' case from that point forward.

On February 6 and 25, 2020, ALJ Rackstraw presided over a hearing at the Board's office. Ms. Matthews represented herself and testified on her own behalf. Ms. Lindley represented the Board. The following persons testified for the Board: Brian Little, DO, former Chief of Medicine at the Oregon State Hospital (OSH); Unoda Moyo, OSH human resources employee; Jennifer Hayes, OSH lab director; Corie Shaevitz, OSH lead nurse practitioner (NP); Kathleen Moynihan, registered nurse (RN) manager; Stacey Spears, OSH mental health transporting aide; Sarah Wickenhagen, NP, Board expert; and Wendy Bigelow, Board Investigator. Assistant Attorney General Lauren Rauch observed a portion of the hearing. The

record closed at the conclusion of the hearing on February 25, 2020.

On July 27, 2020, ALJ Rackstraw issued a Proposed Order finding violations and recommending revocation of Ms. Matthews license. In the Proposed Order, Ms. Matthews was provided the exceptions period information. Ms. Matthews did not file any exceptions to the Proposed Order.

On September 9, 2020, the Board met at its regularly scheduled meeting and reviewed the Proposed Order. The Board voted to issue this Final Order at that time.

### **ISSUES**

1. Whether on December 13, 2016, Ms. Matthews failed to document that four patients refused care and on December 20, 2016, when documenting such refusals, failed to indicate that the documentation was a “late entry,” thereby engaging in conduct derogatory to the standards of nursing under OAR 851-045-0070(3)(a) and (g).<sup>1</sup>

2. Whether between 2015 and 2017, Ms. Matthews failed to follow national standards with regard to cervical cancer screenings and failed to document a follow-up plan of care, thereby engaging in conduct derogatory to the standards of nursing under OAR 851-045-0070(1)(a), (c), and (d), and (4)(b).

3. Whether on or about April 14, 2017, Ms. Matthews displayed “bizarre and erratic” behavior in the workplace that constituted conduct related to impaired function under OAR 851-045-0070(5)(b).

4. Whether, under ORS 678.111(1)(f), the Board may revoke Ms. Matthews’ Nurse Practitioner Certificate and Registered Nurse License.

### **EVIDENTIARY RULINGS**

The Board offered Exhibits A1 through A51, which were admitted into the record without objection.

Ms. Matthews offered Exhibits R1 through R13. Exhibit R1 was admitted into the record without objection as part of Ms. Matthews’ closing argument. With regard to Exhibit R3, Page 7 was excluded as irrelevant, Pages 11-16 were admitted over the Board’s relevancy objection, and the remaining pages were admitted into the record without objection. Exhibit R4 was admitted into the record without objection, with Page 1 considered part of Ms. Matthews’ closing argument. With regard to Exhibit R6, pages 35 through 37 were excluded as irrelevant, and the remainder of the exhibit was admitted without objection. Exhibits R2, R5, and R9 through R12 were admitted into the record without objection. Exhibits R7 and R13 were excluded from the record based on the Board’s relevancy objections. With regard to Exhibit R8, Pages 1-2 were admitted into the record without objection as part of Ms. Matthews’ closing argument, Page 3

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<sup>1</sup> All citations to OAR 851-045-0070 herein refer to the version of the rule that was effective March 1, 2012 through July 31, 2017.

was admitted over the Board's authenticity objection, and the remaining pages were admitted into the record without objection.

Pleadings P1 through P13 were also made a part of the record.

## FINDINGS OF FACT

### *Relevant Background*

1. Since 1977, Ms. Matthews has been a licensed registered nurse (RN) in Oregon. In October 2001, she became certified as a Nurse Practitioner (NP) in Oregon. (Test. of Matthews; *see* Ex. A43 at 1.) Since 1979, Ms. Matthews has held an RN license in Kentucky. Since 2000, she has also held a nurse practitioner license in Kentucky. (Test. of Matthews; *see* Exs. R10 at 4, R12 at 7, A36 at 2.)

2. From November 2001 to March 2003, Ms. Matthews worked at the West Salem Clinic in Salem, Oregon. From August 1, 2003 to March 1, 2005, Ms. Matthews worked at a VA Outpatient Clinic in Bend, Oregon. From March 2007 to November 2009, Ms. Matthews worked for the Oregon Department of Human Services as a program manager for School-Based Health Centers. (*See* Exs. A43 at 1, A31 at 1, A39 at 10-11; test. of Matthews.)

3. From December 2009 to June 8, 2010, Ms. Matthews worked at Liberty Street Clinic in Salem. She quit that job after the employer made an abrupt change in policy regarding on-call scheduling. (*See* Exs. A36 at 2-3, A39 at 11, A43 at 1, A45 at 2-4.)

4. In March 2014, Ms. Matthews began working on a part-time basis (approximately two to three days per month) at the EmUrgent Care Clinic. (Test. of Matthews; *see* Exs. A36 at 3, A43 at 1, A51 at 1.)

5. On February 2, 2015, Ms. Matthews began working for the Oregon Health Authority as an NP at OSH.<sup>2</sup> (Ex. A31 at 1, A41 at 8.) On May 8, 2017, the Oregon Health Authority terminated her employment. (Ex. A36 at 4.)

### *2004 Board Involvement*

6. On March 16, 2004, the Board issued a Notice of Proposed Suspension of Family Nurse Practitioner Certificate to Ms. Matthews, alleging that she had failed to properly assess, prescribe, and provide appropriate treatment for a patient at the West Salem Clinic. The Board proposed to suspend her NP certificate pending, among other things, her completion of two courses of study related to the alleged violation. (Ex. A46 at 5-8.) Ms. Matthews did not request

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<sup>2</sup> OSH provides direct psychiatric hospital care to adults with serious persistent mental illness who are unable to be served in a community setting. (Ex. A31 at 2.)

a hearing to contest the notice.<sup>3</sup> (*Id.* at 2.) On April 15, 2004, the Board issued a Final Order by Default stating, in part:

[T]he Board finds the following:

\* \* \* \* \*

1.2 That between March 8, 2002 and April 23, 2002 Janet Matthews prescribed Wellbutrin for smoking cessation to a patient with Bipolar Manic Depressive illness. During that time period she never collected a comprehensive health history from that patient and did not ask questions to assess whether or not the patient had a mental health history.

1.3 That Janet Matthews did not discontinue the Wellbutrin after the patient acknowledged his Bipolar disorder when he presented for his last visit with rapid speech and flight of ideas. Wellbutrin is an inappropriate medication for an individual diagnosed with Bipolar Manic Depressive illness.

1.4 That Janet Matthews treated this same male patient for a urinary tract infection. She prescribed three days of antibiotics rather than the community standard of seven days of antibiotic prescription. There is no evidence that she followed up on the urinary tract infection at the next and final visit with the patient.

(*Id.* at 1.) The Board ordered that Ms. Matthews' NP certificate be suspended until she successfully completed two courses of study (one regarding psychopharmacology and the other regarding male urinary tract infections), wrote a three- to four-page paper for each course, and appeared before the Board to request reinstatement of her certificate. (*Id.* at 2.) The Board subsequently allowed Ms. Matthews to continue practicing without interruption on her Kentucky license until the Board could review the matter at its next scheduled meeting. At the Board's December 2004 meeting, the Board reinstated Ms. Matthews' certificate. (*See Exs. A39 at 11, A41 at 10-12, A43 at 1.*)

#### *2011 Board Involvement*

7. On January 14, 2011, Ms. Matthews signed a Stipulation for Reprimand of Registered Nurse License and Nurse Practitioner Certificate with Conditions. (Ex. A45 at 2-4.) The written stipulation stated, in part:

On July 22, 2010, Licensee was reported to the Board for failing to document care provided to a patient, for failing to provide care to two scheduled patients, and for leaving before her shift had ended without

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<sup>3</sup> During a March 6, 2018 Board interview, Ms. Matthews reported that she did not receive the notice due to her failure to notify the Board of an address change after she relocated to Bend, Oregon. (*See Ex. A39 at 10-11; see also Ex. A41 at 10 (Addendum B of August 20, 2018 letter to Board).*)

informing clinic staff on June 8, 2010, while working at Liberty Street Clinic. Both patients were seen on the same day by another provider at the clinic. Additionally, it was reported that Licensee had failed to disclose previous disciplinary action on her credentialing application. The Board opened an investigation into the matter.

Licensee acknowledged that she had resigned from her position as a FNP at Liberty Street Clinic without notice on June 8, 2010. She confirmed that when she left the facility, she did not notify clinic staff of her departure, or ensure that she had completed care for all of her scheduled patients[.]

Licensee acknowledged that she did not confirm that all scheduled patients had been seen prior to her departure. She expressed remorse for her actions, and recognized that her behavior did not meet the expectations of a nurse practitioner, or the standards of nursing, and was an inappropriate reaction to an employer/employee dispute[.]

Licensee stated that she had not intentionally omitted disciplinary information from her original credentialing application, but had been confused by the question and how it related to the circumstances of the previous disciplinary action[.]

\* \* \* \* \*

The above contact constitutes behavior and conduct derogatory to the standards of nursing[.]

\* \* \* \* \*

Licensee admits to the above violations and wishes to cooperate with the Board in resolving the present disciplinary matter. Therefore the following will be proposed to the Board and is agreed to by Licensee:

**That the Registered Nurse License and Nurse Practitioner certificate of Janet Matthews shall be Reprimanded with the following conditions:**

1. That Ms. Matthews shall complete a course on Professional Accountability.
2. That Ms. Matthews shall not violate the Nurse Practice Act \* \* \* or any of the administrative rules adopted thereunder.

\* \* \* \* \*

Ms. Matthews understands that in the event she engages in future conduct resulting in violations of law, or violations of the terms and conditions of this Stipulation, the Board may take further disciplinary action against her, up to and including revocation of her nursing license and/or nurse practitioner certificate.

(*Id.*; bold emphasis in original.) On February 16, 2011, the Board issued a Final Order approving the stipulation. (*Id.* at 1.)

8. During a March 6, 2018 Board interview, Ms. Matthews described the circumstances under which she left her employment at the Liberty Street Clinic as follows:

I resigned from an employer after four of the six people that I had started the clinic with were unceremoniously terminated. And then my employment agreement went suddenly from what we had discussed to this is mandatory overtime and so on and so forth. And I just didn't appreciate it. And so, I gave my notice and left. And was accused of leaving without proper documentation. And leaving patients that had not been treated. All of which were not true. And which was never documented by the accusers. And I was told that this particular organization was known for reporting their nurses regularly to the [Board] as a form of retaliation and once all my documentation had been submitted, I, you know, said my peace and a letter of reprimand was issued and that was all that was said.

(Ex. A39 at 11.<sup>4</sup>)

#### *OSH Employment*

9. During all times relevant to this matter, Dr. Brian Little was the Chief of Medicine at OSH,<sup>5</sup> Kathleen Moynihan was the Clinic Nurse Manager, and Corie Shaevitz was the Lead NP. (Test. of Little, Moynihan, and Shaevitz.)

10. Ms. Shaevitz has worked at OSH for approximately 21 years. Ms. Moynihan has worked at OSH for approximately 28 years. (Test. of Ms. Moynihan.) Ms. Moynihan was tasked with the daily running of the medical clinic and coordinating work assignments for the physicians and nurse practitioners. Although Dr. Little was the clinical supervisor for the NPs (including Ms. Matthews and Ms. Shaevitz), Ms. Moynihan functioned as their day-to-day manager. (Test. of Moynihan, Shaevitz, Matthews, and Little; Ex. A35 at 1.)

11. In 2016 and 2017, the NPs at OSH included Ms. Matthews, Ms. Shaevitz, Alyce Huntsinger, Susan Mitchell, and Laurel Lee Corkran. (Test. of Moynihan and Shaevitz.) The

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<sup>4</sup> See also Exhibit R10 at 12-14 (September 23, 2010 letter from Ms. Matthews, denying that she had abandoned patients and stating that she had only gone outside the clinic to "clear her head," she then returned to the clinic to finish up charting, and she resigned the following day).

<sup>5</sup> Dr. Little was OSH's first Chief of Medicine. He left the position (and OSH) in May 2017. (Test. of Little.)

NPs routinely used group emails to communicate and keep each other updated as to patient care appointments — including whether a patient refused a scheduled examination. (See Exs. R3 at 12 and R2 at 12-16.)

12. Ms. Matthews’ OSH duties included the following: performing medical history reviews and physical examinations (H&Ps) on newly admitted patients; conducting yearly H&Ps for existing patients; performing Women’s Health Clinic services (including pap testing, STD testing, *etc.*); appropriately documenting all patient encounters, including refusals; participating in coordination of care with Medical Clinic physicians. (Ex. A31 at 2; test. of Little.)

13. A document titled “Oregon State Hospital Policies and Procedures” (dated September 28, 2017)<sup>6</sup> states, in part, the following with regard to clinical documentation of patient care:

[A] patient’s medical record is confidential and maintained for purposes of communication, accountability, and coordination of care and services provided to patients by staff. Clinical documentation contained in the medical record references significant patient-specific events, included staff interventions and observations regarding patient response to interventions, and records progress related to individual patient treatment care plan (TCP) goals.

\* \* \* \* \*

[A] staff member must complete and document required assessments as indicated in department protocol and applicable regulations or discipline-specific standards of practice.

\* \* \* \* \*

[E]ach staff member is responsible for accuracy and necessity of documentation in the medical record.

\* \* \* \* \*

[L]ate entries must be clearly identified at the beginning of the entry, and must reference the actual date and time of the event or observation.<sup>7</sup>

[S]taff must document in the appropriate section of the electronic health

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<sup>6</sup> There is nothing in the record to suggest that the policies in this document were materially different during Ms. Matthews’ period of employment at OSH.

<sup>7</sup> The standard of care in nursing requires that chart notes not completed on the date of service specify “late entry” or “addendum” and include both the date of service and date of completion. (Test. of Bigelow and Wickenhagen.)

record (EHR)<sup>8</sup> and finalize the entry. All entries placed in draft status in the EHR must be finalized within 48 hours.

\* \* \* \* \*

“Late entry” means an entry that describes events that occurred during a previous work period that was not documented by the end of that shift, or an entry that is not finalized within 48 hours.

“Medical record” means documentation about a patient’s care and treatment contained in the designated blue medical record binder or brown medical record folders, or in the electronic health record (EHR).

\* \* \* \* \*

“Treatment note” \* \* \* means a recording in the medical record that indicates provision of, and a patient’s response to, a specific modality included in the patient’s treatment care plan.

(Ex. A49 at 1-4; underlined emphasis in original.)

14. A document titled “Nurse Practitioner Protocols” (updated February 7, 2017)<sup>9</sup> states, in part, the following with regard to Admission History & Physicals (Admission H&Ps):

[T]he admission physical examination must be completed [or attempted] within 24 hours of admission. This may be done either the day of the patient’s admission or the next day. Completed H&Ps should be documented in Avatar [General Note] and recorded in the NP notebook.

\* \* \* \* \*

If the patient refuses the [Admission] H&P, order admission labs, appropriate TB screening, and admission chest x-ray and EKG. \* \* \*. Document refusal of the H&P in the following places:

1. H&P form
2. Avatar in a General Note
3. The refusal sheet on the NP communication board
4. NP blue notebook
5. Dysphagia Screening form if they refuse also to answer the questions

Recheck protocol:

<sup>8</sup> OSH’s electronic health record is called Avatar. (Test. of Matthews, Shaevitz, and Moynihan.)

<sup>9</sup> There is nothing in the record to suggest that the policies in this document were materially different during Ms. Matthews’ period of employment at OSH.

- \*once daily x 3
- \*weekly x 4 (from the admit date)
- \*monthly until completed or patient is discharged

(Ex. A44 at 20; *see also id.* at 19.)

15. It should take a practitioner no more than five to ten minutes to document a patient refusal (including a brief explanation of the circumstances of the refusal) in Avatar. Refusal documentation is important because it allows the medical team to know whether certain care has been provided to a patient, thereby reducing the risk that the patient will receive duplicate care or not enough care. Refusal documentation also provides a record of a good-faith attempt to provide care, which could be relevant to grievances or lawsuits alleging failure to provide care to OSH's vulnerable patients. Documenting the circumstances of a refusal can be helpful in determining whether there is a pattern of refusal — *e.g.*, whether the patient refuses to leave their unit, or whether they will attend an appointment but then refuse certain care. (Test. of Wickenhagen, Shaevitz, Little, and Moynihan.)

16. Avatar does not have a “tickler” feature. (Test. of Shaevitz.) The NPs at OSH were required, among other things, to document H&P patient refusals on a posted refusal sheet. One of the NPs would enter the information from the refusal sheet into an Excel spreadsheet, and that spreadsheet would serve as a tickler for H&Ps. Because women's health examinations were not mandated (as were H&Ps), refusals for women's health exams were not tracked on a posted refusal sheet. Instead, the Women's Health Clinic kept a “tickler file” (specifically, an envelope) of those refusals, and the women's health exams would be rescheduled in two months' time. (*Id.*) Ms. Shaevitz did not observe Ms. Matthews to regularly use the tickler file for women's health refusals. (*Id.*)

#### *Patient Refusals and Medical Documentation – December 2016*

17. All newly admitted female patients were offered Women's Health Clinic appointments for purposes such as cervical cancer screening, STD screening, and birth control. Patients were assigned 30-minute appointment slots, typically between the hours of 1:00 p.m. and 3:00 p.m. Patients frequently refused Women's Health Clinic appointments. (Test. of Shaevitz and Matthews.)

18. On December 13, 2016, Ms. Matthews was scheduled to work her usual shift—from 7:30 a.m. to 4:00 p.m., with a half-hour lunch. (*See Exs. R3 at 11, A31 at 5; test. of Shaevitz.*) On that date, at least six patients were scheduled to be seen at the Women's Health Clinic — including Patients DB, SH, LS, CP, and VW.<sup>10</sup> (*See Exs. R5 at 1; A44 at 2-3, 6-7.*)

19. According to OSH badge swipe records, Ms. Matthews arrived at OSH on December 13, 2016 at 7:34 a.m.; she left the facility at 2:59 p.m.; she returned to the facility at 24 seconds

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<sup>10</sup> The record establishes that Ms. Matthews documented one patient refusal in Avatar on December 13, 2016. (*See Exs. R5 at 1, A44 at 2, 6.*) The documentation for that patient (who is unnamed on this record) is not at issue in the present matter.

after 7:18 p.m.; and she left again at 48 seconds after 7:18 p.m. (See Ex. A21 at 1-2; test. of Shaevitz.) Each OSH employee who passes through a sally port<sup>11</sup> must scan their badge. With regard to other secured doors at OSH, when more than one employee passes through, it is allowable for just one person to scan their badge. (Test. of Little.)

20. Sometime between 1:00 and 3:00 p.m. on December 13, 2016, Ms. Matthews “received a distress call from [her] brother” and learned that her sister had passed away. (Ex. R3 at 14; test. of Matthews.)

21. At 6:00 p.m. on December 13, 2016, Ms. Matthews filed a leave request for sick time on December 15 and 16, 2016, so that she could visit her family. She did not provide the employer with an explanation for the last-minute leave request. She had a regularly scheduled day off on December 14, 2016. She did not work from December 14, 2016 through December 18, 2016. She resumed work on December 19, 2016, and also worked the following day — December 20, 2016. (See Ex. A44 at 7, 10; test. of Matthews.)

22. On December 20, 2016, Ms. Shaevitz instructed Ms. Matthews to complete any unfinished Avatar charting from December 13, 2016. (Test. of Matthews.) On December 20, 2016, Ms. Matthews documented in Avatar that Patients DB, SH, LS, CP, and VW had each refused care on December 13, 2016. She did not specifically document that her December 20, 2016 chart notes were late entries or addendums, and she did not provide any details regarding the circumstances of the refusals. (See Exs. A23, A24, A25, A47, and A48.)

#### A. Patient DB

23. On December 13, 2016, Patient DB had a Women’s Health Clinic referral appointment for evaluation of discharge. (See Exs. A48 at 1-2, A44 at 6, R5 at 3.) DB refused to go to the Women’s Health Clinic for her appointment because she had a meeting with her attorney. (See Exs. A44 at 6, R3 at 9.) Sometime on December 13, 2016, Ms. Matthews spoke with Donna Bartle, the unit RN, who requested that Ms. Matthews come to the unit after 3:00 p.m. that day to see DB. (See Exs. A44 at 6, R3 at 9.)

24. Patient DB reported to OSH staff that she did not see Ms. Matthews on December 13, 2016. Ms. Matthews did not document anything in Avatar on December 13, 2016 to indicate that she attempted to see, or actually saw, Patient DB on that date. (See Ex. A44 at 6.)

25. On December 15, 2016, an OSH provider examined Patient DB, and noted that she was on antibiotics and her acute UTI was improving. (See Ex. A48 at 3.)

26. On December 20, 2016, at 9:59 a.m., Ms. Matthews created a treatment note for Patient DB that stated, in relevant part:

Progress Note For: Independent Note

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<sup>11</sup> A sally port is a secured area with two sets of doors. Typically, one door must be closed before the other can be opened. (Test. of Little.)

\* \* \* \* \*

54yo Caucasian female with PMH of Hysterectomy declined to attend 12/13/16 WHC referral appointment for evaluation of discharge. Will reschedule in WHC as per OSH policy to evaluate for mammogram referral.

Practitioner: MATTHEWS, JANET A

\* \* \* \* \*

Signed: JANET A MATTHEWS on 12/20/2016 at 09:59 AM Author

(Ex. A48 at 2.) The treatment note did not include any reference to the time that the refusal on December 13, 2016 occurred. The treatment note also did not indicate that it was a late entry. (*See id.*)

*B. Patient SH*

27. On December 13, 2016, Patient SH had a Women's Health Clinic referral appointment for PAP evaluation. (*See Ex. A23 at 1.*) Ms. Matthews did not document anything in Avatar on December 13, 2016 to indicate that she attempted to see, or actually saw, SH on that date. (*See Ex. A44 at 6-7.*)

28. A General Progress Note, created by another provider at 12:54 p.m. on December 13, 2016, documented that Patient SH was seen on that date for assessment of recurrent cellulitis in the left arm. (*Ex. A23 at 2; test. of Bigelow.*) A Nursing Progress Note, created by Erin O'Connor at 2:50 p.m. on December 13, 2016, documented SH's cellulitis condition, her poor nutritional intake, and related treatment goals and objectives. (*See Ex. A23 at 3-4.*) A Nursing Progress Note, created by David Vega at 10:01 p.m. on December 13, 2016, documented shift observations and recommendations. (*See id.* at 5-6.)

29. On December 20, 2016, at 9:46 a.m., Ms. Matthews created a treatment note for Patient SH that stated, in relevant part:

Progress Note For: Independent Note

\* \* \* \* \*

60yo Caucasian female declined to attend WHC referral appointment for PAP evaluation on 12/13/16. Will reschedule in WHC as per OSH policy.

Practitioner: MATTHEWS, JANET A

\* \* \* \* \*

Signed: JANET A MATTHEWS on 12/20/2016 at 09:46 AM Author

(Ex. A23 at 1.) The treatment note did not include any reference to the time that the refusal on December 13, 2016 occurred. The treatment note also did not indicate that it was a late entry. (*See id.*)

*C. Patient LS*

30. On December 13, 2016, Patient LS had a Women's Health Clinic referral appointment for PAP evaluation. (*See Ex. A24 at 1.*) Ms. Matthews did not document anything in Avatar on December 13, 2016 to indicate that she attempted to see, or actually saw, LS on that date. (*See Ex. A44 at 6-7.*)

31. A Nursing Progress Note, created by Lateef Animashaun at 9:54 p.m. on December 13, 2016, documented SH's observed behavior during the shift, summarized her mental health issues, and listed treatment goals and objectives. (*See Ex. A24 at 2-3.*)

32. On December 20, 2016, at 9:51 a.m., Ms. Matthews created a treatment note for Patient LS that stated, in relevant part:

Progress Note For: Independent Note

\* \* \* \* \*

54yo Caucasian female declined to attend WHC referral appointment for PAP evaluation on 12/13/16. Will reschedule in WHC as per OSH policy.

Practitioner: MATTHEWS, JANET A

\* \* \* \* \*

Signed: JANET A MATTHEWS on 12/20/2016 at 09:51 AM Author

(Ex. A24 at 1.) The treatment note did not include any reference to the time that the refusal on December 13, 2016 occurred. The treatment note also did not indicate that it was a late entry. (*See id.*)

*D. Patient CP*

33. On December 13, 2016, Patient CP had a Women's Health Clinic referral appointment for PAP evaluation. (*See Ex. A25 at 1.*) Ms. Matthews did not document anything in Avatar on December 13, 2016 to indicate that she attempted to see, or actually saw, CP on that date. (*See Ex. A44 at 6-7.*)

34. A Nursing Progress Note, created by Leslie McCloud at 2:16 p.m. on December 13, 2016, documented CP's observed behavior during the shift, summarized her mental health

issues, and listed treatment goals and objectives. (See Ex. A25 at 2-3.)

35. On December 20, 2016, at 9:48 a.m., Ms. Matthews created a treatment note for Patient CP that stated, in relevant part:

Progress Note For: Independent Note

\* \* \* \* \*

50yo Caucasian female declined to attend WHC referral appointment for PAP evaluation on 12/13/16. Will reschedule in WHC as per OSH policy.

Practitioner: MATTHEWS, JANET A

\* \* \* \* \*

Signed: JANET A MATTHEWS on 12/20/2016 at 09:48 AM Author

(Ex. A25 at 1.) The treatment note did not include any reference to the time that the refusal on December 13, 2016 occurred. The treatment note also did not indicate that it was a late entry. (See *id.*)

*E. Patient VW*

36. On December 13, 2016, Patient VW had a Women's Health Clinic referral appointment for PAP evaluation. (See Ex. A47 at 1.) Ms. Matthews did not document anything in Avatar on December 13, 2016 to indicate that she attempted to see, or actually saw, VW on that date. (See Ex. A44 at 6-7.)

37. On December 20, 2016, at 9:49 a.m., Ms. Matthews created a treatment note for Patient VW that stated, in relevant part:

Progress Note For: Independent Note

\* \* \* \* \*

62yo Caucasian female declined to attend WHC referral appointment for PAP evaluation on 12/13/16. Will reschedule in WHC as per OSH policy.

Practitioner: MATTHEWS, JANET A

\* \* \* \* \*

Signed: JANET A MATTHEWS on 12/20/2016 at 09:49 AM Author

(Ex. A47 at 2.) The treatment note did not include any reference to the time that the refusal on December 13, 2016 occurred. The treatment note also did not indicate that it was a late entry. (See *id.*)

*F. Patient KC*

38. On December 23, 2016, Ms. Matthews was assigned to perform an Admission H&P on a newly admitted patient, KC, in the maximum security unit of OSH. (Test. of Shaevitz.) At 1:42 p.m. that day, Ms. Matthews emailed her NP colleagues and reported that KC had refused an exam. (Ex. A44 at 22; *see also* Ex. A44 at 1, 6.) According to OSH records, Ms. Matthews did not badge scan onto KC's unit until 3:43 p.m. on that date. (See Ex. A44 at 1, 6.)

39. Ms. Shaevitz realized that she had not seen Ms. Matthews very much on December 23, 2016. (Test. of Shaevitz.) At 3:03 p.m. that day, Ms. Shaevitz sent an email to Dawn Pope, RN, that provided, in part:

Just curious, the new admit today, [KC] refused his [History and Physical] \* \* \* as per NP Janet'[s] report[.] Just double checking if there was a specific reason, as he seemed very cooperative with the rest of his admit process. Do you know any details[?] He won't be recheck[ed] now until Tuesday[.]

(Ex. A44 at 21.)

40. At 3:59 p.m. on December 23, 2016, Ms. Matthews created a treatment note for Patient KC that stated, in relevant part:

Progress Note For: Independent Note

\* \* \* \* \*

55yo athletic appearing Caucasian male with ruddy complexion, found talking on the telephone with his mother – declined to participate in Admission H&P at this time, denying any acute physical health concerns. Staff reports he has been eating and drinking without difficulty i.e. Dysphagia Screening completed and admission labs entered into Avatar. Will re[approach] as per OSH Admission H&P protocol.

Practitioner: MATTHEWS, JANET A

\* \* \* \* \*

Signed: JANET A MATTHEWS on 12/23/2016 at 03:59 PM Author

(Ex. A44 at 4.)

41. On December 27, 2016, Ms. Pope responded to Ms. Shaevitz's December 23, 2016 email inquiry and stated, "I do not believe that he refused. I do not remember seeing anyone other than yourself here that day." (Ex. A44 at 21; test. of Shaevitz.)

42. Ms. Shaevitz subsequently sent the following documentation to the employer:

RE: Janet

12/23/16: here in the a.m., then not returned to desk all day. Emails responded to, but not seen nor signed out at the clinic.

Wrote that admit on LH2 refused at 1:42 pm, but nothing documented in Avatar as of 1530, and nothing in the hard chart, including the H&P. Pt approached and states he doesn't remember being approached by NP for physical. Very pleasant when approached...H&P not done by me at this time due to the lateness, and possibly that the patient did actually decline earlier. Emailed day RN, Dawn Pope to inquire on refusal details, as pt reported to be totally cooperative. She responded this a.m., Tuesday 12/27/16[.]

\* \* \* \* \*

I have no hard proof...but [Ms. Matthews'] documentation pattern strongly indicates that she wasn't here for a large part of the day. I also strongly suspect she fabricated the patient refusal, but cannot prove it without a doubt.

Email re: admit refusal at 0943 on LF3, but no documentation in Avatar as of 1510.

Emailed re: d/c PE done at 0730 on BG2. Documentation in Avatar at 1500.

(Ex. A44 at 1; test. of Shaevitz.)

43. In an email to Dr. Little dated December 21, 2016, Ms. Shaevitz wrote, in part:

**Women's Clinic Incidents with Janet:**

October 4, 2016 in Harbors

- \*Incident with requesting transport staff wait outside exam room
- \*Gay, clinic LPN assisting
- \*Transporters involved: Stacey Spears & Tamra Coleman

November 29, 2016 in Clinic

- \*Janet reacted poorly to transporter's chair "scraping on the floor" during

a pt's exam (Patient JA<sup>12</sup>)

\* Transporters involved: Stacey Spears & Tamra Coleman

**Women's Clinic patients seen by Janet:**

November 29, 2016

JE, MH, JA, TB

December 13, 2016 (\*\*Refusals were not documented. Janet took leave the rest of the week—last minute, and did not communicate this to anyone, aside from Kathleen at the last minute via leave request)

JJ, SH, CP, VW, LS, DB

December 20, 2016

ES, KF, EH, AS

**H&P's done (or refused) by Janet:**

12/20/2016: KH

12/19/16: CS, TG

12/13/16: JM

12/12/16: GW, RB, CO, MH

12/9/16: ML-R, AK, JH, MS

12/8/16: CP, JA

12/6/16: RW, LD

12/5/16: DG, JC

(Ex. A44 at 2-3; bold and underlined emphasis in original; test. of Shaevitz.)

44. In an August 20, 2018 letter to the Board, Ms. Matthews stated, in part:

Regarding my 12/2016 documentation \* \* \*, rather than share the specific news of my sister's suicide, I chose to be 100% professional and describe simply a family emergency. I thought I was handling things, but when I returned to work, I was told I had not charted on 5 [Women's Health Clinic] refused visits. I entered the current day's date at the top of each note and initiated each entry with the actual date of the appointment that was missed within each note. In my rush to comply, I overlooked the additional, appropriate title entry in each note of "Late Chart Entry[.]"

Then there was the allegation of my not seeing a patient that I had documented a visit on, because there was no unit entry documentation on

<sup>12</sup> Exhibit A44 lists the actual patient names, not initials.

my badge. I explained the common OSH practice of a “group entry” where only one badge is used but several people enter or exit a unit at one time. I suggested we review the video from the entire afternoon in question to validate my presence, as I absolutely recall making this specific visit, late in the day, as documented.

(Ex. A41 at 5-6.)

45. In a November 30, 2018 letter to the Board (titled “Petition for Reconsideration of OBN License Revocation”), Ms. Matthews stated, in part:

On 12/23/16, close to 4pm, I completed an OSH admission exam refusal and documented the same. However, I was accused of not visiting a patient, because my badge did not document my LH2<sup>13</sup> presence. I explained that it is common OSH practice to enter or exit an OSH locked unit, with a group of employees, as long as everyone is wearing a visible badge, the entire group can use a single employee’s badge swipe to gain unit entry. Completing an OSH admission exam within the 24hr statute, on an unstable patient that is in high demand by numerous departments, often includes numerous unsuccessful visits to the unit, before the exam, or the exam refusal is obtained. Even if I receive a phone refusal from nursing, as I did from LH2 on 12/23/16, I typically return to the unit and make an attempt to see the patient face-to-face, as even if the patient refuses, I found they are more likely to say yes next time, if they have already met me. This was the scenario on 12/23/16 when I finally located said patient, on the LH2 hallway phone with his mother. According to my progress note, I received a 1:42pm LH2 staff refusal and then at 3:43 pm, I returned to LH2 in hopes of a face-to-face encounter with the patient. I found him on the phone at the end of the hall, where he immediately refused to have an exam, which I then documented in Avatar[.]

(Ex. R4 at 4; *see also* Ex. R11 at 10-13 (January 3, 2020 letter to Board that is substantially similar to the November 30, 2018 letter).

*Patient Transporting Aides and Patient Privacy*

46. Stacey Spears works at OSH as a transporting mental health aide. Her responsibilities include transporting patients to and from medical appointments on the grounds (by foot) and off the grounds (by vehicle). OSH rules require that she remain with and keep some degree of visual observation on each an assigned patient during a medical appointment. Such visual observation could be as minimal as a patient’s foot during an examination. (Test. of Spears.)

47. During Ms. Matthews’ examinations of Women’s Health Clinic patients, a privacy curtain (consisting of a metal frame with a hanging white cloth) was utilized in the examination

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<sup>13</sup> LH2 refers to one of the buildings on the OSH campus. (*See* Ex. A28 at 2.)

room. (Test. of Spears.) Some of the OSH examination rooms were quite small and felt crowded when occupied by Ms. Matthews, a patient, and one or more transporters. (Test. of Matthews and Spears.)

48. It was important to Ms. Matthews that her Women's Health Clinic patients feel that their privacy was protected during examinations. (Test. of Matthews.)

49. On at least two occasions, Ms. Matthews requested that Ms. Spears leave the examination room while Ms. Matthews examined a patient. Ms. Spears did not honor the request, because it would have been a violation of her duty to maintain visual supervision on a transport patient. (Test. of Spears.)

50. On one occasion, Ms. Spears was in a small examination room with another transporter, a patient, and Ms. Matthews. The privacy curtain was in use. At one point during the patient's examination, Ms. Spears shifted her position from behind the curtain because she felt crowded. In response, Ms. Matthews forcefully pushed the curtain back, and the curtain and frame fell on top of Ms. Spears. Ms. Spears documented the incident and reported it to Dr. Little and OSH's human resources department. (Test. of Spears.)

#### *Cervical Cancer Screening – OSH Patients<sup>14</sup>*

51. Many OSH patients have extensive histories of sexual trauma. (Test. of Matthews and Wickenhagen.) Performing gynecological examinations with pap smears more frequently than the recommended guidelines (*i.e.*, standards of care) may result in these patients experiencing anxiety and further trauma. (Test. of Wickenhagen; Ex. A42 at 1.)

52. OSH follows the cervical cancer screening guidelines set forth by the American Cancer Society (ACS), the American Society for Colposcopy and Cervical Pathology (ASCCP),<sup>15</sup> and the American Society for Clinical Pathology (ASCP). (Test. of Wickenhagen; *see* Ex. R2 at 9.) During the time period relevant to this matter, Ms. Shaevitz kept a notebook in her cubicle with all of the cervical cancer screening guidelines/algorithms. Such information was also available to practitioners online. Because Ms. Shaevitz believed that Ms. Matthews had more women's health experience than her, she viewed Ms. Matthews as a "senior" women's health practitioner. (Test. of Shaevitz.)

53. ASCCP published revised screening guidelines in 2012. (*See* Ex. A42 at 9-32.) Under the heading, "General Comments," the guidelines state, in part:

Although the guidelines are based on evidence whenever possible, for certain clinical situations limited high-quality evidence exists. In these situations the guidelines are based on consensus expert opinion. The guidelines should never be a substitute for clinical judgment. Clinical

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<sup>14</sup> The patients at issue were treated by Ms. Matthews during the period May 5, 2015 through March 14, 2017 (the relevant time period). (*See* Exs. A1 through A27, A42 at 1-3.)

<sup>15</sup> ASCCP guidelines are considered the "gold standard" for screening. (Test. of Wickenhagen.)

judgment should always be used when applying a guideline to an individual patient since guidelines may not apply to all patient-related situations.

(*Id.* at 11.)

54. The document “Nurse Practitioner Protocols” (updated February 7, 2017) states, in part, the following with regard to the Women’s Health Clinic:

[Current ASCCP screening guidelines (2012-2013) recommend the following pap screening:

- Age 21-29, pap test every 3 years (with reflex to HPV testing)
- Age 30-65, pap with HPV testing every 5 years
- For guidelines regarding appropriate follow-up for abnormal results, see ASCCP Algorithms (2013).

(Ex. R2 at 9.)

55. In 2014, ASCCP published a minimal update to the guidelines. The 2012 guidelines nonetheless remained the standard of care. From 2012 through 2017, there was a “very consistent national standard” for cervical cancer screening. (Test. of Wickenhagen.)

56. HPV is most common in patients under the age of 30, and it often resolves on its own in that population. For patients between the ages of 30 to 65, there is a lower incidence of HPV, but a greater likelihood that HPV may result in cervical dysplasia and cancer. (Test. of Wickenhagen; *see* Ex. A42 at 1-3.)

57. During the relevant time period, the ACS, ASCCP, and ASCP screening guidelines provided that cervical cancer screening start at age 21, and that women less than 21 years of age not be screened regardless of the age of sexual initiation or other risk factors. (*See* Exs. A42 at 3, A50; test. of Wickenhagen.)

58. During the relevant time period, the American College of Obstetricians and Gynecologists (ACOG) screening guidelines provided that cervical cancer screening start at age 21, regardless of the age of onset of sexual activity, and that women less than 21 years of age not be screened regardless of the age of sexual initiation and other behavior-related risk factors. (*See* Exs. A42 at 3, A50; test. of Wickenhagen.)

59. During the relevant time period, the U.S. Preventive Services Task Force (USPSTF) screening guidelines recommended that cervical cancer screening start at age 21 (an “A recommendation”), and recommended against screening women less than 21 years of age (a “D recommendation”).<sup>16</sup> (*See* Exs. A42 at 3, A50; test. of Wickenhagen.)

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<sup>16</sup> An “A recommendation” means that the service is recommended and that there is a “high certainty that the net benefit is substantial.” (Ex. R6 at 42.) A “D recommendation” means that the service is not

60. Unnecessarily screening a patient under the age of 21 for cervical cancer may result in repeated pap smears (or other invasive monitoring, such as colposcopy) that otherwise would not be needed. (Test. of Wickenhagen; Ex. A42 at 3.)

61. On August 4, 2015, Ms. Matthews performed a pap test on Patient LE. At the time, LE was 20 years of age and had never undergone pap testing. Neither LE's treatment notes nor lab results explain Ms. Matthews' clinical rationale for performing the pap test. (See Ex. A5 at 1-3; test. of Wickenhagen.)

62. During the relevant time period, ACS, ASCCP, ASCP, and ACOG screening guidelines provided that a pap test (*i.e.*, cytology) be performed for women between the ages of 21 and 29, as well as for women between the ages of 30 and 65, every three years. During the relevant time period, the USPSTF recommended that a pap test for women in both of those age groups be performed every three years (an "A recommendation"). (See Exs. A42 at 1-3, A50; test. of Wickenhagen.)

63. During the relevant time period, under ASCCP guidelines, for women under the age of 30, a pap test with reflex to HPV (HPV reflex testing) is appropriate. With HPV reflex testing, if a patient's pap is positive for atypical squamous cells of undetermined significance (ASC-US), HPV testing is then performed. If the subsequent HPV test is negative, the patient should be re-tested in three years. If a pap results in a finding of ASC-US for a patient under age 30 and no reflex to HPV was ordered, the patient will require a repeat pap smear in one year's time. If a pap results in a finding of ASC-US for a patient under age 30 and a subsequent reflex test is found to be positive, further follow-up care (including colposcopy) is warranted due to the increased risk of cervical dysplasia. (See Ex. A42 at 1, 15; test. of Wickenhagen.)

64. Ms. Matthews ordered a pap test for each of the following patients, who were all younger than 30 years of age, without ordering reflex HPV testing:

<u>Patient</u>	<u>Date Pap Ordered</u>	<u>Age at the Time</u>	<u>Exhibit</u>
MP	9/20/2016	25	A19 at 1-2.
RB	10/4/2016	30	A20 at 1-2.
AS	12/20/2016	25	A22 at 1-5. <sup>17</sup>
JL	1/24/2017	26	A26 at 1-4. <sup>18</sup>

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recommended and that there is a "moderate or high certainty that the service has no net benefit or that the harm outweighs the benefits." (*Id.*)

<sup>17</sup> Notably, Ms. Matthews ordered no HPV testing for Patient AS in conjunction with her pap test, despite documentation in Patient AS's medical record indicating that AS had a history of high-risk HPV. (See Ex. A22 at 1.)

Ms. Matthews did not document any rationale for deviating from the screening guidelines for the above patients. (*See* Exs. A19, A20, A22, A26, A27; test. of Wickenhagen.)

65. During the relevant time period, under ACS, ASCCP, ASCP, and ACOG guidelines, HPV co-testing<sup>19</sup> should not be used for women under the age of 30. During the relevant time period, the USPSTF recommended against HPV co-testing in women under the age of 30 (a “D recommendation”). (*See* Exs. A42 at 1, 13; A50; test. of Wickenhagen.)

66. Ms. Matthews ordered a pap with HPV co-testing on each of the following patients, who were all younger than 30 years of age and did not have any history of high-risk HPV:

<u>Patient</u>	<u>Date Ordered</u>	<u>Age at the time</u>	<u>Exhibit</u>
JH	5/5/2015	27	A1 at 1-4. <sup>20</sup>
CH	5/26/2015	25	A2 at 1-5. <sup>21</sup>
TB	6/23/2015	25	A3 at 1-4.
DA	7/12/2016	21	A18 at 32-34. <sup>22</sup>
VG	7/12/2016	27	A17 at 1-3. <sup>23</sup>

Ms. Matthews did not document any rationale for deviation from the screening guidelines for the above patients. (*See* Exs. A1, A2, A3, A17, A18; test. of Wickenhagen.)

<sup>18</sup> Patient JL’s medical record, dated January 24, 2017, notes that JL has a history of high-risk HPV. (*See* Ex. A26 at 1.)

<sup>19</sup> With HPV co-testing, a pap smear and HPV test are administered together. (*See* Exs. A42, A50; test. of Wickenhagen.)

<sup>20</sup> Ms. Matthews noted in Patient JH’s medical record, dated May 7, 2015, that her plan was for JH to have HPV reflex testing. (*See* Ex. A1 at 2.) However, the lab results for JH, dated May 11, 2015, indicate that Ms. Matthews ordered the HPV co-test for JH. (*See id.* at 4; test. of Wickenhagen.) The medical record contains no explanation for the discrepancy. (*See* Ex. A1 at 1-4.)

<sup>21</sup> Patient CH’s medical record contains the same discrepancy previously discussed with regard to Patient JH’s medical record (*i.e.*, Ms. Matthews noted that the patient would have HPV reflex testing, but she inexplicably ordered the HPV co-test instead). (*See* Ex. A2 at 2, 4.)

<sup>22</sup> Patient DA’s medical record contains the same discrepancies previously discussed with regard to Patients JH and CH. (*See* Ex. A18 at 32-33.)

<sup>23</sup> Patient VG’s medical record contains the same discrepancies previously discussed with regard to Patients JH, CH, and DA. (*See* Ex. A17 at 1-3.)

67. During the relevant time period, under ACS, ASCCP, ACCP, and ACOG guidelines, for women between the ages of 30 and 65, HPV co-testing is appropriate. If both tests are negative, then the “preferred method” is to repeat co-testing in five years. (Ex. A50; test. of Wickenhagen.) During the relevant time period, under USPSTF guidelines, for women who want to extend their screening interval, HPV co-testing every five years is an option (an “A recommendation”). (See Ex. A50; test. of Wickenhagen.)

68. During the relevant time period, under ASCCP guidelines, for women between the ages of 30 and 65, if a pap test is positive for ASC-US, but the HPV test is negative, repeat co-testing in three years is appropriate. (See Ex. A42 at 1-2, 15; test. of Wickenhagen.)

69. On or about July 12, 2016, Ms. Matthews referred 51-year-old Patient JG to Willamette Valley Health Partners for a colposcopy after JG tested positive for ASC-US, but negative for HPV. Willamette Valley Health Partners denied the referral, stating that JG only needed retesting in three years’ time. Ms. Matthews did not document any rationale for deviating from the screening guidelines for JG. (See Exs. A15 at 1-6, A42 at 2; test. of Wickenhagen.) Colposcopy can caused damage to the cervix, so unnecessary colposcopy poses a risk of harm to a patient. (Test. of Wickenhagen.)

70. During the relevant time period, under ASCCP guidelines, a patient between the ages of 30 and 65 whose pap smear is negative for ASC-US (*i.e.*, cytology negative), but who has a positive HPV test should have repeat co-testing in one year. (Ex. A42 at 2, 14; test. of Wickenhagen.)

71. Ms. Matthews ordered a pap with reflex HPV testing, instead of co-testing, on each of the following patients, who were all age 30 or older:

<u>Patient</u>	<u>Date Ordered</u>	<u>Age at the Time</u>	<u>Exhibit</u>
SB	8/31/2015	46	A9 at 1-4.
SM	8/31/2015	32	A11 at 1-6.
MT	8/4/2015	30	A6 at 1-4.
LM	8/4/2015	55	A7 at 1-4.
NK	8/4/2015	39	A4 at 1-3.
BA	3/22/2016	32	A13 at 1-2.
CR	4/15/2016	50	A14 at 1-4.
IH	5/31/2016	35	A16 at 1-4.

Ms. Matthews did not document any rationale for deviating from the screening guidelines for the above patients. (See Exs. A4, A6, A7, A9, A11, A13, A14, A16; test. of Wickenhagen.)

72. Ms. Matthews ordered a pap with reflex HPV testing, instead of co-testing, on the following patients, who all have a documented history of high-risk HPV:<sup>24</sup>

<u>Patient</u>	<u>Date Ordered</u>	<u>Age at the Time</u>	<u>Exhibit</u>
VS	8/24/2015	55	A8 at 1-5.
PP	8/31/2015	51	A10 at 1-6.
LB	8/31/2015	51	A12 at 1-2.

Ms. Matthews did not document any rationale for deviating from the screening guidelines for the above patients. (See Exs. A8, A10, A12; test. of Wickenhagen.)

73. The May 2017 edition of *Obstetrics & Gynecology* discussed a study showing that upon review of 284 patient charts, “providers were not always managing abnormal PAP smears according to the current [2012] ASCCP guidelines.” (Ex. A42 at 4.) The authors of the study suggested that the results “may reflect that providers are unaware of the recent guidelines or the guidelines are too complicated.” (*Id.*)

74. In September 2017, the USPSTF posted draft recommendations on screening for cervical cancer, which included the following:

The Task Force recommends that primary care clinicians screen for cervical cancer in women ages 21 to 29 every three years with cervical cytology, more commonly known as the Pap test. For women ages 30 to 65, the Task Force recommends either screening with cervical cytology alone every three years or screening with high-risk Human Papilloma Virus (hrHPV) testing alone every five years. **This is an A recommendation.**

\* \* \* \* \*

[T]he Task Force looked at the evidence on the effectiveness of different screening tests and intervals based on age, and found that after age 30, the Pap test and hrHPV tests are both effective for cervical cancer screening[.] \* \* \*. [W]omen ages 30 to 65, therefore, have a choice between the Pap test every three years or hrHPV test every five years[.]

(Ex. A42 at 8; underlined and bold emphasis in original.) The proposed recommendations

<sup>24</sup> VS had a history of abnormal pap tests with HPV and required a LEEP (“loop electrosurgical excision procedure”) in 2013. (See Ex. A8 at 1.) PP had a history of high-risk HPV. (See Ex. A10 at 4.) LB had a history of abnormal pap tests and high-risk HPV. (See Ex. A12 at 2.)

became effective in 2018, *after* Ms. Matthews had treated the cervical cancer screening patients referenced herein. (Test. of Wickenhagen.)

### *OSH Disciplinary Actions*

75. On February 14, 2017, Ms. Matthews, accompanied by a union representative, attended a compulsory fact-finding meeting at OSH. Other meeting attendees included Dr. Little, Ms. Moynihan, OSH's chief medical officer, and an OSH labor management coach. (Ex. A31 at 4; test. of Matthews, Little, Moyo, and Moynihan.) The meeting became contentious, particularly between Ms. Matthews and Dr. Little. (*See* Ex. R8 at 1; test. of Little, Matthews, Moyo, and Moynihan.) Sometime thereafter, Ms. Matthews provided OSH with written responses to some of the questions posed to her at the February 14, 2017 meeting. (*See* Exs. R3 at 11-15 and A31 at 4.)

76. By letter dated April 14, 2017 (Duty-Station Letter), OSH's Human Resource Manager, Billy Martin, informed Ms. Matthews that effective immediately she was duty stationed at home, pending a determination regarding her OSH employment status. The Duty-Station Letter directed Ms. Matthews to appear at the Office of Human Resources on April 21, 2017, at 9:00 a.m., for a pre-dismissal meeting. (Ex. A30 at 1-2.) Mr. Martin intended for the Duty-Station Letter to be hand-delivered to Ms. Matthews. (*See id.* at 1.) In a related letter, also dated April 14, 2017 (Pre-Dismissal Letter) and intended to be hand-delivered to Ms. Matthews, Mr. Martin stated that OSH was commencing a pre-dismissal process against her. (Ex. A31 at 1-9.) The Pre-Dismissal Letter alleged, in part:

**1. You failed to work your entire scheduled shift twelve times between October 1, 2016 and December 27, 2016, and you reported having worked entire shifts on those days.**

\* \* \* \* \*

During the fact finding meeting, \* \* \* you acknowledged that your schedule was from 730-1600, with half an hour lunch. However, the record shows on twelve occasions, you clocked out with less than 8.5 h[ours] (.5 being lunch), recorded during a three[-]month period. You did not explain any of these days regarding leaving early nor why you did not inform any supervisor[.] [Y]ou continued to write down 8 hours in the recorded time book and were paid for 8 hours when you were not here for all of your shift.<sup>25</sup> \* \* \*

During fact finding, you stated that you worked in your car. You were not able to provide any proof of the work you completed in your vehicle. You did not obtain permission to work from your vehicle and outside of patient care areas. You understood this is not an approved practice at [OSH] and outside of nursing practice standards outlined by the [Board]. You did not

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<sup>25</sup> *See* Exhibit A44 at 8-10.

request approval to work from home o[r] outside of the hospital facilities. You acknowledged that you were aware of the need to obtain prior approval from any deviations in your schedule, however, you did not obtain approval for any of the noted deviations. You understood this could be considered abandonment of patient care, it resulted in undue hardship and extra work for your colleagues.

**2. Over the past two years you have excessively used NP Educational Leave and you have failed to provide documentation that supported that you actually attended any training.**

[Y]our usage is almost double the allowable amount. You used 72 hours in 2015 and 104 h[ours] in 2016. Dr. Little asked you for evidence that \* \* \* you attended the trainings, that you said you did. You did not produce evidence to support your attendance. Additionally, you have provided no proof of attending meetings and classes that you claim to have attended.

**3. On at least two occasions in the last three months, you claimed to have seen a patient you did not see[.]**

\* \* \* \* \*

During fact-finding and in your written responses, you were unable to confirm why there was a difference between when you sent an email to a colleague at 1:42 pm and the charting time of 3:59 pm, and also not arriving on unit until 3:43 pm. You claimed, in your written response, that you received a phone call from unit staff, which you did not remember during the fact finding, and that this is the information you used to send an e-mail. No unit staff verified that they spoke to you, and you would not identify whom you spoke to.

You provided a note \* \* \* for December 12, 2016 from the unit RN, among other things, explaining that per MD \* \* \* [the] patient is to be seen in women's clinic by a NP in 24 h[ours]. Patient signed up for women's clinic December 13, 2016. \* \* \*. This example you provided does not address the issue of the patient not being seen by you on December 13, 2016. On December 14, 2016 the same RN called the clinic and relayed to the LPN that you had stated to her, you would go to the unit on December 13, 2016, as [the] patient was worried regarding potential schedule conflict with her previously scheduled meeting with her lawyer. The RN found that there was no record of [the] patient being seen by you, even after asking [the] patient. It was not until December 20, 2016 that you charted the refusal only.

**4. On several occasions over the last three months, you alleged patients refused to be seen by you, and yet there was no charting on those patients[.]**

\* \* \* \* \*

You failed to document the patient's refusal (although there is no record you approached the patient), for one week after the purported refusal. Your written response does not address why you did not see the patient, nor where you were the afternoon of December 13, 2016.

Of the 5 patients scheduled for the Women's Health Clinic on December 13, 2016, only the first one at 1:00 was seen, the rest declined. All were entered without note of 'late entry' when finally entered into Avatar on December 20, 2016. The card index that the NPs keep on each patient for this clinic was not completed, but was later completed by another NP. Furthermore, on this day, December 13, 2016, you were here until 6 pm, and yet no charting was completed or started on the 5 patients. There is no record or explanation of what you did on that day. You also did not explain why it took 7 days to chart on 5 patients.

**5. You provided a forged CPR card, and presented it as authentic in order for you to not take a CPR training[.]**

\* \* \* \* \*

In or around October 2016, you provided a questionable CPR card, and presented it as authentic, in order for you to not take a CPR training offered by the hospital at no cost to you and on worktime. Upon contacting the American Heart Association – National Office, as well as the Kentucky American Heart Association office, we were notified that the CPR card you provided was fraudulent, and that we should not accept it. During fact finding, you claimed that you took CPR training that was offered at the Kentucky Derby event you attended. When the card was checked by our EDD via the American Heart Association (AHA), it was found to be fraudulent. They also indicated that the organization that issued the card, had not been a participating member of the \* \* \* AHA for a long period of time. Providing false documentation, particularly in a medical setting, by a medical provider is very serious[.]

(*Id.* at 4-8; bold emphasis in original.)

*Events of April 14, 2017*

77. Dr. Little planned to hand-deliver the Duty-Station and Pre-Dismissal letters to Ms. Matthews during her work shift on April 14, 2017. He asked Jennifer Hayes, who was then the

OSH lab manager, to accompany him on the task. (See Exs. A28 at 1 and A29 at 1; test. of Little and Hayes.)

78. Initially, Dr. Little had difficulty locating Ms. Matthews on the OSH grounds on the morning of April 14, 2017. Sometime shortly after 9:30 a.m., he and Ms. Hayes approached Ms. Matthews in an examination room.<sup>26</sup> Ms. Matthews appeared visibly upset when Dr. Little gave her the letters and told her that was being placed on duty-station at home and that she needed to leave the hospital immediately. She gathered up her belongings, exited the room, and slammed the door behind her. The door struck Dr. Little's forearm and he admonished her for the conduct. During the approximately 15 minutes that followed, Dr. Little and Ms. Hayes followed Ms. Matthews through the OSH grounds as she wound her way through various buildings, courtyards, and hallways seeking her way off the grounds. Along the way, she entered some patient care areas where patients were present, she repeatedly muttered to herself, she appeared disoriented and lost, and she continued to slam doors shut behind her — striking Dr. Little at least two more times in the process. She also slammed a door on Ms. Hayes and one other employee before finally leaving the OSH grounds. (Test. of Little and Hayes; see Exs. A28, A29, and A35 at 2.)

79. Dr. Little documented his April 14, 2017 interactions with Ms. Matthews, later that day, as follows:

This morning, I repeatedly tried getting in touch with \* \* \* Janet Matthews. I called the Clinic at approximately 8 AM, and was informed that she was on-grounds. I then obtained her extension \* \* \*, and tried to call. There was no answer. I also called her cell phone \* \* \*, which went directly to voicemail.

I asked for Jennifer Hayes, Lab Manager, to accompany me as a witness to delivering two letters: one indicating immediate duty station at home, and another detailing a meeting regarding her pre-dismissal.

I met Ms. Hayes in the Medical Clinic. Janet was not in the Clinic, nor was she in the cubicle area where Janet's desk is located. I was informed by one of the Nurse Practitioners that she was to see a patient on Tree 3.

Jennifer and I went to Tree 3,<sup>27</sup> and staff there indicated they had not seen Janet. I proceeded to send two separate emails, and repeatedly called her cell phone (which continued to go directly to voicemail).

I returned to my desk, and told Jennifer I would notify her as soon as I could locate Janet.

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<sup>26</sup> According to Ms. Matthews, two men also accompanied Dr. Little and Ms. Hayes. (Test. of Matthews.) The identities and roles of the two men are unknown.

<sup>27</sup> Flower(s), Tree, and Bridge(s) refer to buildings located on OSH grounds. (See Ex. A28 at 2; test. of Little and Hayes.)

I received a call from the Clinic that Janet was on Flowers 2. I called the unit station, and asked to speak with Janet. She got on the phone, and I told her that I was trying to get in touch with her, and that I needed to see her immediately. I also indicated that she had to stop what she was doing. She said "I am with a patient" and abruptly hung up the phone.

I then met Jennifer outside the entrance to Flowers 2. I knocked on the Exam Room door, and received no response. We entered the exam room to find Janet, alone in the room, looking at the computer.

I started to tell Janet that I was looking for her, and I did not appreciate being hung up on. She then turned away from me, and began picking up her bag, and packing up belongings. I then started to tell her that she was to leave the hospital immediately, and that she was placed immediately on duty-station at home. I gave her the packet with both letters, she grabbed it from my hands, and began to leave the exam room. I was right behind her, and she slammed the exam room door against me, but I was able to stop it with my forearm. I informed her that slamming the door on someone was assault, and I would be documenting it. She then stated, "I am trying to leave quickly." I continued to follow her, and she also slammed the door leading out of Flowers 2 against me. Again, I repeated that [t]his constituted assault, and it would be documented. She then went into the stairwell, and we followed her. She appeared to become disoriented, and entered into the passage to a small courtyard. She stated she didn't know where she was, and proceeded to go back through the stairwell to the area in front of Flowers 1. On her way through the doors leading out to the Treatment Mall, I managed to catch the door she slammed, with my hands. On the way out into the large hospital court[lyard], she did manage to slam the door against my forearm again. All the while, she was walking very quickly, and saying over and over, "Leave grounds immediately."

She then went through the hallway in the Clinic building. I thought she was going to her desk to collect some belongings, however, she made a left out of the Clinic building, and then began walking in a long loop in the large courtyard. I asked her where she was going, and [told her] that she needed to leave immediately. She then began heading toward the Bridges Treatment Mall hallway adjacent to the Kirkbride Café. I then followed her into the Sally port in the center of Kirkbride. Upon going through the outer door of that Sally port, she attempted to slam the door against us, however, her coat became tangled on the door handle. This caused the door to only partially shut, closing it on [employee] Camille Wallen, who was in the Sally port with us.

Janet then slammed the door leading out of the stairwell, hitting Jennifer Hayes. I informed Janet that this was the fourth assault she committed, and I would also be notifying her Nursing Board.

I continued to remind her to review the letters in the envelope I gave her, and that she was not to come back on grounds until the date indicated in her packet. She did not turn around to look at me.

(Ex. A29 at 1-2; test. of Little.)

80. Approximately 15 minutes after Ms. Matthews left the OSH facility, Ms. Hayes wrote a statement detailing what had occurred. (See Ex. A28 at 1; test. of Hayes.) That written statement provides, in part:

I accompanied Dr. Brian Little to the Flowers 2 Exam room at approximately 0938 on the morning of April 14, 2017.

Upon entering the [Flower 2] exam room that was only occupied by Janet Matthews, NP, Dr. Little advised her that she needed to leave the grounds immediately, could go back to her office to collect any items, gave her a packet of papers, and advised her to not return until she ha[d] read the packet and follow-up listed in the packe[t]. She logged out of the computer, grabbed her belongings (backpack and coat), left the exam room, and tried to close the door on Dr. Little. I followed behind. Dr. Little advised her that the purposeful slamming of a door \* \* \* [against another person constituted] assault and that it would be documented.

Janet proceeded to try and exit to the courtyard between Flower and Tree[] all the while repeatedly chanting, "Leave the grounds immediately!" Her badge did not let her enter the cube land next to the courtyard. Janet redirected and ended up next to the East Plaza area. During this short distance, she closed another door on Dr. Little while exiting the Flower stack. Dr. Little advised her again that the purposeful slamming of the door \* \* \* [against another person constituted] assault and that it would be documented. She stopped chanting at this point with much prompting from Dr. Little to act professional and continued to walk towards the medical clinic. Upon entering the medical building, she closed the door on Dr. Little for a third time. Dr. Little repeated [the warning regarding] assault[.]

She proceeded north through the Medical Building. Upon exiting the building, she turned around and was going southbound back towards the Flowers stack. It was apparent that she was not going back to her cube (now going the opposite direction) and Dr. Little asked her what exit she was going to leave from \* \* \* [and] where she was parked at. After asking twice, she redirected saying she was leaving "this way[.]"

We arrived at the Sally Port just west of the Bridges stack. We entered the Sally Port uneventfully with two additional employees \* \* \*. Immediately upon exiting the Sally Port, Janet tried to close another door on Dr. Little or myself, but her coat was caught on the push-handle and she ended up partially closing it on [one of the employees]. Janet, Dr. Little and myself proceeded to the nearest exit, going through one more door. Janet managed to close the door on me. \* \* \*. The entire incident spanned over approximately 15 minutes time.

(Ex. A28 at 1.)

#### *Current Board Involvement*

81. On May 3, 2017, Board Investigator Rick Sexton<sup>28</sup> conducted a telephone interview with Hal Mitchell, D.O., of the EmUrgent Care Clinic. (Ex. A51.) During the interview, Dr. Mitchell stated that he had no concerns regarding Ms. Matthews' nursing skills and practice. However, he reported that he had spoken with her "fairly recently" after she became "really mad" at several of the medical assistants and "unloaded on them a little bit" because she believed they were not performing their required duties. He further reported that Ms. Matthews apologized for her behavior towards the medical assistants and that she was generally regarded at the office as friendly and capable. (*Id.* at 1-2.)

82. On October 4, 2017, Board Investigator Sexton conducted a telephone interview with Dr. Little. (Ex. A35 at 1-3.) During the interview, Dr. Little expressed various concerns regarding Ms. Matthews, including that she did not see certain patients that she documented seeing, that she left the workplace without informing anyone that she was leaving, that she claimed to have worked in her car, and that she submitted a fraudulent CPR card. (*Id.* at 1-2.)

83. At the Board's request, Sarah Wickenhagen, NP,<sup>29</sup> reviewed a random sampling of Ms. Matthews' OSH Women's Health Clinic patients between the period of April 28, 2015 and February 28, 2017.<sup>30</sup> (Ex. A42 at 1; test. of Wickenhagen; *see* Exs. A1 through A27.) She determined that Ms. Matthews deviated from the ASCCP guidelines in multiple instances, and that Ms. Matthews did not document any justification(s) for doing so. Ms. Wickenhagen also determined that in several instances, Ms. Matthews documented a plan to order one type of test, but she in fact ordered a different type. (*See* Exs. A42 at 1-3, A50; test. of Wickenhagen; *see* Exs. A1 through A27.) In Ms. Wickenhagen's opinion, there may be "one offs" or "interesting

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<sup>28</sup> At the time of the hearing, Investigator Sexton no longer worked for the Board. (Test. of Bigelow.)

<sup>29</sup> Ms. Wickenhagen received a Bachelor's degree in 1996, a Master's degree in 2008, and a Doctoral degree in Nursing Practice in 2013. At the time of the hearing, she was an Army officer, she owned her own consulting business, and she worked 30 hours per week as an NP for Salem Health. (Test. of Wickenhagen.)

<sup>30</sup> Ms. Wickenhagen subsequently reviewed records for Patient AL, dated March 14, 2017, as well. (*See* Exs. A27, A42 at 1-2; test. of Wickenhagen.)

cases” where a practitioner might deviate from the screening guidelines. (Test. of Wickenhagen.) However, Ms. Wickenhagen could discern no reasonable pattern or rationale for why Ms. Matthews ordered the screenings she did for the patients at issue. In Ms. Wickenhagen’s opinion, the fact that Ms. Matthews may not have had access to historical treatment records for the patients at issue does not explain or justify Ms. Matthews’ screening decisions. (*Id.*)

*May 22, 2017 Psychiatric Evaluation*

84. Upon referral from the Board, on May 22, 2017, Katy Powell, PMHNP, conducted an Initial Psychiatric Evaluation of Ms. Matthews. (Ex. A33 at 1-7.) Ms. Powell’s written evaluation report states, in part:

[Ms. Matthews] worked part-time in 2004 at West Salem Clinic. While working in this position, she describes being in a “snafu” with the [Board]. She describes helping a man with smoking cessation and working very well with him. She describes this being a meaningful patient relationship in which she was very beneficial for his making healthy lifestyle changes. Ms. Matthews states his “jealous wife” complained to the [Board] about her care for the man and that the basis of the complaint was jealousy regarding his working relationship with her. With questioning, Ms. Matthews tells of the [Board] complaint being about her prescription of an antidepressant for smoking cessation that the wife argued was risky due to the man’s mental health history. She denies any ill outcome from this. When the [Board] attempted to contact her about the complaint, they were unable to reach Ms. Matthews due to her having moved and not updating her contact information. For a period of time, she was deemed to be non-compliant with the complaint due to non-contact[.]

\* \* \* \* \*

[At OSH, on] April 14, 2017, Ms. Matthews was in the middle of a physical exam on a gentleman with Autism. She was pulled out of the exam to take a phone call from Dr. Little. She was frustrated about having been interrupted in an exam with a patient who may not respond well to interruptions. She states that on the phone “I was more curt than I had ever been in my life.” Dr. Little requested to come [*sic*] to his office within the next 5 minutes and she responded that she was in the middle of an exam, then hung up on him. She returned to the exam and was documenting following its completion, when Dr. Little and several other people arrived at her work area. She denies yelling, slamming doors, running, or any other disruptive behaviors. She reports she was escorted off the unit with dismissal papers that day and was told she would be reported to the [Board] for her behaviors[.]<sup>31</sup>

<sup>31</sup> During a subsequent neuropsychological evaluation on July 27, 2017, Ms. Matthews reported that after Dr. Little and several security staff came to the exam room to physically escort her off the OSH premises

\* \* \* \* \*

[M]s. Matthews denies a history of inappropriate workplace behavior and continues to describe herself as a model of professionalism with very good practice skills. She denied a history of mental diagnoses. \* \* \*. She denies a history of problematic mood swings. [She states,] “I think I am viewed as a solid, stable, calming influence.” \* \* \*. She reports \* \* \* that she is able to maintain healthy supportive relationships.

(*Id.* at 1-3.)

85. After reviewing collateral documentation that Board Investigator Sexton provided regarding Ms. Matthews’ Board disciplinary history and OSH employment history, Ms. Powell determined that the collateral documentation was “somewhat conflicting” with information that Ms. Matthews had provided to her on May 22, 2017. (Ex. A33 at 7; *see id.* at 1-3, 6.) In her evaluation report, Ms. Powell concluded, in part:

[I]n her 5/22/17 interview, Ms. Matthews did not provide the full details of her [Board] reprimands. She did not mention the negative consequences with potential injury which resulted from her action in 2004. She demonstrated little insight or remorse and instead focused on this being triggered from interpersonal jealousy, not from a lapse in clinical judgment that had negative consequences. In other words, she is not taking on full responsibility for an error and she has not seemed to have incorporated this as a learning experience as one would like to see in a health care professional. Ms. Matthews also failed to mention her 2011 issue with the [Board]. Of concern is that a similar complaint, which Ms. Matthews denies, was made by the Oregon State Hospital.

[M]s. Matthews denies any poor practice habits and describes herself as a model clinician who holds herself to high standards. This is in conflict with reports from her most recent supervisor[,] Dr. Little[,] who describes a clinician who has provided fraudulent documentation, left her post, and was unprofessional in clinical areas. Dr. Little additionally describes aggressive and erratic behaviors in clinic around staff and patient areas.

[P]er her 5/22/17 assessment, Ms. Matthews does not meet criteria for a mood disorder or thought disorder. She was regulated at our visit. Symptoms/behaviors of concern that do not meet criteria for a diagnosis include a history of dismissive nature when in a corrective action, be it from a supervisor at work or the [Board], as well as poor insight into the severity of her actions and how they affect others.

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on April 14, 2017, she was “speechless, frightened, and went in[]to fear mode.” (*See Ex. A34 at 2.*)

[I]n light of the above, I have questions regarding Ms. Matthews['] overall state of wellness, cognition, and awareness. It is not clear that she is at all impaired at this time, however there is recorded documentation of dysregulated behaviors. To gain clarity regarding Ms. Matthews['] emotional and cognitive strengths and potential deficits, I recommend she undergo a neuropsychiatric evaluation[.]

(*Id.* at 7.)

*July 27, 2017 Neuropsychological Evaluation*

86. Upon referral from Ms. Powell, on July 27, 2017, Megan Callahan, PsyD, conducted a Neuropsychological Evaluation of Ms. Matthews. (Ex. A34 at 1-6.) Dr. Callahan's evaluation was based on a clinical interview of Ms. Matthews, a medical records review, a review of Ms. Powell's report, an interview with Ms. Powell, and findings from neuropsychological testing. (*Id.* at 1.)

87. Dr. Callahan's evaluation report states, in part:

[B]ased on her assessment results, education, and employment history, [Ms. Matthews'] baseline general cognitive ability is estimated to be in the above average range. \* \* \*.

\* \* \* \* \*

Ms. Matthews' responses on a measurement of personality and psychological function depict an individual with a high level of defensiveness and, perhaps, limited insight or a lack of understanding into her own behavior. She endorsed symptoms of depression and anxiety. These are likely related to her recent termination and the distress of potentially losing her license. Notably, her high level of defensiveness makes it likely that she is experiencing greater distress than she is letting on to others; as such, her clinical profile may underrepresent her true level of distress. Interpersonally, she tends to present a façade of adequacy and control, yet she appears to have difficulty admitting to minor weaknesses. She is likely to seem warm and charismatic initially, but this persona may fade over time as she is challenged by even minor conflicts. In such cases, she may resort to anger and resentment, particularly towards figures of authority. Her responses suggest that she has had limited success in learning from past experiences, integrating feedback, and modifying her behavior.

Diagnostically, Ms. Matthews does not meet criteria for a mood or anxiety disorder. \* \* \*. She expressed some difficulty coping with the current events and related emotional distress. Given her pattern of defensiveness, it is likely that she is having more trouble than she has disclosed.

Ms. Matthews has exhibited a history of defiant behavior in her professional career, with some limited insight and remorse. This is further supported by the evaluation completed by Ms. Katie Powell[.] Although she describes herself as an exemplary clinician and appears to have many strengths, these repetitive offenses are concerning and highlight her emotional immaturity. They also support the clinical finding that she has demonstrated an inability to learn from past mistakes. Given the above information, the [B]oard should take caution when determining if Ms. Matthews[] can resume working in the nursing profession.

(Ex. A34 at 5-6.)

88. Dr. Callahan diagnosed Ms. Matthews with adjustment disorder with mixed anxiety and depression. Dr. Callahan recommended, among other things, that Ms. Matthews engage in psychotherapy to address her pattern of defensiveness, interpersonal conflict, and defiant behaviors, particularly if she were to resume working as a nurse. Dr. Callahan also made the following recommendation:

Should Ms. Matthews be allowed to resume the practice of nursing in Oregon, it is recommended that she be formally provided with documentation of the standards of practice (SOP) in nursing by her employer and/or the [Board]. Performance evaluations should be conducted quarterly during the first year of employment, decreasing in frequency to six months and one year, thereafter. Performance reviews should be specifically tied to the SOP for her employer and the [B]oard, and direct, written feedback given at each interval. A documented and mutually agreed upon remediation plan should be put into place if Ms. Matthews[] does not meet the requirements of the SOP. To mitigate the concern a future miscommunication, it is recommended that professional feedback and reviews be provided by two supervisors, or a supervisor and colleague (witness), along with written documentation.

(Ex. A34 at 6.)

89. During a March 6, 2018 Board interview, Ms. Matthews expressed that the behaviors noted by the two evaluators, and the conclusions the evaluators reached (*e.g.*, that she struggled to admit even minor weaknesses, that she is emotionally immature, and that she has demonstrated an inability to learn from past mistakes) were exclusively limited to “behavior that was responsive to the treatment that [she] received at [OSH].” (Ex. A39 at 21.) In an August 20, 2018 letter to the Board, Ms. Matthews stated, in part:

It is my contention that both the OSH allegations and the resulting 7/2017 neuropsychological evaluation were exclusive and isolated events, relevant only within the extreme and hostile context of my former OSH employment.

(Ex. A41 at 2; *see also id.* at 3.)

*Ms. Matthews' Board Interviews*

90. On December 8, 2017, Board Investigator Sexton conducted an in-person interview with Ms. Matthews. (Ex. A36 at 1-19.) During the interview, she informed Investigator Sexton that the privacy rights of OSH patients were “commonly violated,” but she denied ever yelling at or raising her voice towards OSH transportation staff. (*Id.* at 4.) When Investigator Sexton questioned her about reports that she failed to work her entire shift on 12 occasions during a three-month period at OSH, she claimed that she sometimes took her employer-issued laptop outside on the OSH grounds to work and/or performed work in her parked car. She reported that she never failed to see her scheduled patients and that OSH staff was always able to locate her. (*Id.* at 4, 6-7.) She explained that records of her badge use (*i.e.*, swiping her badge to get through secured doors on the OSH grounds) might not always accurately reflect her movements on the OSH grounds (and therefore might not substantiate that she saw a particular patient in a particular location) because she sometimes moved through security areas at the same time as other staff members and one of those other staff members might use their badge to let the entire group through the area. (*Id.* at 7.) She reported that of the six patients she was scheduled to see on December 13, 2016, she saw one and the other five refused to be seen. She admitted that she did not document the refusals until seven days later, but she claimed that “there was no patient harm.” (*See id.* at 8.) During the interview, Investigator Sexton questioned Ms. Matthews about the April 14, 2017 incident, stating that the employer reported that she had “displayed erratic, bizarre behavior \* \* \* [r]unning through the campus \* \* \* [f]lailing your arms \* \* \* [f]orcibly closing doors behind you \* \* [h]itting the medical director with the doors \* \* \* [h]itting the lab manager with the doors. In response, Ms. Matthews stated, in relevant part:

That’s a pretty extreme description. [I] was charting and finishing up on a patient and suddenly they burst into the exam room. \* \* \*. And yeah, I was upset. And I knew that \* \* \* I was supposed to leave. \* \* \* [H]e was \* \* \* escorting me like I was [a] danger. But I mean I was trying to leave as discretely as possible. It is a high security environment. You always close the doors behind you[.]

\* \* \* \* \*

[A]nd no, I never did anything physically like that. I think I left down a stair well that I wasn’t familiar with.

\* \* \* \* \*

It’s huge. \* \* \*. So it is a little bit disorient[ing] if you go somewhere, you’re not sure of. And then where was my car? Cause suddenly I’m going home, you know? And so, I was kind of like where am I? But I think that’s a little extreme. \* \* \*.

\* \* \* \* \*

[T]hat's not to say I wasn't upset. I was ambushed. I was \* \* \* afraid. This is a person who had always been nice to me and now suddenly was screaming at me. And I'm told that I'm losing my job. So, yes, I was upset. I don't recall doing anything physically assertive much less aggressive towards anyone. There is a protocol to shut every door behind you in a high security environment. I did comply with that.<sup>32</sup> I was a little disoriented based on the circumstances as to where my car was suddenly. And that could have been construed as part of the issue.

(*Id.* at 11-12.) During a subsequent Board interview with Investigator Sexton, on March 6, 2018, Ms. Matthews stated, in part:

[I] never exited the hospital from that location. I wasn't even sure where my car was. \* \* \*

\* \* \* \* \*

[OSH is] huge. There's like six sally ports where you can get out. And it's really easy to get disoriented. And so, you know, I was trying to figure out and we were off. I didn't say a word. We were off the \* \* \* patient care unit. Almost immediately. But I mean he just kept threatening me about I'm reporting you to the Board. And \* \* \* don't you ever come back. I mean he's just s[o] dramatic[.]

(Ex. A39 at 16-17.) When Investigator Sexton asked Ms. Matthews on March 6, 2018 whether she had been walking briskly through patient areas, talking incoherently, and waiving her arms, Ms. Matthews replied, "That's so not true." (*Id.* at 17.)

91. During the December 8, 2017 interview, when Investigator Sexton asked Ms. Matthews about concerns that she was not following ASCCP guidelines with respect to reflex testing for women under the age of 30, Ms. Matthews responded, in part:

[A]s of the 2014 reprint [of ASCCP]. \* \* \*. [B]ecause so many kids are, I mean basically everybody's positive for HPV, that that guidance directed you not to test at all[.] \* \* \*. So, that included not reflexing[.]

\* \* \* \* \*

[T]he idea is that if you diagnose somebody with HPV and then say okay you have HPV \* \* \* [w]hen indeed it's going to go away in two years \* \* \* [t]hen why even diagnose them, why put them through the trauma of it when it's going to clear anyway? Alright.

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<sup>32</sup> See also Exhibit A39 at 18.

\* \* \* \* \*

So, that's why the 2014 reprint said don't even test anymore which is why I stopped reflex testing.

\* \* \* \* \*

And that's my understanding. Now I need to check all these records. But I thought I was being progressive and not stressing out these young girls based on that. And in fact, you know, the folks that are still testing these young gals are actually kind of not only doing unnecessary testing but they're traumatizing \* \* \* their young girls unnecessarily[.]

(Ex. A36 at 14-15.)

92. On January 18, 2018, Board Investigator Sexton conducted a second in-person interview with Ms. Matthews. (Ex. A37.) The purpose of the interview was for Ms. Matthews to review progress notes and lab results for certain patients she saw between April 2015 and February 2017, and then explain her rationale for ordering (or not ordering) certain cervical cancer screenings for those patients. During the interview, Ms. Matthews again stated (as she had on December 8, 2017) that women under the age of 30 did not need to be tested for HPV because of the significant likelihood that HPV in that population would resolve on its own. (*See id.* at 1-2.) She specifically stated:

And that's why we don't screen under that age. That with these particular individuals their vulnerability made it a better choice not to make that diagnosis and that information discussed with their minds. That was a more humane choice[.]

\* \* \* \* \*

And so, making decisions within the realm of their vulnerability to having a \* \* \* very distraught reaction to an HPV diagnosis that really didn't need to be made \* \* \* [w]as a consideration particularly within this population. And that's something that I would discuss with the team. [W]e would usually make \* \* \* a decision as a team before we would make a decision along those lines.<sup>33</sup> \* \* \*. [W]e had consensus with the staff on the units

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<sup>33</sup> However, during a Board interview on March 6, 2018, Ms. Matthews stated, in part, the following with regard to the "team" and her deviation from cervical screening guidelines:

It isn't really a team so much as you would be assigned to the women's health clinic[.]

\* \* \* \* \*

as well. So, I think it was population specific and very specific to the individuals as to why these exceptions were made.

\* \* \* \* \*

[W]hat would happen is if you ordered reflex on these gals and it came back positive what research said is that we still weren't going to treat them. They're under 30 \* \* \* and it's going to self-resolve. So \* \* \* you're going to test them again anyway in a year. So, regardless of whether you do the test or not, you're going to see them again in a year. So, here's this fragile person. You don't want to say if [they] have HPV because it's going to resolve anyway. So, why put them through that traumatic diagnosis?

\* \* \* \* \*

You would test them again in a year anyway even if it was positive. They're a high risk individual for STDs because of their behavior.

\* \* \* \* \*

[A]nd these new 2018 ASCCP recommendations \* \* \* are very supportive of it primarily because [the] most harmful thing[s] are these increased colposcopies under the age of 30. That's what we want to avoid. So, I feel very good about those decisions.

(*Id.* at 2-4.) Ms. Matthews also told Investigator Sexton that “a lot” of insurance companies would not pay for certain HPV testing and that it “was a matter of reimbursement.”<sup>34</sup> (*Id.* at 3.) During the interview, Investigator Sexton asked Ms. Matthews why she made a gynecological referral for colposcopy on a patient with a finding of ASC-US but a negative HPV test. Ms. Matthews responded, in relevant part:

[T]hat was a mistake. And that's when I first learned about the algorithms. I hadn't done paps in a while. And I was asked to start working in the women's health clinic when I started at [OSH] in 2/15.<sup>35</sup>

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[I] worked alone. I was the only one who did the women's health clinic. That's why I was able to change it.

(Ex. A38 at 7.)

<sup>34</sup> It is unclear from the January 18, 2018 interview transcript whether Ms. Matthews is referring to HPV reflex testing, HPV co-testing, or both with regard to insurance reimbursement difficulties. However, during a Board interview on March 6, 2018, Ms. Matthews specified that “a lot” of insurance companies will not pay for HPV *co-testing* and “they try to not reimburse for it.” (*See* Ex. A39 at 9.)

<sup>35</sup> Later in the interview, Ms. Matthews clarified that she did not begin working in the Women's Health Clinic until approximately one year after starting her OSH employment. (*See* Ex. A37 at 5.) However, the record establishes that Ms. Matthews began seeing patients in the Women's Health Clinic at least as

And, you know, when I got that refusal, that's when I looked it up online. And I realized that there was [*sic*] these very specific referral guidelines. So, I definitely adopted those ever since then. And in fact, have used the 2014 reprints since then. And like I say, I just got the \* \* \* email yesterday about the 2018 updates coming out.

(*Id.* at 4.) When Investigator Sexton questioned Ms. Matthews about ordering HPV reflex testing (as opposed to co-testing) on several patients who were ages 30 and older, Ms. Matthews responded, in part:

[Y]eah, these three,<sup>36</sup> you know if I had it to do over again, I would probably have written it as a co[-]test. I can't see anything from my documentation as a rationale. I \* \* \* would [have] appreciated this as feedback earlier. I never got any feedback like this in my evaluation. But it would be quite helpful. One of the points raised in the email yesterday that I received is that one of the issues about the algorithms is that the majority of providers still don't use them.

\* \* \* \* \*

[I] mean even though they are still heavily research[-]based and supported by these wonderful professional organizations, it's still a matter of educating the educators. So, it's nice to get this feedback.

\* \* \* \* \*

[B]ased on compliance with the algorithms these three would \* \* \* more strictly fall in line with co[-]testing[.]

(*Id.* at 5-7.) When Investigator Sexton questioned Ms. Matthews about ordering HPV co-testing on three patients between the ages of 21 and 29 (TB, VG, and JH), Ms. Matthews stated that she could discern no obvious basis for ordering co-testing for TB, and she suggested that a "lab error" could have occurred. (*See id.* at 9.) Ms. Matthews told the investigator that she ordered an HPV test for VG because VG "was concerned about her folliculitis being HPV" and VG was "very, very pelvic focused." (*Id.*) Ms. Matthews further reported that she ordered the test for VG "mainly for reassurance based on her request and the staff requesting it as well on the unit." (*Id.* at 10.)

93. On March 6, 2018, Board Investigator Sexton conducted a third in-person interview with Ms. Matthews to further review and discuss patient medical records pertaining to cervical cancer screening. (*See Exs.* A38 and A39.) Early in the interview, Ms. Matthews informed

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early as May 7, 2015. (*See Exs.* A1, A39 at 4.) The record also contains treatment notes for patients Ms. Matthews saw in the Women's Health Clinic on May 26, 2015, August 4, 2015 (three patients), August 24, 2015, and August 31, 2015 (three patients). (*See Exs.* A2, A5 through A11.)

<sup>36</sup> Ms. Matthews and Investigator Sexton were specifically discussing patients SM, BA, and LB. (*See Ex.* A37 at 6-7.)

Investigator Sexton that two things caused her to “make the clinical judgments that [she] did regarding having patients return to clinic and rely on [cytology] screening rather than do HPV screening \* \* \* [t]he fragility of the chronically vulnerable female population with common pelvic fixations and associated anxiety[;] \* \* \* [a]nd the in-house patient status which allowed for convenient follow up and appointment rescheduling.” (Ex. A38 at 1.) She further stated:

[A]nd I think this \* \* \* [may be why] it was easy to not understand some of my thinking regarding this fragile population and why I chose to use a standard tickler system for any cervical screening population. And instead of saying okay you’re going to be screened for HPV \* \* \* I would have them return to the clinic in one year. \* \* \*. [The] screening time interval guidelines the ASCCP recommended were really too long for this vulnerable population. Usually there was a lot of sexual activity even within the hospital \* \* \*. Much less associated with the revolving door that is our mental health system[.]

\* \* \* \* \*

So, under the umbrella of doing no harm where [sic] the building blocks behind my practice to use shortened time interval[s] with [cytology] screenings rather than HPV testing for this vulnerable \* \* \* population[] came to be my practice. \* \* \*. [I] chose to adjust my practice to the [cytology] and the frequent returns approach. \* \* \*.

\* \* \* \* \*

[M]y practice did achieve what my goals were and that was to deliver safe care, screen them for cancer without having a possible harmful unnecessary diagnosis of HPV[,] which a lot of them would have been with some of the ages of this population[.]

\* \* \* \* \*

[I]t’s not that I don’t strive to comply with national guidelines. I do. And I believe my certification history and my work record indicate that. But I do believe this was an appropriate adjustment for this population[.]

\* \* \* \* \*

[I] weigh the USPSTF just as much as \* \* \* ASCCP and others. And I continue to weigh and balance...and consider my own clinical experiences[.]

(*Id.* at 2-4.) Ms. Matthews further stated:

[W]hen you weigh all these national standards. And certainly, ASCCP is

\* \* \* one of the ones that people look to. HPV testing is optional if you follow their interval screening guidelines for [cytology] which is paps only. And I was very aggressive with a shorter interval with this [OSH] \* \* \* population because they were right there at the hospital. And a lot of times it helped compensate for the high refusal rate.<sup>37</sup>

(Ex. A39 at 9.) When Investigator Sexton asked Ms. Matthews whether her methodology could mean that patients were subjected to pap tests on a yearly basis, instead of every three years, Ms. Matthews replied, “Well, you know, that is a possibility.” (*See id.*)

94. Ms. Matthews informed Investigator Sexton that with respect to patients under the age of 30, her practice was to conduct cytology screening, not order any HPV testing, and have the patients return for further cytology screening in one year.<sup>38</sup> (Ex. A38 at 4-5.) When Investigator Sexton questioned why Ms. Matthews ordered HPV reflex testing (instead of HPV co-testing) for certain patients who were 30 years of age and older, Ms. Matthews stated, in part:

[T]his is the age population that I was talking about in the tickler system that could fall into that one-year return to clinic if they meet that demographic[.]

(*Id.* at 9.) Ms. Matthews told Investigator Sexton that because Patients SM (age 32),<sup>39</sup> BA (age 31), CR (age 50), IH (age 34), SB (age 46),<sup>40</sup> MT (age 30),<sup>41</sup> LM (age 55), and HS (age 47) had no history of HPV or abnormal paps, and Ms. Matthews knew those patients would be seen in one year for follow-up care, she elected HPV reflex testing in lieu of HPV co-testing. (*Id.* at 9-11; Ex. A39 at 1-3.) When Investigator Sexton questioned Ms. Matthews about not ordering HPV co-testing on patients with documented histories of HPV, Ms. Matthews suggested that the failure to do so could have been an “oversight.” (*See* Ex. A38 at 5.) She also suggested that she may have elected not to order any HPV testing if the patients were less than 30 years of age (despite their positive HPV history). (*See id.* at 6.) With regard to Patient VS (age 51, with a history of HPV, abnormal pap, and a LEEP), Ms. Matthews stated:

Okay so this is a really high-risk gal so I’m sure we’d be \* \* \* seeing her.

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<sup>37</sup> In an email that Ms. Matthews sent to the Board on or about March 19, 2018, she similarly expresses her understanding of the national standards and explains her reasons for deviating from those standards on OSH patients. (*See* Ex. A40 at 1-2.)

<sup>38</sup> Ms. Matthews told Investigator Sexton: “[I]f it was someone [with whom] I was using [cytology] exclusively in place of HPV testing they would automatically come back every year for retesting.” (Ex. A38 at 5.) However, Ms. Matthews contradicted herself later during the interview when she told Investigator Sexton that women between 21 and 29 years of age who had no history of abnormal cytology would only need to return for repeated cytology testing after *three* years. (*See id.* at 7-8.)

<sup>39</sup> *See* Ex. A11 at 1.

<sup>40</sup> *See* Ex. A9 at 1.

<sup>41</sup> *See* Ex. A6 at 1.

And she's postmenopausal. Okay, so again, she's going to be seen. She's an in-patient. She's got pending diagnostics. I put her on antibiotics and yeah, she'd be coming back in a year or for sure probably even sooner.

(Ex. A39 at 3.) With regard to Patient PP (age 52, with a history of high risk HPV),<sup>42</sup> Ms. Matthews stated, in part:

[I] opted for the HPV reflex because I would at this stage, it looks like, I still was going to be seeing her or she was going to be following up in Portland with these mammogram results. But either way, I do recall that she was very committed to having the \* \* \* option that was available to her in Portland which was the HPV genotyping 16/18 blood test. So, yeah. We did the reflex testing as just a bridge gesture. And she had no symptoms. She had no issues since 7/15. She was actually one of our success cases. It was a good one.

(*Id.* at 3-4.)

95. On March 6, 2018, Investigator Sexton questioned Ms. Matthews about ordering HPV co-testing for several patients under the age of 30. With regard to Patient JH (age 27), Ms. Matthews stated, in part:

[I]t is an inconsistency. Certainly, wasn't my philosophy. I look at the date it was ordered \* \* \* 5/7/15. This could have been like one of my very first women[']s health clinic rotations. Even before I learned about the updated ASCCP algorithms which I believe was triggered by that denial for a colposcopy[.]

(Ex. A39 at 4.) With regard to Patient CH (age 25), Ms. Matthews stated, in part:

[T]his is again in that same time frame of \* \* \* May 2015 \* \* \* my extremely early days at [the] women's health clinic. And again, thankfully negative. So, no harm. No foul.

(*Id.* at 5.) With regard to Patient TB (age 23), Ms. Matthews suggested that she did not order the HPV co-test, despite there being a lab report listing her as the ordering practitioner. (*See id.* at 5-6.) With regard to Patient VG (age 27), Ms. Matthews stated, in part:

HPV is on the differential of folliculitis depending on its appearance. So, you know, this is appropriate. \* \* \*. Now again she falls into this category but, you know, as a provider, \* \* \* that sometimes a decision to say [*sic*] this is what we're going to do. And that's what an HPV reflex is, \* \* \* the compromise that works for everybody. And, you know, I wouldn't be surprised if that was the case because I often have this

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<sup>42</sup> See Ex. A10 at 1-4.

conversation regarding folliculitis[,] particularly if it's a highly anxious personality. And having an HPV reflex can be just the reassurance they need.<sup>43</sup>

(*Id.* at 6.) When Investigator Sexton questioned Ms. Matthews about performing a pap test on Patient LE, who was only 20 years of age at the time, Ms. Matthews stated that LE was “Dr. Mattel’s patient that was referred to us specifically for this exam and additional testing.” (*Id.* at 7-8.) Ms. Matthews further explained:

[I]’m not exactly sure why she wanted specific cervical testing, but she did. And so, we just \* \* \* went ahead and did the pap since we were doing cervical a CI [*sic*] screening based on [the patient’s] strong STI background. And, yeah it was a matter of getting along with the referring physician as I recall. Again, this probably would have been my second or third time in the women’s health clinic at that point \* \* \*. That’s when I was still learning the ropes.

(*Id.* at 8.) Ms. Matthews also suggested to Investigator Sexton that it was possible she did not order the pap for LE, and that a “locum nurse” may have instead ordered the test under Ms. Matthews’ name. (*See id.*)

96. By letter to the Board dated August 20, 2018, Ms. Matthews stated, in part:

In March, 2012, Annals of Internal Medicine recommended that no women under the age of 30 years be tested for HPV due to the self[-] limited nature of the HPV infection, and the fact that the diagnosis can do more harm than good within this age group.

Cervical cancer can be tested for in 2 different ways, with an HPV test or with cytology during a Pap smear. ASCCP supports cervical cancer screening (CCS) for qualified women ages 21-65 q3y with cytology alone, stating that this provides a reasonable balance between benefits and harms. I always complied with this minimum standard in my practice at OSH[.]

Each OSH patient’s cervical cancer screening was made on a case by case basis, with as much patient participation as possible. However, no OSH patient was screened less than q3y with cytology.

Using the national guideline option of q3y cytology testing for qualified [OSH] patients, avoided the unnecessary, yet often triggering diagnosis of HPV in this vulnerable population. However, any abnormal cytology results would have prompted one of 3 actions: repeat cytology,

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<sup>43</sup> Ms. Matthews’ statements to Investigator Sexton regarding VG appear to be predicated on her belief that she ordered an HPV reflex test for VG. Although Ms. Matthews’ treatment note dated July 12, 2016 lists an HPV reflex test under a section titled “Plan,” the lab results for VG indicate that Ms. Matthews actually ordered an HPV co-test (and not a reflex test) for VG. (*See Ex. A17 at 1-3.*)

colposcopy, or HPV testing, depending on the case.<sup>44</sup> Many providers prefer not to use the Reflex HPV testing option because this means the lab tech immediately runs an HPV test if there is abnormal cytology, when the provider and the patient may prefer to first of all, have a chance to discuss the three treatment options and secondly, decide to choose to repeat cytology or go right to colposcopy, rather than have the lab tech immediately test for HPV.

(Ex. A41 at 4.)

### CONCLUSIONS OF LAW

1. On December 13, 2016, Ms. Matthews failed to document that four patients refused care and on December 20, 2016, when documenting such refusals, she failed to indicate that the documentation was a “late entry,” thereby engaging in conduct derogatory to the standards of nursing under OAR 851-045-0070(3)(a) and (g).

2. Between 2015 and 2017, Ms. Matthews failed to follow national standards with regard to cervical cancer screenings, thereby engaging in conduct derogatory to the standards of nursing under OAR 851-045-0070(1)(a) and (4)(b).

3. On or about April 14, 2017, Ms. Matthews displayed “bizarre and erratic” behavior in the workplace. However, the Board did not establish that such behavior constituted conduct related to impaired function under OAR 851-045-0070(5)(b).

4. Pursuant to ORS 678.111(1)(f), the Board may revoke Ms. Matthews’ Nurse Practitioner Certificate and Registered Nurse License.

### OPINION

The Board seeks to revoke Ms. Matthews’ Nurse Practitioner Certificate and Registered Nurse License on the ground that she has engaged in conduct derogatory to the standards of nursing. ORS 678.111(1)(f) provides the authority for the Board to take such action against a licensee and states:

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

\* \* \* \* \*

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<sup>44</sup> If HPV testing is order more than three weeks after a pap specimen has been collected, then a new specimen must be collected for the testing. (Ex. A42 at 6.)

(f) Conduct derogatory to the standards of nursing.

The Board must prove its allegations against Ms. Matthews by a preponderance of the evidence, and it must also establish that the proposed sanction (*i.e.*, certificate and license revocation) 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).

(1) *December 2016 Patient Records*

The Board’s Notice of Proposed Revocation states, in relevant part:

The Board alleges that or about December 13, 2016, while working at OSH, [Ms.] Matthews had 5 patients to see, that she documented seeing the first patient but failed to document the other four patients refusing care until 7 days later and failed to indicate the notes seven days later as a “Late entry[.]” This is in violation of ORS 678.111(1)(f) and OAR 851-045-0070(3)(a)(g).

Pleading P1 at 1. The Board thus alleges two instances of conduct derogatory to the standards of nursing: 1) on December 13, 2016, Ms. Matthews failed to document four patient care refusals that occurred on that date; and 2) on December 20, 2016, when documenting the patient care refusals from December 13, 2016, she failed to indicate “late entry” on the documentation.

During the relevant time period, OAR 851-045-0070(3)(a) and (g) provided as follows:

Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:

\* \* \* \* \*

(3)(a) Inaccurate recordkeeping in client or agency records.

\* \* \* \* \*

(g) Failing to maintain client records in a timely manner which accurately reflects management of client care, including failure to make a late entry within a reasonable time period.

A preponderance of evidence in the record establishes the following: Women's Health Clinic appointments were typically scheduled for one-half hour each during the hours of 1:00 to 3:00 p.m.; patients frequently refused Women's Health Clinic appointments; on December 13, 2016, Ms. Matthews was assigned to see six patients with appointments at the Women's Health Clinic; on that date, she documented one patient refusal in the electronic health record (Avatar); on that date, she did not document anything in Avatar for the other five patients who had appointments (Patients DB, SH, LS, CP, and VW) to indicate that she attempted to see, or actually saw, those patients; for personal reasons, she took a sudden leave of absence from work for several days following December 13, 2016; on December 20, 2016, after returning from her leave of absence, she documented in the patient records for DB, SH, LS, CP, and VW that each patient had refused care on December 13, 2016; none of the December 20, 2016 patient records regarding the refused care indicated "late entry" or "addendum," and none of the December 20, 2016 patient records described any of the circumstances of the refusals (*e.g.*, what time a refusal occurred; whether the patient refused to leave their unit; whether the patient refused care at the actual appointment, *etc.*)

OSH's document titled "Oregon State Hospital Policies and Procedures" provides that staff must document patient care in Avatar, all draft entries in Avatar must be finalized within 48 hours, any patient care not documented in Avatar by the end of the shift (or any draft entry in Avatar not finalized within 48 hours) is considered a late entry, and late entries "must be clearly identified at the beginning of the entry, and must reference the actual date and time of the event or observation." *See* Exhibit A49 at 2. OSH's documentation policy regarding late entries is consistent with the standard of care in nursing that requires chart notes not completed on the date of service to specify "late entry" or "addendum" and include both the date of service and date of completion. *See* Testimony of Bigelow and Wickenhagen.

Given the above, the record persuasively establishes that Ms. Matthews failed to timely document in the Avatar electronic health record at least four patient care refusals on December 13, 2016. And, when she documented the refusals in Avatar seven days later, she failed to accurately reflect that they were late entries by specifically designating each entry as a "late entry" or "addendum." The Board has therefore established that Ms. Matthews engaged in conduct derogatory to the standards of nursing under OAR 851-045-0070(3)(a) and (g). For those violations, she is subject to discipline under ORS 678.111(1)(f).

## (2) *Cervical Cancer Screenings*

Next, the Board alleges that during the period May 5, 2015 through March 14, 2017 (the relevant time period or time period at issue), Ms. Matthews failed to follow applicable national standards with regard to cervical cancer screenings and failed to document a follow-up plan of care, thereby engaging in conduct derogatory to the standards of nursing under OAR 851-045-0070(1)(a), (c), and (d), and (4)(b).

During the relevant time period, OAR 851-045-0070 defined "conduct derogatory to the standards of nursing," in part, to include the following:

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

(a) Developing, modifying, or implementing standards of nursing practice/care which jeopardize patient safety.

\* \* \* \* \*

(c) Failing to develop, implement and/or follow through with the plan of care.

(d) Failing to modify, or failing to attempt to modify the plan of care as needed based on nursing assessment and judgment, either directly or through proper channels.

\* \* \* \* \*

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

\* \* \* \* \*

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

OSH follows the cervical cancer screening guidelines set forth by the ACS, ASCCP, and the ASCP, with the ASCCP guidelines being the "gold standard." Testimony of Wickenhagen. An OSH document titled "Nurse Practitioner Protocols" (updated February 7, 2017)<sup>45</sup> set forth the "[c]urrent ASCCP screening guidelines (2012-2013)" at that time, and noted the following recommendations:

- Age 21-29, pap test every 3 years (with reflex to HPV testing)
- Age 30-65, pap with HPV testing every 5 years
- For guidelines regarding appropriate follow-up for abnormal results, see ASCCP Algorithms (2013).

Exhibit R2 at 9.

*A. Pap testing for patient under 21 years of age*

During the relevant time period, the ACS, ASCCP, and ASCP (as well as ACOG and USPSTF) uniformly recommended against performing cervical cancer screening, including pap tests, on women younger than 21 years of age, regardless of the age of sexual initiation or other risk factors. Nonetheless, on August 4, 2015, Ms. Matthews performed a pap test on Patient LE. At the time, LE was 20 years of age and had never undergone pap testing.

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<sup>45</sup> Given that this document (updated in February 2017) references the 2012-2013 ASCCP screening guidelines, it is reasonable to infer that any version(s) in effect from 2015 to February 2017 also referenced those same screening guidelines.

During a Board interview with Investigator Sexton, Ms. Matthews provided various, and contradictory, explanations for performing the pap test on LE, including that Dr. Mattel had referred the patient to the Women's Health Clinic specifically for a pap test and Ms. Matthews recalled "it was a matter of getting along with the referring physician," that it was probably only Ms. Matthews' second or third time working in the Women's Health Clinic and she was still "learning the ropes," and that a "locum nurse" may have actually ordered the test under Ms. Matthews' name. *See* Exhibit A39 at 7-8.

The August 4, 2015 progress note establishes that Ms. Matthews examined LE and collected material for a pap test on that date. Under the heading "Assessment," Ms. Matthews noted, in part, "Routine Pap \* \* \* sent to lab," and under the heading "Plan," she noted, "Sure Path Pap with GC/CT pending." Exhibit A5 at 1-2. Neither the progress note nor the lab results explain Ms. Matthews' clinical rationale for performing the pap test in contravention of the applicable screening guidelines. By deviating from the guidelines without documenting a clinical justification for doing so, Ms. Matthews failed to conform to the essential standards of acceptable and prevailing nursing practice. *See* OAR 851-045-0070(4)(b).

#### *B. Referral for colposcopy*

During the relevant time period, under ASCCP guidelines, for women between the ages of 30 and 65, if a pap test is positive for ASC-US, but the HPV test is negative, repeat co-testing in three years is appropriate. The relevant guidelines do *not* recommend colposcopy under those circumstances, and unnecessary colposcopy poses a risk of harm to a patient.

On or about July 12, 2016, Ms. Matthews referred 51-year-old Patient JG to Willamette Valley Health Partners for a colposcopy after JG tested positive for ASC-US, but negative for HPV. Willamette Valley Health Partners denied the referral, as per the applicable guidelines. Ms. Matthews did not document any rationale for deviating from the screening guidelines for JG.

During a Board interview, Ms. Matthews informed Investigator Sexton that referring Patient JG for colposcopy was "a mistake." Exhibit A37 at 4. She further explained:

And that's when I first learned about the algorithms. I hadn't done paps in a while. And I was asked to start working in the women's health clinic when I started at [OSH] in 2/15. And, you know, when I got that refusal, that's when I looked it up online. And I realized that there \* \* \* [were] very specific referral guidelines. So, I definitely adopted those ever since then. And in fact, have used the 2014 reprints since then[.]

*Id.* at 4. By referring JG for a colposcopy, in contravention of the applicable guidelines and without a reasonable basis for so doing, Ms. Matthews subjected JG to a risk of harm from an unnecessary procedure. This constitutes conduct derogatory to the standards of nursing under OAR 851-045-0070(1)(a) and (4)(b).

### *C. Co-testing for patients under the age of 30*

During the relevant time period, ACS, ASCCP, ASCP, and ACOG (as well as USPSTF) recommended that HPV co-testing (*i.e.*, conducting pap and HPV testing at the same time) not be used for women under the age of 30. Given that HPV is common in patients under the age of 30, and it often resolves on its own in that population, unnecessary HPV testing of this population could result in unnecessary follow-up testing or procedures.

During the relevant time period, without any documented rationale for deviating from the screening guidelines, Ms. Matthews ordered a pap with HPV co-testing for Patients JH (age 27), CH (age 25), TB (age 25), DA (age 21), and VG (age 27), each of whom had no history of high-risk HPV.

When Board Investigator Sexton questioned Ms. Matthews about ordering HPV co-testing for patients under the age of 30, Ms. Matthews stated that doing so was inconsistent with her screening philosophy, and she suggested that she may have seen Patients JH and CH during her early days at the Women's Health Clinic, before she "learned about the updated ASCCP algorithms[.]" See Exhibit A39 at 4-5. Medical records for JH, CH, DA, and VG indicate that Ms. Matthews intended to order HPV reflex testing for those four patients — which would have been in accordance with applicable screening guidelines. However, lab result documentation shows that she nonetheless ordered HPV co-testing for those patients, and their respective records contain no explanations for the discrepancies. During a Board interview, Ms. Matthews suggested that she did not order co-testing for JH, CH, DA, and VG, and that the lab may have erred in performing those tests.<sup>46</sup> However, lab errors of that type and frequency seem improbable, particularly when considering that while cross-examining Ms. Wickenhagen at hearing, Ms. Matthews at times seemed genuinely confused when trying to distinguish between the two types of tests and identify which tests were reflected in lab records. More likely than not, Ms. Matthews ordered HPV co-tests for JH, CH, DA, VG, and TB in contravention of the applicable guidelines and without a reasonable basis for doing so. This constitutes conduct derogatory to the standards of nursing under OAR 851-045-0070(4)(b).

### *D. Reflex testing for patients 30 to 65 years of age*

For women between the ages of 30 to 65, there is a lower incidence of HPV, but a greater likelihood that HPV may result in cervical dysplasia and cancer. During the relevant time period, under ACS, ASCCP, ACCP, and ACOG guidelines, for women in that age range, HPV co-testing was appropriate. If both tests were negative, then the recommended method was to repeat co-testing in five years. During the relevant time period, under USPSTF guidelines, for women in that age range who wanted to extend their screening interval, HPV co-testing every five years was an option. During the relevant time period, under ASCCP guidelines, a woman in that age range whose pap smear was negative for ASC-US, but who had a positive HPV test should have repeat co-testing in one year.

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<sup>46</sup> Ms. Matthews also raised the possibility to Investigator Sexton that she may not have ordered the HPV co-test for TB, despite the evidence of a lab report listing her as the ordering practitioner and there being no conflicting plan set forth in the treatment notes. (See Ex. A37 at 9.)

Without documenting any rationale for deviating from the screening guidelines, Ms. Matthews ordered a pap with reflex HPV testing, instead of co-testing, on each of the following patients, who were all age 30 or older: SB (age 46); SM (age 32); MT (age 30); LM (age 55); NK (age 39); BA (age 32); CR (age 50); and IH (age 35).

When Investigator Sexton questioned Ms. Matthews about ordering reflex testing for Patients SM, BA, and LB, Ms. Matthews responded, in part:

[Y]eah, these three, you know if I had it to do over again, I would probably have written it as a co[-]test. I can't see anything from my documentation as a rationale. I \* \* \* would [have] appreciated this as feedback earlier. I never got any feedback like this in my evaluation[.]

\* \* \* \* \*

[B]ased on compliance with the algorithms these three would \* \* \* more strictly fall in line with co[-]testing[.]

Exhibit A37 at 5-7. Upon subsequent questioning by Investigator Sexton as to why she ordered HPV reflex testing on Patients SM, BA, CR, IH, SB, MT, LM, and HS, Ms. Matthews stated that because those patients had no history of HPV or abnormal paps, and she intended to place the patients in the tickler system for a “one-year return to clinic,” she elected HPV reflex testing in lieu of HPV co-testing. *See* Exhibit A38 at 9.

By disregarding the applicable guidelines for the above patients, and having the patients return to the clinic in one year for repeat testing, Ms. Matthews was *under-screening* the patients while at the same time subjecting them to an *increased frequency of screening*. For example, if Ms. Matthews had chosen to follow the applicable guidelines in effect between 2015 and 2017 and ordered HPV co-testing for a 39-year-old patient, if both tests were negative, the patient would not have had to undergo repeat co-testing for five years. Under Ms. Matthews' protocol, however, that same patient would have been reflex tested only and then required to return for additional invasive testing the very next year. Given the vulnerable nature of the OSH patient population,<sup>47</sup> adopting a screening protocol contrary to established screening guidelines that was likely to have an adverse impact on patients (by increasing the frequency/number of invasive medical procedures) seems illogical and constitutes conduct derogatory to the standards of nursing under OAR 851-045-0070(4)(b).

*E. Reflex testing for patients with documented history of high-risk HPV*

Without documenting any rationale for deviating from the screening guidelines in effect during the relevant time period, Ms. Matthews ordered a pap with reflex HPV testing, instead of co-testing, on three patients over the age of 50 with documented histories of high-risk HPV: VS (age 55); PP (age 51); and LB (age 51).

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<sup>47</sup> Many OSH patients have extensive histories of sexual trauma. Performing gynecological examinations with invasive procedures (such as pap smears) more frequently than the recommended guidelines could cause such patients anxiety and further trauma. (Test. of Wickenhagen; Ex. A42 at 1.)

Upon initial questioning from Investigator Sexton, Ms. Matthews suggested that the failure to order HPV co-testing on patients with documented histories of HPV may have been an “oversight.” See Exhibit A38 at 5. However, with regard to Patient VS, she subsequently provided the following justification to Investigator Sexton:

Okay so this is a really high-risk gal so I’m sure we’d be \* \* \* seeing her. And she’s postmenopausal. Okay, so again, she’s going to be seen. She’s an in-patient. She’s got pending diagnostics. I put her on antibiotics and yeah, she’d be coming back in a year or for sure probably even sooner.

Exhibit A39 at 3. And, with regard to Patient PP, Ms. Matthews stated, in part:

[I] opted for the HPV reflex because \* \* \* I still was going to be seeing her or she was going to be following up in Portland with these mammogram results. But either way, I do recall that she was very committed to having the \* \* \* option that was available to her in Portland which was the HPV genotyping \* \* \* test. So, yeah. We did the reflex testing as just a bridge gesture. And she had no symptoms. She had no issues since 7/15[.]

*Id.* at 3-4.

In Ms. Wickenhagen’s expert opinion, Patients VS, PP, and LB should have been co-tested to identify which HPV strains were present. At hearing, Ms. Wickenhagen testified, “I simply don’t understand why [co-testing] wasn’t ordered.” The explanations Ms. Matthews has offered for reflex testing Patients VS, PP, and LB are insufficient to justify her deviation from the applicable guidelines in effect at the time, and those deviations therefore constitute conduct derogatory to the standards of nursing under OAR 851-045-0070(4)(b).

*F. Pap tests with no reflex testing for patients 21 to 29 years of age*

During the relevant time period, ACS, ASCCP, ASCP, and ACOG screening guidelines provided that a pap test be performed every three years for women between the ages of 21 and 65. Similarly, the USPSTF recommended that a pap test for women in both of those age groups be performed every three years.

During the relevant time period, under ASCCP guidelines, for women between the ages of 21 and 29, a pap test with reflex to HPV (HPV reflex testing) was appropriate. If a woman in this age range had a pap that was positive for ASC-US, but no reflex to HPV was ordered, the patient would require a repeat pap in one year. If a woman in this age range had a pap that was positive for ASC-US and a subsequent HPV test was negative, re-testing in three years was appropriate. If a woman in this age range had a pap that was positive for ASC-US and a subsequent HPV test was positive, further follow-up care (including colposcopy) was warranted due to the increased risk of cervical dysplasia.

Without documenting any rationale for deviating from the applicable screening guidelines, during the time period at issue, Ms. Matthews ordered a pap test with no HPV reflex testing for five patients between the ages of 21 and 29: MP (age 25); RB (age 30); AS (age 25); JL (age 26); and AL (age 28).

Ms. Matthews has subsequently — in documentation prepared for and submitted to the Board, during several Board interviews, and at the contested case hearing — attempted to justify her rationale for ordering pap tests without reflex testing for the above-cited patients, as well as for other patients in that age range who she treated during the relevant time period.

During her December 8, 2017 Board interview, when Investigator Sexton questioned her about ASCCP guidelines with respect to reflex testing for women under the age of 30, Ms. Matthews responded, in part:

[A]s of the 2014 reprint [of ASCCP]. \* \* \*. [B]ecause so many kids are \*  
\* \* positive for HPV, \* \* \* that guidance directed you not to test at all[.] \*  
\* \*. So, that included not reflexing[.]

\* \* \* \* \*

[I]f you diagnose somebody with HPV and then say okay you have HPV  
\* \* \* [w]hen indeed it's going to go away in two years \* \* \* [t]hen  
why even diagnose them[.]

\* \* \* \* \*

So, that's why the 2014 reprint said don't even test anymore which is why  
I stopped reflex testing.

\* \* \* \* \*

[I] thought I was being progressive and not stressing out these young girls  
based on that[.]

Exhibit A36 at 14-15. Ms. Matthews' statements to Investigator Sexton, cited above, suggest that she (incorrectly) believed the ASCCP guidelines in effect during the relevant time period directed practitioners "not to [HPV] test at all" for women ages 21 to 29, and that she therefore "stopped reflex testing" women in that age range to comply with the guidelines. *See id.*

Subsequently, on January 18, 2018, Ms. Matthews reiterated to Investigator Sexton that women under the age of 30 did not need HPV testing because of the significant likelihood that HPV in that age range would resolve on its own. *See Exhibit A37 at 2-3.* She emphasized the specific vulnerability of OSH's female patients and explained to Investigator Sexton that she believed it was more humane to spare those young women an HPV diagnosis than to test them and risk a "very distraught reaction" to such a diagnosis, particularly when "we still weren't going to treat them [for HPV.]" *Id.* at 2-3. She explained that her decision not to HPV test

patients in that age range was made in concert with “staff on the units” and that it was “population specific and very specific to the individuals as to why these exceptions were made.” *Id.* at 2. She also informed Investigator Sexton that regardless of whether she ordered HPV reflex testing for a patient in this age range, “you’re going to see them again in a year” and “[y]ou would test them again in a year anyway” because they are at high risk for STDs “because of their behavior.” *Id.* at 3. Finally, Ms. Matthews told Investigator Sexton that the new 2018 ASCCP recommendations support her practice decisions. *Id.* at 4. Ms. Matthews’ statements to Investigator Sexton during this interview suggest that she no longer believed that ASCCP guidelines in effect during the relevant time period recommended against HPV testing for women ages 21 to 29, but rather, that she elected to deviate from (or make exceptions to) the applicable guidelines when treating female OSH patients in that age range.

Then, during a March 6, 2018 Board interview, Ms. Matthews emphasized that the primary factors guiding her HPV screening decisions were 1) the fragility of the OSH female population; and 2) the “in-house patient status which allowed for convenient follow up and appointment rescheduling.” *See* Exhibit A38 at 1. She explained that, in her opinion, under the national standards, “HPV testing is optional if you follow their interval screening guidelines for [cytology] which is paps only.” *See* Exhibit A39 at 9. She further stated that, in her opinion, the ASCCP’s recommended screening interval guidelines were too long for OSH’s vulnerable population, given that “there was a lot of sexual activity even within the hospital” and the fact that the mental health system often operated as a “revolving door.” *See* Exhibit A38 at 1-2. She explained to Investigator Sexton that she opted for a protocol of cytology (*i.e.*, pap) screenings rather than HPV testing at shortened time intervals, referring to it as the “[cytology] and frequent returns approach.” *See id.* at 2. When Investigator Sexton asked whether such a methodology could mean that patients were subjected to pap tests on a yearly basis, instead of every three years, Ms. Matthews replied, “Well, you know, that is a possibility.” *See id.* Ms. Matthews’ statements to Investigator Sexton during this interview suggest that she once again (mistakenly) believed that applicable ASCCP guidelines in effect at the time allowed her to forego HPV testing in the 21 to 29 age range, as long as those patients had pap testing at least every three years. And, her statements further demonstrate that she believed yearly invasive pap testing for vulnerable OSH patients was preferable to pap testing every three years (or pap testing with HPV reflex every three years).

In a letter to the Board dated August 20, 2018, Ms. Matthews reiterated many of the same points she made during her Board interviews. And, she appears to have relied on the revised 2018 ASCCP guidelines (which were not in effect during the time period at issue) when asserting in the letter that “ASCCP supports cervical cancer screening \* \* \* for qualified women ages 21-65 q3y with cytology alone[.]” *See* Exhibit A41 at 4. She also explained in the letter that any abnormal cytology results would have prompted her to take one of three actions: repeat cytology; colposcopy; or HPV testing, and she stated:

Many providers prefer not to use the Reflex HPV testing option because this means the lab tech immediately runs an HPV test if there is abnormal cytology, when the provider and the patient may prefer to first of all, have a chance to discuss the three treatment options and secondly, decide to

choose to repeat cytology or go right to colposcopy, rather than have the lab tech immediately test for HPV.

*Id.* Ms. Matthews' three proffered "options" for when a patient tests positive for ASC-US (in the absence of any HPV testing) each involve the patient undergoing further invasive procedures. These additional procedures could have been avoided (or the duration within which they are required could have been lessened) by following the ASCCP guidelines in effect at the time and ordering reflex testing for a patient between 21 and 29 years of age. Moreover, going "right to colposcopy" after a positive ASC-US when there has been no positive HPV test is contrary to acceptable guidelines and poses an unnecessary risk of harm to a patient.

At hearing, Ms. Matthews asserted that she's a "conservative provider," and she emphasized a portion of ASCCP's "General Comments" that state, in part:

The guidelines should never be a substitute for clinical judgment. Clinical judgment should always be used when applying a guideline to an individual patient since guidelines may not apply to all patient-related situations.

Testimony of Matthews and Exhibit A42 at 11.

The Board has persuasively established that from 2012 through 2017 (which covers the time period at issue), there was a consistent national standard for cervical cancer screening, including standards specific to HPV testing for women ages 21 to 29. The record shows that Ms. Matthews was, at times, unaware of, unfamiliar with, and/or confused by the applicable standards. In addition, she has attempted to justify some of her 2015-2017 treatment decisions by retroactively applying certain 2018 standards (which did not exist when she made the treatment decisions at issue). Finally, she has argued that her treatment decisions were based on exercises of "clinical judgment" that supported deviation from the guidelines. That argument fails for several reasons, the most glaring of which is that the sampling of treatment records in this case shows almost a complete absence of consistency in ordering (or not ordering) cervical cancer screening and no evidence that clinical judgment was exercised in any rational, uniform manner.

The Board has proven that on numerous occasions between 2015 and 2017, Ms. Matthews failed to follow national standards with regard to cervical cancer screenings, thereby engaging in conduct derogatory to the standards of nursing under OAR 851-045-0070(1)(a) and (4)(b). For those violations, she is subject to discipline under ORS 678.111(1)(f).

*G. Failure to document a follow-up plan of care*

The Board also alleges that, with regard to the Women's Health Clinic patients at issue, Ms. Matthews failed to document a follow-up plan of care, thereby engaging in conduct derogatory to the standards of nursing under OAR 851-045-0070(1)(c) and (d).

Ms. Matthews contends that the Board did not obtain all available relevant

documentation for the patients at issue. She asserts that “[r]eview of the entire referral process and all related progress notes, along with the \* \* \* Women’s Health Clinic tickler file, the Medical Clinic daily updates and the Medical Clinic scheduling book” will together demonstrate “a complete picture, including a RTC (return to clinic) validation on each of said patients.” See Exhibit A4 at 1. She also argues that some progress notes do not require a RTC—for example, a progress note written after a routine Women’s Health Clinic exam that describes the exam and documents that a pap specimen is being sent to the lab. She contends that the “follow-up plan” in that situation is to get the pap results, which then generate the next Women’s Health Clinic progress note, and that note would include the pap results, which specifically determine the patient follow-up plan (such as when the patient should return to the clinic and/or whether referral is appropriate). See *id.* at 1. Ms. Matthews’ arguments on these points are well taken.

For the majority of the Women’s Health Clinic patients at issue, the evidentiary record contains only one progress note (*i.e.*, treatment note) documenting the examination during which a specimen was collected, and then one lab report, which contains the results of the testing for which a specimen was collected. See Exhibits A1 through A14, A16, A17, and A21 through A27.<sup>48</sup> The Board did not present any testimony or documentary evidence to establish that it requested and received from OSH all potentially relevant treatment records for those patients. It is therefore reasonably likely that additional documentation exists for some or all of those patients that might show a documented follow-up plan of care, if appropriate.

For Patient JG, the record contains a lab result report and two progress notes—one dated July 5, 2016, and one dated July 12, 2016. See Exhibit A15. On the July 12, 2016 progress note, Ms. Matthews documented a referral for JG to a gynecologist based on the results of JG’s July 5, 2016 pap test, which was positive for ASC-US. *Id.* at 1. That progress note constitutes sufficient documentation of a plan of care with regard to JG’s pap results.

For the above reasons, the Board did not establish, more likely than not, that Ms. Matthews engaged in conduct derogatory to the standards of nursing under OAR 851-045-0070(1)(c) and (d) by failing to document a follow-up plan of care for the Women’s Health Clinic patients at issue.

(3) “Bizarre and Erratic” Workplace Behavior on April 14, 2017

Finally, the Board contends that on April 14, 2017, Ms. Matthews displayed aberrant behavior in the workplace, thereby engaging in conduct derogatory to the standards of nursing under OAR 851-045-0070(5)(b). During the relevant time period, OAR 851-045-0070(5)(b) provided:

(5) Conduct related to impaired function:

\* \* \* \* \*

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<sup>48</sup> For Patients MP and RB, the evidentiary record contains only a two-page lab result report for each patient. See Exhibits A19 and A20. For Patient DA, the record contains two lab result reports, one progress note, and three Treatment Care Plans (for which Ms. Matthews was not the author). See Exhibit A18.

(b) Practicing nursing when unable/unfit to perform procedures and/or make decisions due to psychological or mental impairment as evidenced by documented deterioration of functioning in the practice setting and/or by the assessment of a health care provider qualified to diagnose mental condition/status; and

Ms. Matthews admits that she was upset on April 14, 2017, but contends that she was “triggered” and fearful after Dr. Little “burst” into the exam room, directed her to leave the grounds immediately, and subsequently began “screaming” at her and threatening to report her to the Board. *See* testimony of Matthews and Exhibits A34 at 2 (Powell Psychiatric Evaluation), A36 at 11-12 (December 8, 2017 Board interview) and A39 at 16-17 (March 6, 2018 Board interview). She further contends that, given the immense size of the high-security facility, and her shock at being escorted off the grounds, she became disoriented as she tried to hurriedly find an exit. She denies behaving in a physically aggressive manner towards Dr. Little or other OSH employees, and insists that she was only following OSH protocol by closing doors behind her. *See* testimony of Matthews and Exhibits A34 at 2, A36 at 11-12, and A39 at 16-17.

A preponderance of credible evidence establishes that on the date at issue, Ms. Matthews became upset after Dr. Little approached her as she was working on a computer in an OSH examination room, informed her that she was being placed on duty-station at home, and instructed her to leave the hospital immediately. In response, she quickly gathered up her belongings, exited the room, and closed the door behind her, striking Dr. Little’s forearm in the process. For approximately the next 15 minutes, Dr. Little and at least one other OSH employee followed Ms. Matthews as she hurried through various buildings, courtyards, and hallways looking for an appropriate exit. Along the way, she entered patient care areas where patients were present, she was disoriented, she repeatedly muttered to herself, and she continued to slam doors shut behind her — striking Dr. Little at least two more times, as well as closing doors on two other employees. Testimony of Little and Hayes; *see* Exhibits A28, A29, and A35 at 2.

Even assuming that Ms. Matthews did not intend to strike Dr. Little (and other employees) as she slammed doors behind her on April 14, 2017, her conduct was nonetheless reckless, erratic, and inappropriate. The Board fell short, however, of establishing that her behavior during the approximately 15-minute time period that she rushed through the OSH campus looking for an exit, slamming doors along the way, constituted “[c]onduct related to impaired function” as described in OAR 851-045-0070(5)(b).

Under OAR 851-045-0070(5)(b), a person engages in conduct related to impaired function if they practice nursing when unable or unfit to perform procedures or make decisions due to a psychological or mental impairment, and such a finding must be supported either by 1) documentation showing a deterioration of functioning in the practice setting; or 2) by a mental health assessment.

First, the record does not contain sufficient evidence of a documented deterioration of functioning in the practice setting. While both Ms. Moynihan and Ms. Shaevitz testified that they perceived a decline in the quality of Ms. Matthews’ work and changes in her demeanor and

appearance during the latter portion of her employment, and the evidence suggests that Ms. Matthews had interpersonal difficulties with one or more coworkers,<sup>49</sup> there is no documentation of a *deterioration in functioning due to psychological or mental impairment*.

Second, the record does not contain a mental health assessment concluding that Ms. Matthews was unable or unfit to perform nursing duties due to a psychological or mental impairment. PMHNP Katy Powell concluded in May 2017 that despite Ms. Matthews being dismissive of corrective actions and having poor insight into her behavior and its effect on others, Ms. Matthews did not meet the criteria for a mood or thought disorder. Ms. Powell also concluded that although she had some questions regarding Ms. Matthews' "overall state of wellness, cognition and awareness," it was not clear to Ms. Powell that Ms. Matthews was "at all impaired at this time." Exhibit A33 at 7. Then, in July 2017, neuropsychologist Megan Callahan noted that Ms. Matthews had a history of defiant behavior in the workplace, some limited remorse and behavioral insight, and difficulties "learning from past experiences, integrating feedback, and modifying her behavior." Exhibit A34 at 5. Dr. Callahan diagnosed adjustment disorder with mixed anxiety and depression and opined that Ms. Matthews' reported symptoms of depression and anxiety were likely related to the termination of her OSH employment and the Board's subsequent actions against her license. While Dr. Callahan recognized that Ms. Matthews appeared to have "many strengths," she recommended that the Board take caution when determining whether Ms. Matthews should resume working in the nursing profession, and she offered specific recommendations if that were to occur.<sup>50</sup> *Id.* at 5-6. Dr. Callahan did not, however, opine that Ms. Matthews was *unable or unfit* to perform procedures or make decisions in the nursing context due to her adjustment disorder with mixed anxiety and depression, or some other psychological or mental impairment. *See id.* at 1-6.

In sum, the Board has not established by a preponderance of evidence that on April 14, 2017, Ms. Matthews engaged in conduct related to impaired function, constituting conduct derogatory to the standards of nursing under OAR 851-045-0070(5)(b).

#### (4) *Sanction*

Pursuant to ORS 678.111(1)(f), the Board seeks to revoke Ms. Matthews' Nurse Practitioner Certificate and Registered Nurse License.

As previously set forth, the Board has established that Ms. Matthews engaged in conduct derogatory to the standards of nursing based on two sets of conduct: 1) her failure to timely and accurately maintain patient records in December 2016; and 2) her failure to follow national standards for cervical cancer screening for multiple patients between 2015 and 2017.

The evidentiary record contains a significant amount of documentation and testimony

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<sup>49</sup> *See, e.g.*, testimony of Shaevitz, Moynihan, Spears, and Little.

<sup>50</sup> Dr. Callahan's recommendations included providing Ms. Matthews with documentation of relevant standards of practice, conducting quarterly performance evaluations related to those standards of practice, and having a documented remediation plan if Ms. Matthews failed to meet the standards. *See* Exhibit A34 at 6.

suggesting that Ms. Matthews engaged in other questionable, inappropriate conduct — such as that she failed to work all of her claimed work hours; that coworkers could not always locate her during scheduled work hours, that her badge swipes did not always correlate to her claimed whereabouts during the work day; that she documented some patient refusals when she had not actually attempted to see such patients; that she sometimes treated coworkers in a physically aggressive manner, and that she provided the employer with a knowingly fraudulent CPR card. *See, e.g.*, Exhibits A21 at 1-2; A31 at 4-8; A32 at 4-10A41 at 5-6; A44 at 1-4, 6-7, 10, 21-22; R3 at 9, 13-14; R4 at 4; R5 at 5; R11 at 10-13; testimony of Little, Moynihan, and Shaevitz. Such allegations, if true, are serious and concerning.

Ms. Matthews has denied the above-cited allegations, and she has provided various explanations to account for discrepancies in her badge swipes (*e.g.*, that she sometimes entered a unit with a group of employees and didn't swipe her badge), her perceived disappearances from the hospital (*e.g.*, that she sometimes worked in her car or in outdoor areas on the grounds), charges that she did not make attempts to contact a patient (*e.g.*, a newly admitted patient is unlikely to remember a nurse contact during the patient's chaotic first 24 hours at OSH), allegations that she pushed or shoved a coworker (*e.g.*, she merely tripped and "fell into" Ms. Moynihan as they entered a room), and charges that her CPR card was not authentic (*e.g.*, the American Heart Association's transition from state training affiliates to corporate franchise training centers was the source of the problem). Ms. Matthews has also argued that the Board's current action is predicated on the unjust termination of her OSH employment, with the allegations being the mere product of "malicious, unregulated employer bias" that includes OSH Nurse Manager Moynihan's systematic and unfair targeting of her and Dr. Little's hostile, retaliatory, and intimidating actions towards her. *See* Exhibits R1 at 1 and R11 at 8, 10; testimony of Matthews.

The above-cited allegations raise serious questions about Ms. Matthews' credibility, integrity, and fitness for licensure. However, the Board did not specifically cite any of those allegations as a basis for discipline in its September 18, 2018 Notice of Proposed License Revocation. *See* ORS 183.415(3)(d) (requiring that a contested case notice include "[a] short and plain statement of the matters asserted or charged"). Moreover, the disputed evidence falls short of establishing any of the allegations by a preponderance of the evidence. Thus, on this record, the above-cited allegations do nothing more than raise some unanswered (though admittedly, troubling) questions about Ms. Matthews' conduct during her previous employment at OSH.

The Board's counsel asserted at hearing that Ms. Matthews does not appreciate any distinction between the termination of her OSH employment and the Board's current action. Counsel also asserted that Ms. Matthews has tried to manipulate facts (such as details regarding her previous Board discipline to examining mental health practitioners); she has provided hearing testimony that was often inconsistent, self-serving, and largely uncorroborated; and she has a history of failing to get along with others (such as patient transporters and coworkers at OSH and medical assistants at EmUrgent Care Clinic). Counsel argued in closing that Ms. Matthews has demonstrated a pattern of conduct that is incompatible with continued licensure and certification.

Given Ms. Matthews' prior Board disciplinary actions, the current proven violations, and her demonstrated difficulties with accepting responsibility for and learning from past mistakes, revocation of her Nurse Practitioner Certificate and Registered Nurse License is warranted.

### **ORDER**

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

Janet Matthews' Nurse Practitioner Certificate and Registered Nurse License are REVOKED.

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Kathleen Chinn FNP, BC  
Board President

### **FINAL ORDER**

After considering all the evidence, the proposed order, and the timely filed exceptions, if any, the Board will issue the final order in this case. This final order may adopt the proposed order prepared by the Administrative Law Judge as the final order or modify the proposed order and issue the modified order as the final order. *See* OAR 137-003-0655.

### **APPEAL**

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.*

**CERTIFICATE OF MAILING**

On September , 2020, I mailed the foregoing FINAL ORDER issued on this date in OAH Case No. 2019-ABC-02488.

By: Electronic Mail

Janet Matthews  
3682 Silverstone Court NE  
Salem OR 97305  
Email: [janmatt88@gmail.com](mailto:janmatt88@gmail.com)

By: Electronic Mail

Lori H Lindley  
Assistant Attorney General  
Department of Justice  
1162 Court St NE  
Salem OR 97301

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Amanda Moser  
Board of Nursing

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Maureen O’Dea, RN** ) **REPRIMAND and CIVIL PENALTY**  
)  
**License No. 201700239RN** ) **Reference No. 19-01301**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Maureen O’Dea (Licensee) was issued a Registered Nurse License by the Board on January 19, 2017.

On or about May 3, 2019, the Board received information that Licensee caused injury to her child on April 7, 2019, while imposing corporal punishment for disruptive behavior. Licensee also allowed another adult in the home to impose corporal punishment for the same incident.

Licensee asserts that the injury was accidental and she has obtained additional parenting training and behavioral resources for the children.

Licensee has completed the following training: *Child Abuse: Identification, Management, and Reporting* (6 credit hours).

By the above actions, Licensee is subject to discipline pursuant to ORS 678.111(1)(f), ORS 678.117(1), ORS 851-045-0070 (1)(a) and OAR 851-045-0100(2)(d)(D) which read as follows:

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

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

(f) Conduct derogatory to the standards of nursing.

**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.

**OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined**

- (1) Conduct related to general fitness to practice nursing:
  - (a) Demonstrated incidents of violent, abusive, intimidating, neglectful or reckless behavior;

**OAR 851-045-0100 Imposition of Civil Penalties.**

- (2) Civil penalties may be imposed according to the following schedule:
  - (f) Conduct derogatory to the standards of nursing \$1,000-\$5,000. The following factors will be considered in determining the dollar amount, to include, but not be limited to:
    - (A) Intent;
    - (B) Damage and/or injury to the client;
    - (C) History of performance in current and former employment settings;
    - (D) Potential danger to the public health, safety and welfare;
    - (E) Prior offenses or violations including prior complaints filed with the Board and past disciplinary actions taken by the Board;
    - (F) Severity of the incident;
    - (G) Duration of the incident; and
    - (H) Economic impact on the person.

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 Registered Nurse License of Maureen O’Dea be reprimanded and a civil penalty of \$1,500.00 be imposed.**

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 she engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against her license, up to and including revocation of her license to practice as a Registered Nurse License.

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 this Order is a document of public record.

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 the Licensee to sign this Order.

This Civil Penalty shall become due and payable within twenty (20) days from the date this Stipulated Order is signed by the Board President. Payments shall be made payable to the Oregon State Board of Nursing at 17938 SW Upper Boones Ferry Road, Portland, OR 97224; alternatively, payment may be made by phone at 971-673-0685.

Licensee may make monthly payments of not less than \$100.00 in any one payment, the first payment to be received by the Board before the end of business on October 1, 2020, and a like payment on the first day of every month thereafter until the whole sum is paid. Payments shall be made payable to the Oregon State Board of Nursing at 17938 SW Upper Boones Ferry Road, Portland, OR 97224; alternatively, payment may be made by phone at 971-673-0685.

Licensee understands that if payment is 60 days overdue from the date due as stated in this Stipulation, collection of the Civil Penalty will be assigned to the Oregon Department of Revenue. In the event any amount is assigned for collection, the Licensee may be subject to further disciplinary action by the Board which could include suspension, revocation or denial of licensure.

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

\_\_\_\_\_  
Maureen O’Dea, RN

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Kathleen Chinn, FNP-BC  
Board President

\_\_\_\_\_  
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**  
**Patty Olson, RN** ) **VOLUNTARY SURRENDER**  
)  
**License No. 202002727RN** ) **Reference No. 21-00119**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Patty Olson (Licensee) was issued a Registered Nurse License/Certificate by the Board on April 13, 2020.

On or about August 5, 2020, the Board received information that Licensee had voluntarily surrendered her Arizona Licenses for misappropriation of Patient Property or Other Property.

By the above actions, Licensee is subject to discipline pursuant to ORS 678.111 (1) (f), and OAR 851-045-0070 (1) (a)(b)(8)(v).

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

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

(f) Conduct derogatory to the standards of nursing.

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

(1) Conduct related to general fitness to practice nursing:

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

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

(V) Failure to report to the Board the licensee's arrest for a felony crime within 10 days of the arrest: or.

Licensee wishes to cooperate with the Board in this matter and voluntarily surrender their Registered Nurse license.

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

**That the voluntary surrender of the Registered Nurse license of Patty Olson be accepted. If, after a minimum of three years, Ms. Olson wishes to reinstate their Registered Nurse license, Patty Olson may submit an application to the Board to request reinstatement.**

Licensee agrees that they will not practice as a Registered Nurse 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, **Patty Olson** 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 has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Voluntary Surrender.

---

Patty Olson, RN

---

Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

---

Kathleen Chinn, FNP-BC  
Board President

---

Date

PLEASE RETURN ALL PAGES OF THIS STIPULATED ORDER AFTER SIGNING

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of**

**Bradley Patrick, CRNA**

**License No. 200760034CRNA,  
200743831RN**

)

) **FINAL ORDER OF REVOCATION**

) **BY DEFAULT**

)

)

) **Reference No. 19-00614**

---

The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Certified Registered Nurse Anesthetists. Bradley Patrick (Licensee) was issued a Registered Nurse License by Endorsement by the Board on December 17, 2007, and a Certified Registered Nurse Anesthetist License by the Board on December 17, 2007.

This matter was considered by the Board at its meeting on November 13, 2019.

On October 7, 2019, a Notice stating that the Board intended to Revoke the Registered Nurse License and Certified Registered Nurse Anesthetist License of Bradley Patrick was sent to Licensee via certified and first-class mail to the address of record. Additionally, the Notice was emailed to the Licensee.

The Notice alleged that on or about November 7, 2018, The Board received a NURSYS alert that Licensee's CRNA had been Revoked in California.

The Notice granted Licensee an opportunity for hearing if requested within twenty (20) days of the mailing of the Notice. No such request was received.

On November 15, 2019, the Board mailed the Final Oder of Revocation by Default to Licensee using a certificate of mailing. A copy was also emailed to the Licensee.

On November 16, 2019, upon receiving email of Final Order of Revocation by default, Licensee responded that he had requested a Hearing by email in a timely manner.

On November 26, 2019, Board staff, through a review of State emails, did find an email sent by Licensee to the Investigator that was blocked as "spam" by the State system. This was assumed to be the request for Hearing, despite the content of the email not being available.

On December 18, 2019, The Board reconsidered the Final Order of Revocation by Default and granted the Licensee Hearing Rights. The Final Order was removed and the Notice of Revocation was posted.

On August 24, 2020, Licensee failed to show for Hearing. As stated in the Notice of Revocation, “in the event of a default resulting from either s failure to request a hearing or to appear at a scheduled hearing, the Board’s record of the proceeding to date, including the investigative file, shall constitute the record for purposes of establishing a prima facie case.”

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

**-I-**

### **FINDINGS OF FACT**

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

1. Licensee was issued a Registered Nurse License by Endorsement and a Certified Registered Nurse Anesthetist License in the state of Oregon on December 17, 2007.
2. On or about November 7, 2018, The Board received a NURSYS alert that Licensee’s CRNA had been revoked in California.
3. On or about August 7, 2014, while working at a hospital in California, Licensee led a surgeon to believe he had administered a medication during surgery that he had not.
4. On or about May 19, 2017, The California Board of Registered Nursing mailed Licensee a letter of “Accusation.” On January 22, 2018, Licensee, when asked in his Oregon renewal application “since the date of your last renewal, have you been investigated for any alleged violation of any state or federal law, rule, or practice standard regulating a health care profession” answered “no.”
5. On October 7, 2019, Board staff mailed a Notice of Proposed Revocation to Licensee via first-class and certified mail. The Notice granted Licensee twenty (20) days from the date of the mailing of the Notice to request a hearing. The Notice also designated that the agency file would be the record for purposes of default.

**-II-**

### **CONCLUSIONS OF LAW**

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

That Licensee’s conduct is in violation of ORS 678.111(1)(f)(g)(h) and OAR 851-045-0070 (2)(a), (3)(a)(b), (4)(f) and (10)(b) and OAR 851-052-0100 ((1)(2)(4), which reads as follows:

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

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

(f) Conduct derogatory to the standards of nursing.

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

(h) Revocation or suspension of a license to practice nursing by any state or territory of the United States or any foreign jurisdiction authorized to issue nursing credentials whether or not that license or credential was relied upon in issuing that license in this state. A certified copy of the order of revocation or suspension shall be conclusive evidence of such revocation or suspension.

**OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined**

Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:

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

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

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

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

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

(4) Conduct related to communication:

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

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

(b) Failing to answer truthfully and completely any question asked by the Board on an application for licensure or during the course of an investigation or any other question asked by the Board;

2. That Licensee defaulted on the Notice by not appearing at the Hearing, as scheduled, on August 24, 2020.

**-III-**

**ORDER**

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

ORDERED that the Registered Nurse License and Certified Registered Nurse Anesthetist License of Bradley Patrick is REVOKED.

DATED this \_\_\_\_\_ day of September, 2020

**FOR THE BOARD OF NURSING OF THE STATE OF OREGON**

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Kathleen Chinn, FNP-BC  
Board President

TO: BRADLEY PATRICK:

You may file a petition for reconsideration or rehearing of this Order. Reconsideration or rehearing may be obtained by filing a petition with the Board of Nursing within (sixty) 60 days from the service of this Order. Your petition shall set forth the specific grounds for reconsideration. Reconsideration or rehearing is pursuant to the provisions in ORS 183.482.

As an alternative to filing a Petition for Reconsideration of this Order, you are entitled to judicial review of this Order. Judicial review may be obtained by filing a petition with the Oregon Court of Appeals for review within sixty (60) days from the date of service of this Order. Judicial review is pursuant to the provisions of ORS 183.482.

If, after a minimum of three (3) years, you wish to reinstate your Certified Registered Nurse Anesthetist License/Certificate, you may submit an application to the Board to request reinstatement.

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of  
Joanna Pelton, RN**

) **STIPULATED ORDER FOR**  
) **SUSPENSION OF LICENSE WITH**  
) **CONDITIONS FOLLOWED BY**  
) **PROBATION**  
)  
) **Reference No. 19-00394**

**License No. 201600051RN**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Joanna Pelton (Licensee) was issued a Registered Nurse license by the Board on January 06, 2016.

In June 2015, the Board issued Licensee an Oregon RN license on probation which they completed in January 2018. On January 31, 2018, Licensee successfully completed their Board-ordered probation.

In July 2018, Licensee drank alcohol and was arrested for Driving Under the Influence of Intoxicants (DUII). In September 2018, Licensee drank alcohol and was arrested again for DUII. In December 2018, Licensee was arrested again for DUII. On or about June 1, 2020, Licensee was convicted of the above-mentioned three counts of DUII. Additionally, on or about April 6, 2019, Licensee drank alcohol and reported to work intoxicated.

By the above actions, Licensee is subject to discipline pursuant to ORS 678.111(1)(a)(e)(f)(g) and OAR 851-045-0070(7)(b)(c) which provide as follows:

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

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

(a) Conviction of the licensee of crime where such crime bears demonstrable relationship to the practice of nursing. A copy of the record of such conviction, certified to by the clerk of the court entering the conviction, shall be conclusive evidence of the conviction.

(e) Impairment as defined in ORS 676.303.

(f) Conduct derogatory to the standards of nursing.

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

Suspension of License with Conditions Followed by Probation

**OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined**

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

(7) Conduct related to impaired function:

(b) Practicing nursing when physical or mental ability to practice is impaired by use of a prescription or non-prescription medication, alcohol, or a mind-altering substance;

(c) The use of a prescription or non-prescription medication, alcohol, or a mind-altering substance, to an extent or in a manner dangerous or injurious to the licensee or others or to an extent that such use impairs the ability to conduct safely the practice of nursing.

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 Registered Nurse license of Joanna Pelton be SUSPENDED for 730 days, commencing five business days from the date this Order is signed by the Oregon State Board of Nursing. Within 90 days of being suspended, Licensee will enroll in a Board-approved substance use disorder treatment program and then must adhere to the following conditions during the period of suspension:**

**a. Licensee shall follow all of the treatment program's recommendations. Licensee shall provide the Board with proof of compliance on a monthly basis and provide the Board with proof of completion of all treatment recommendations.**

**b. Licensee shall abstain from using alcohol and/or other intoxicating, mind altering, or potentially addictive drugs, including over-the-counter or prescription drugs during the period of suspension, except as provided in Section "c" below.**

**c. Licensee may take medication for a documented medical condition, provided that they obtain such medication only by a legal prescription written by a person authorized by law to write such a prescription. Licensee shall provide the Board with a copy of the prescription(s).**

**d. Licensee shall sign a Release of Information with their medical provider(s) regarding any medication involving pain or controlled substances. Licensee's medical provider(s) must provide the Board with any changes in Licensee's medication and must notify the Board of any non-compliance issues.**

**e. Licensee shall be financially responsible for any costs they may incur as a result of compliance with the terms and conditions of this stipulation.**

**Upon completion of this suspension, the Registered Nurse license of Joanna Pelton will be placed on Probation. 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 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's acceptance of this Order to complete twenty-four (24) months of monitored practice.
- 3) Licensee shall notify Board staff, in writing, prior to any change of address or employment setting during the probation period.
- 4) Licensee shall maintain an active license.
- 5) Licensee shall inform Board staff in advance of any absences from Oregon and/or any move from Oregon to another licensing jurisdiction. If Licensee leaves the state and is unable to practice in the state of Oregon, Licensee's probationary status will be re-evaluated.
- 6) Licensee shall appear in person or by phone, to designated Board staff for interviews on a monthly basis during the probationary period. Frequency of contact may be reviewed and revised periodically at the discretion of Board staff.
- 7) Licensee shall notify Board staff of any citations, arrests, or convictions for any offense, whether felony, misdemeanor, violation, or citation within seven (7) days of the occurrence.
- 8) Licensee will not look for, accept, or begin a new nursing position without prior 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 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 perform the duties of a nurse.

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

13) Licensee shall not work in any practice setting when on-site monitoring is not available. This generally includes home health agencies, traveling agencies, 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 participate in and comply with any treatment recommendations set forth by a third party evaluator approved by the Board. Within fourteen (14) days of completing treatment, Licensee shall submit to Board staff a copy of Licensee's completion certificate or discharge summary. Licensee shall attend Narcotics Anonymous (NA), Alcoholics Anonymous (AA) or similar recovery program on a weekly basis and provide proof of attendance to Board staff. Licensee shall sign any release of information necessary to allow Board staff to communicate with Licensee's treatment provider and release Licensee's treatment records to the Board.

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

18) Licensee shall abstain from using alcohol and/or other intoxicating, mind altering, or potentially addictive drugs, including over-the-counter or prescription drugs while participating in the Board's random urine drug testing program, except as provided in **Section 19** below. Licensee shall avoid any over-the-counter products and food items containing alcohol, marijuana and poppy seeds.

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

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

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

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

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

Licensee understands that the conduct resulting in the violations of law described in this 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 this Stipulated Order and/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 Registered Nurse.

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

Licensee understands that by signing this Stipulated Order, 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 has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Suspension.

IT IS SO AGREED:

\_\_\_\_\_  
Joanna Pelton, RN

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Kathleen Chinn, FNP-BC  
Board President

\_\_\_\_\_  
Date

PLEASE RETURN ALL PAGES OF THIS STIPULATED ORDER AFTER SIGNING

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of  
Jennifer Quesada**

)  
) **FINAL ORDER OF DENIAL OF**  
) **REGISTERED NURSE LICENSE**  
) **APPLICATION BY DEFAULT**  
)  
) **Reference No. 20-00450**

**License No. 200742059RN (Expired)**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Jennifer Quesada (Licensee) was issued a Registered Nurse license by the Board on July 10, 2007.

On January 19, 2011, the Board approved Licensee entry into the Health Professionals' Services Program (HPSP) related to her mental health diagnosis.

On July 8, 2011 and December 22, 2011, Licensee was reported to the Board by HPSP for failing to test on July 6, 2011 and December 21, 2011. Licensee's failures to test were a result of missing calls to the toxicology Inter-active Voice Response (IVR) line. Licensee explained that in July, she and her family were on vacation and she forgot to call the toxicology IVR line. The second missed test was related to a family emergency. Licensee was in the process of hospitalizing a family member and forgot to call the toxicology IVR line.

On October 30, 2012, the Board received a memo from HPSP noting that Licensee reported that she will discontinue participation in the monitoring program. Licensee stated that she talked with her family and has decided that a future in nursing is no longer in her family's best interest.

On January 16, 2013, the Board accepted Licensee's signed Stipulated Order for Voluntary Surrender.

On or about January 14, 2019, Licensee applied for reinstatement of their Registered Nurse license.

This matter was considered by the Board at its meeting on June 10, 2020.

On June 12, 2020, a Notice stating that the Board intended to deny the application for Registered Nurse License was sent to Licensee via certified and first-class mail to Licensee's address of record. The Notice alleged that Licensee had a mental health condition that required monitored practice.

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

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

## **I FINDINGS OF FACT**

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

1. On or about March 5, 2020, Licensee underwent an evaluation and mental health therapy was recommended.
2. On or about April 22, 2020, a Stipulated Order For Probation - Re-Entry was mailed to Licensee for consideration requesting that Licensee review the document and if agreeable, return it to Board staff by May 8, 2020. Licensee did not return the stipulation.
4. On June 10, 2020, the Board reviewed the facts of the case against Licensee and voted to issue a Notice of Proposed Denial of Registered Nurse License Application.
5. On June 12, 2020, Board staff mailed a Notice of Proposed Denial of Registered Nurse License Application to Licensee via first-class and certified mail. The Notice granted Licensee sixty (60) days from the date of the mailing of the Notice to request a hearing. The Notice also designated that the agency file would be the record for purposes of default.

## **II CONCLUSIONS OF LAW**

1. That the Board has jurisdiction over Licensee, Jennifer Quesada, and over the subject matter of this proceeding.
2. That Licensee's conduct is in violation of ORS 678.111(1)(f) and OAR 851-045-0070(7)(B) which read as follows:

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

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

(f) Conduct derogatory to the standards of nursing.

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

(7) Conduct related to impaired function:

(B) Psychological or mental impairment as evidenced by documented deterioration of functioning in the practice setting or by the assessment of an LIP qualified to diagnose mental conditions or status.

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

### III ORDER

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

ORDERED that the Application for Registered Nurse License is denied.

Dated this \_\_\_\_\_ day of September, 2020

FOR THE OREGON STATE BOARD OF NURSING

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Kathleen Chinn, FNP-BC  
Board President

You may file a petition for reconsideration or rehearing of this Order. Reconsideration or rehearing may be obtained by filing a petition with the Board of Nursing within 60 days from the service of this Order. Your petition shall set forth the specific grounds for reconsideration. Reconsideration or rehearing is pursuant to the provisions in ORS 183.482.

As an alternative to filing a Petition for Reconsideration of this Order, you are entitled to judicial review of this Order. Judicial review may be obtained by filing a petition with the Oregon Court of Appeals for review within 60 days from the date of service of this Order. Judicial review is pursuant to the provisions of ORS 183.482 to the Oregon Court of Appeals.

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Brandon Seward, RN** ) **PROBATION**  
)  
**License No. 201501006RN** ) **Reference No. 20-00789**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Brandon Seward (Licensee) was issued a Registered Nurse License by the Oregon State Board of Nursing on February 18, 2015.

On or about January 31, 2020, the Board received information that Licensee self-reported his arrest for Domestic Violence, which was related to substance use.

By the above actions, Licensee is subject to discipline pursuant to ORS 678.11 (1), and OAR 851-045-0070 (1)(a), and (7)(c).

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

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

- (f) Conduct derogatory to the standards of nursing.
- (g) Violation of any provisions of ORS 678.010 to 678.448 or rules adopted thereunder.

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

- (1) Conduct related to general fitness to practice nursing:
  - (a) Demonstrated incidents of violent, abusive, intimidation, neglectful or reckless behavior, or.
- (7) Conduct related to impaired function:
  - (c) The use of a prescription or non-prescription medication, alcohol, or a mind-altering substance, to an extent or in a manner dangerous or injurious to the licensee or others or to an extent that such use impairs the ability to conduct safely the practice of nursing.

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

That the Registered Nurse License of Brandon Seward 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's acceptance of this Order to complete twenty-four (24) months of monitored practice.
- 3) Licensee shall notify Board staff, in writing, prior to any change of address or employment setting during the probation period.
- 4) Licensee shall maintain an active license.
- 5) Licensee shall inform Board staff in advance of any absences from Oregon and/or any move from Oregon to another licensing jurisdiction. If Licensee leaves the state and is unable to practice in the state of Oregon, Licensee's probationary status will be re-evaluated.
- 6) Licensee shall appear in person or by phone, to designated Board staff for interviews on a monthly basis during the probationary period. Frequency of contact may be reviewed and revised periodically at the discretion of Board staff.
- 7) Licensee shall notify Board staff of any citations, arrests, or convictions for any offense, whether felony, misdemeanor, violation, or citation within seven (7) days of the occurrence.
- 8) Licensee will not look for, accept, or begin a new nursing position without prior 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 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 perform the duties of a nurse.

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

13) Licensee shall not work in any practice setting when on-site monitoring is not available. This generally includes home health agencies, traveling agencies, 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 participate in and comply with any treatment recommendations set forth by a third party evaluator approved by the Board. Within fourteen (14) days of completing treatment, Licensee shall submit to Board staff a copy of Licensee's completion certificate or discharge summary. Licensee shall attend Narcotics Anonymous (NA), Alcoholics Anonymous (AA) or similar recovery program on a weekly basis and provide proof of attendance to Board staff. Licensee shall sign any release of information necessary to allow Board staff to communicate with Licensee's treatment provider and release Licensee's treatment records to the Board.

17) Licensee shall participate in the Board's random urine drug testing program. Failure to comply with random urine or any other requested drug test shall result in Licensee's immediate removal from nursing practice. Licensee shall submit to observed tests to determine the presence of unauthorized substances immediately upon request by Board staff or Licensee's employer. Licensee shall sign any release of information necessary to ensure the Board will receive the results of such testing. The presence of unauthorized substances may be considered a violation of the terms and conditions of this Stipulated Order. Upon request of Board staff, Licensee shall obtain an evaluation by a Board approved chemical abuse or

dependence evaluator. Licensee understands that Licensee is financially responsible for any and all costs related to testing and evaluating. Licensee's failure to maintain an account in good standing with the Board's laboratory vendor shall be considered a violation of this Stipulated Order.

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

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

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

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

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

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

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

Licensee understands that in the event Licensee engages in future conduct resulting in



**BEFORE THE OFFICE OF ADMINISTRATIVE HEARINGS  
STATE OF OREGON  
for the  
OREGON STATE BOARD OF NURSING**

IN THE MATTER OF: ) **FINAL ORDER**  
 )  
**BRANDI SLATON, C.N.A.** ) OAH Case No. 2019-ABC-02709  
 ) Agency Case No. 17-01516

On September 9, 2020, the Board reviewed the Proposed Order issued by Senior Administrative Law Judge (ALJ) Jennifer H. Rackstraw. Ms. Slaton did not file exceptions. After considering the record, the Board adopts the Proposed Order as the Final Order and revokes Ms. Slaton's Nursing Assistant Certificate as explained below.

**HISTORY OF THE CASE**

On April 17, 2019, the Oregon State Board of Nursing (Board) issued a Notice of Proposed Revocation of Nursing Assistant Certificate to Brandi Slaton. On or about May 1, 2019, Ms. Slaton requested a hearing. On May 6, 2019, the Board referred the matter to the Office of Administrative Hearings (OAH). The OAH assigned ALJ Rackstraw to preside over the matter.

On June 4, 2019, ALJ Rackstraw held a telephone prehearing conference. Ms. Slaton represented herself. Senior Assistant Attorney General (AAG) Tom Cowan represented the Board. A hearing was scheduled for May 28, 2020.

On June 19, 2019, the Board filed a Motion for Qualified Protective Order. On July 15, 2019, ALJ Rackstraw granted the unopposed motion and issued a Qualified Protective Order Limiting Use and Disclosure.

On September 20, 2019, the Board filed a Notice of Substitution of Counsel, stating that the matter was reassigned to Senior AAG Catriona McCracken. On March 12, 2020, the Board filed another Notice of Substitution of Counsel, stating that the matter was reassigned to AAG Lauren Rauch.

On April 15, 2020, with the parties' consent, the OAH converted the hearing from an in-person hearing to a telephone hearing. On April 30, 2020, Ms. Slaton requested a postponement of the May 28, 2020 hearing. On May 5, 2020, the Board objected to the postponement request. On May 7, 2020, ALJ Rackstraw convened a telephone status conference to discuss the postponement request and related matters. Ms. Slaton represented herself. Ms. Rauch represented the Board. Board staff Britney Noel was also present. After some discussion, ALJ Rackstraw denied the postponement request.

On May 28, 2020, a hearing was held via telephone, with ALJ Rackstraw presiding. Ms. Slaton represented herself and testified. Ms. Rauch represented the Board. Robert Slaton, Jr., Ms. Slaton's father, and Dorothy "Dodie" Slaton, Ms. Slaton's sister, testified on Ms. Slaton's behalf. The following persons testified for the Board: Board Investigator Dante Messina; Nikki Blomquist, a Compliance Specialist III with the Board;<sup>1</sup> and James Slaton, Ms. Slaton's brother.

The record remained open for the receipt of additional exhibits from the Board. On May 29, 2020, the Board filed Exhibits A14 and A15 and also requested that the record remain open until June 12, 2020, so Investigator Messina could, if necessary, correct a portion of his hearing testimony related to an ADAPT Crossroads authorization. By email dated May 29, 2020, Ms. Slaton stated that she had no objections to Exhibits A14 and A15. On June 5, 2020, the Board filed a Declaration of Dante Messina (Exhibit A16). On June 9, 2020, ALJ Rackstraw notified Ms. Slaton that she had until June 12, 2020 to file any objection to A16. Ms. Slaton did not file an objection to Exhibit A16, and the record closed on June 12, 2020.

### ISSUES

1. Whether, between 2012 and July 2018, Ms. Slaton diverted and abused controlled substances on multiple occasions, thereby engaging in conduct unbecoming a nursing assistant under OAR 851-063-0090(1)(b), (7)(c), and (8)(i) and (j).<sup>2</sup>
2. Whether, on or about June 21, 2017, Ms. Slaton submitted a renewal application to the Board that contained untruthful responses to several questions, thereby engaging in conduct unbecoming a nursing assistant under OAR 851-063-0090(1)(b), (9)(a), and (10)(b).
3. Whether, on or about March 6, 2018, Ms. Slaton untruthfully denied diverting controlled substances or having a substance abuse issue, while speaking with Board staff regarding such issues, thereby engaging in conduct unbecoming a nursing assistant under OAR 851-063-0090(1)(b) and (10)(b).
4. Whether the Board may revoke Ms. Slaton's nursing assistant certificate, pursuant to ORS 678.442(2)(b), (d), and (f).

### EVIDENTIARY RULINGS

The Board's Exhibits A1 through A16 and Ms. Slaton's Exhibits R1 through R11 were admitted into the record without objection. In addition, Pleadings P1 through P21 were made a part of the record.

### FINDINGS OF FACT

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<sup>1</sup> Ms. Blomquist is a Certified Alcohol and Drug Counselor – Level III. (Test. of Blomquist.)

<sup>2</sup> There were two versions of OAR 851-063-0090 in effect during the time period relevant to this allegation: a previous version that was effective from September 30, 2010 through December 31, 2014; and the present version that became effective on January 1, 2015. Differences between the two versions are discussed in a later section of this order.

### *Background*

1. In 2006, the Board issued a nursing assistant certificate to Ms. Slaton. (Ex. A4 at 1; test. of Messina.)

2. From January 2007 to November 2009, Ms. Slaton worked as a certified nursing assistant (CNA) for Rogue Valley Medical Center. From December 2011 to June 2018, Ms. Slaton worked as a CNA for Providence Medford Medical Center. (Ex. A2 at 1.) During that same time period, from February 2015 to January 2017, she also worked as a front office coordinator at Rogue Community Health Clinic. (See Ex. A5 at 22.)

3. On or about September 17, 2018, Ms. Slaton began working as a CNA for Coquille Valley Hospital. (Exs. A2 at 1, A5 at 4.) At the time of the hearing, she remained employed at Coquille Valley Hospital. (Test. of Slaton.)

### *Use and Abuse of Prescriptions Medications*

4. In 2012, Ms. Slaton began using prescription pain medication after injuring her back at work. (Ex. A5 at 16.)

5. In approximately mid-2015, Ms. Slaton recognized that she had a “problem” abusing pain medication — specifically oxycodone and hydrocodone. (Ex. A5 at 16, 33.) At that time, she was taking her own prescribed medication, as well as her then-husband’s (now ex-husband’s) pain medication, to combat stress and emotional pain, rather than to treat physical pain. (Ex. A5 at 16-18, 25.) Her then-husband had an ongoing monthly prescription for oxycodone, which she filled every month for her own use, without his knowledge. (Test. of James Slaton; Ex. A5 at 25-26.) She also occasionally purchased narcotics from friends. (Ex. A5 at 33.)

6. In 2015, Ms. Slaton was hospitalized after taking one or more Soma pills (a prescribed muscle relaxant) and subsequently having seizures. (See Ex. A5 at 29-31.)

7. On January 28, 2016, Ms. Slaton’s family engaged in an “intervention” and she stopped using the pain medications “cold turkey” for some period.<sup>3</sup> (Ex. A5 at 16-18, 32; see Ex. A7 at 14.)

8. Ms. Slaton never went to work as a CNA while she was knowingly “high.” (See Ex. A5 at 18-20.) Although she had opiates in her system from off-hours use, she never felt impaired or under the influence of opiates while at work. (See *id.* at 20.)

9. Oregon Prescription Drug Monitoring Program (PDMP) records show that between April 1, 2015 and April 26, 2017, Ms. Slaton filled prescriptions from nine different prescribers at six different pharmacies for a total of 15 tablets of Tramadol HCL (50 mg), 30 tablets of Oxycodone HCL (5 mg), 162 tablets of Hydrocodone-Acetaminophen (5-325), and 1,104 tablets

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<sup>3</sup> The Board modified this paragraph to correct what appears to be a scrivener’s error regarding the spelling of Ms. Slaton’s name.

of Hydrocodone-Acetaminophen (10-325). (*See* Ex. A12 at 2-3.) From September 4, 2017 to May 1, 2018, she filled prescriptions from five different prescribers at three different pharmacies for a total of 110 tablets of Tramadol HCL (50 mg) and 41 tablets of Hydrocodone-Acetaminophen (5-325). (*See id.* at 5-6.) From May 1, 2018 to November 2, 2018, she filled prescriptions from three different prescribers at three different pharmacies for a total of 5 tablets of Tramadol HCL (50 mg), 20 tablets of Hydrocodone-Acetaminophen (5-325), and 10 tablets of buprenorphine. (*See id.* at 8-11.)

#### *Board Involvement*

10. On February 6, 2017, the Board received a complaint regarding Ms. Slaton. (*See* Ex. A4 at 1.) The Board assigned Investigator Shanon Rahimi to the matter. (Test. of Messina; *see* Exs. A14 and A15.)

11. On April 14, 2017, Ms. Rahimi conducted a telephone interview with Mary Sanderson, Ms. Slaton's sister. (Ex. A6 at 1-22.) Ms. Sanderson reported that for approximately two years, Ms. Slaton was filling and taking all of her (Ms. Slaton's) then-husband's prescribed opioid medication. Ms. Sanderson also reported that any time her family had opiates in their house, they would come up missing after Ms. Slaton visited the house. Ms. Sanderson further reported that when her son broke his leg, Ms. Slaton called while he was still in the hospital and asked whether Ms. Sanderson had filled his pain medication yet, because Ms. Slaton wanted some of it. (*Id.* at 3-4, 15-16.) Ms. Sanderson reported that approximately 20 of her son's leftover pills subsequently came up missing. (*Id.* at 6.) Ms. Sanderson reported that although Ms. Slaton did not hide her use of opiates from the family, she hid the extent of that use. (*Id.* at 4-5.) Ms. Sanderson reported that Ms. Slaton engaged in drug-seeking behavior from medical providers, alleging injuries and ailments for both herself and her own children. (*See id.* at 6.) Ms. Sanderson reported that Ms. Slaton began using opiates in approximately 2006, when her daughter was born. (*Id.* at 7.) Ms. Sanderson reported that she received a phone call from a coworker of Ms. Slaton's who alleged that Ms. Slaton asked the coworker if they had any pain medication. That same coworker reached out to Ms. Sanderson a few days later and reported seeing Ms. Slaton "going through somebody's pain pill cup that was sitting at the bedside." (*Id.* at 8-9, 18-19.)

12. On April 17, 2017, Ms. Rahimi sent a letter to Ms. Slaton at 446 Red Blanket Road, in Prospect, Oregon. (Ex. A14 at 1-2; test. of Messina.) The letter notified Ms. Slaton that the Board had received a complaint alleging that she misused opiate medications and used medications not prescribed to her. The letter also notified her that, by May 1, 2017, she needed to call the phone number provided therein to schedule a Board investigative interview. The letter further instructed her to provide the following to the Board by May 1, 2017: a copy of her work history; a written statement that directly addresses the allegations; and a list of medications prescribed within the past year. Finally, the letter directed her to sign releases of information with her medical providers and ask such providers to send all medical records for the past year to the Board. (Ex. A14 at 1-2.)

13. On May 4, 2017, Ms. Rahimi sent another letter to Ms. Slaton at 446 Red Blanket Road, in Prospect, Oregon. (Ex. A15 at 1.) The letter indicated that it was a "FINAL

REQUEST” and that Ms. Slaton’s immediate response was required. (*See id*; emphasis in original.) The letter stated that Ms. Slaton had not yet called the Board to schedule an investigatory interview, and that she needed to do so within five business days from the date of the letter. The letter also requested a copy of her work history and a detailed written statement describing the alleged conduct that brought her to the Board’s attention. Finally, the letter informed Ms. Slaton that failure to cooperate with the Board could result in disciplinary action. (*Id.*)

14. For unknown reasons, Ms. Slaton did not receive the April 17, 2017 and May 4, 2017 letters. (*See* Ex. A4 at 3; test. of Slaton.)

*June 2017 Renewal Application*

15. On or about June 21, 2017, Ms. Slaton filed an online renewal application with the Board. (Ex. A1 at 1-3; test. of Messina.) She answered “no” to the following questions:

1.a. Since the date of your last renewal, have you used alcohol or any drugs in a way that could impair your ability to practice nursing or perform nursing assistant duties with reasonable skill and safety?

\* \* \* \* \*

1.c. Since the date of your last renewal, have you used any illegal drugs, or prescription drugs in a manner other than prescribed?

2. Other than any information you may have provided in Question 1, since the date of your last renewal, do you have a physical, mental or emotional condition that could impair your ability to practice nursing or perform nursing assistant duties with reasonable skill and safety?

\* \* \* \* \*

5.a. Since the date of your last renewal, have you been investigated for any alleged violation of any state or federal law, rule, or practice standard regulating a health care profession? Include any pending investigations.

(Ex. A1 at 1-2.) When she filled out the renewal application, and answered question 5a, she was unaware of the Board’s investigation of her. (Test. of Slaton.)

16. On March 14, 2018, Ms. Rahimi sent an email to Ms. Slaton, notifying Ms. Slaton of the previous attempts to reach her and instructing her to contact Ms. Rahimi no later than March 21, 2018. (Ex. A4 at 3.)

17. On March 16, 2018, Ms. Slaton contacted Ms. Rahimi and they spoke via telephone. During their phone conversation, Ms. Slaton confirmed that her mailing address was the same address where Ms. Rahimi sent the April 17, 2017 and May 4, 2017 letters. Ms. Slaton reported

that she did not receive Ms. Rahimi's letters. When Ms. Rahimi asked whether Ms. Slaton was ever prescribed opiates, Ms. Slaton stated that she had been previously prescribed opiates on short-term bases for injuries. Ms. Slaton reported that she was last prescribed opiates when a wood stack fell on her in January 2018, and after a few days of taking the prescribed medication, she "flushed the rest." (Ex. A4 at 3-4.) Ms. Slaton further reported that she was prescribed Tramadol after being stung by a bee eight months prior, and that she had a "short-term" opiate prescription in November of the previous year after falling during hunting season. (*Id.* at 4.) When Ms. Rahimi asked if Ms. Slaton was getting opiate pills from any other source, Ms. Slaton assured her that she was not getting pills from any source other than a prescription. Ms. Slaton reported that she had been on opioid pain medication "regularly" until a few years ago, when she asked her primary care physician to take her off the medication. (*Id.*) She told Ms. Rahimi that she went off the medication, experienced withdrawal, and was "deathly ill" for 14 days. (*Id.*) She also told Ms. Rahimi that she has not experienced any difficulty stopping opiates when she has since taken them on a short-term basis. When Ms. Rahimi asked Ms. Slaton why she thinks the Board would receive a complaint that Ms. Slaton was abusing opiates and taking medications not prescribed to her, Ms. Slaton reported that her father and other family members think she is a drug addict, but her father is verbally and emotionally abusive and her older siblings think they can tell her what to do. Ms. Slaton stated that she does not know why her family members think she is a drug addict. She also reported that after a coworker of hers was fired, the coworker was "pissed off" at Ms. Slaton and falsely told Ms. Slaton's sister that Ms. Slaton had been looking for pills. (Ex. A4 at 3-4.)

18. On April 24, 2018, the Board reassigned Ms. Slaton's case to Investigator Dante Messina.<sup>4</sup> (Test. of Messina; Ex. A4 at 4.)

#### *Substance Abuse Treatment*

19. By July 2018, Ms. Slaton realized that she had hit "rock bottom" with regard to her drug use. (Test. of Slaton.) On July 9, 2018, after having abused prescription medication that day, she checked into ADAPT Crossroads (ADAPT) to detox from opiates. On July 10, 2018, an ADAPT evaluator diagnosed her with severe opioid dependence, uncomplicated, and recommended that she follow a medically monitored detox with residential treatment services. On or about July 15, 2018, Ms. Slaton completed medical detox. There were no open residential treatment beds available, so she returned home for two days. On July 17, 2018, she returned to ADAPT and began residential treatment. (*See* Exs. A5 at 32; A13 at 2-13, 15, 19-22, 27-28; test. of Slaton.)

20. On July 18, 2018, Ms. Slaton participated in an ADAPT individual therapy session. (Ex. A13 at 23.) The therapist noted in the treatment note that Ms. Slaton reported gambling issues and a "3[-]year history of 'prescription pill abuse that le[d] up to my wanting to die because I was such a failure as a wife, a mother, and a friend to my co-workers and church community.'" (*Id.*) The therapist also noted, in part:

[Ms. Slaton] appears to be functioning in the Preparation Stage of Change and Recovery as evidenced by her having come to residential treatment

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<sup>4</sup> Ms. Rahimi no longer works for the Board. (Test. of Messina.)

due to her inability to remain clean and sober despite unwanted negative consequences. [Ms. Slaton] appears willing and honest in reporting a desire to incorporate healthy proactive life skills in order to alter her past poor thinking and behavioral patterns that have perpetuated ongoing unwanted lifestyle choices. [Ms. Slaton] has begun to attend and engage in all daily treatment groups and activities.

\* \* \* \* \*

[Ms. Slaton] will continue to fully engage in \* \* \* all daily treatment activities as she begins to delve into the emotional and physical cues and triggers of her relapse process and will start to create a working plan and strategies to avoid a potential return to [her] past destructive lifestyle in addiction. [She] will work in cooperation with case-manager and primary counselor, to seek-out community resources and community partners to aid in a smooth transition back into the community and her family upon transition into lowered level continuum of care. [She] and this writer will meet a minimum of once weekly to review her progress[.]

(*Id.*)

21. On August 9, 2018, Ms. Slaton was discharged from residential treatment for non-compliance with rules prohibiting the use and possession of vape pens at the facility.<sup>5</sup> (*See* Exs. A5 at 13-14, 42-43; A13 at 14; test. of Slaton.) She did not complete the recommended residential treatment. She did not transfer to a lower level of care, such as outpatient treatment, after her discharge.<sup>6</sup> (*See* test. of Slaton and Blomquist.) There is no evidence of any continued plan of care following her discharge. (Test. of Blomquist.)

22. Following her ADAPT discharge, Ms. Slaton immediately contacted Lori Mattie, her sobriety mentor, and began participating in weekly spiritually-based Celebrate Recovery 12-step meetings through her church. (*See* Ex. A5 at 44; test. of Slaton.)

23. Ms. Slaton moved from southern Oregon to Coos Bay to “start a new life,” and distance herself from drug-using acquaintances and her former drug-abusing lifestyle. (*See* Ex. A5 at 44-45; test. of Slaton.) She began participating in weekly Celebrate Recovery meetings in her new geographic location. (Test. of Slaton.)

#### *Board’s Continuing Investigation*

24. On November 1, 2018, Investigator Messina conducted a telephone interview with Ms. Sanderson. (Ex. A7 at 1-25; test. of Messina.) Ms. Sanderson reported that in the summer

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<sup>5</sup> Ms. Slaton had facilitated the purchase of one or more vape pens for nicotine use at the facility. (*See* Ex. A5 at 42-44.)

<sup>6</sup> Ms. Blomquist testified at hearing that she typically sees Board licensees transferred to a lower level of care for continuing treatment (of varying durations) after discharge from a residential substance abuse program. (Test. of Blomquist.)

of 2018, Ms. Slaton's then-husband learned that Ms. Slaton had cleared out his retirement and that their home was being foreclosed because Ms. Slaton had not paid the mortgage. She also reported that around that time, Ms. Slaton signed over custody of her three children to their (Ms. Slaton's and Ms. Sanderson's) brother, James Slaton. (Ex. A7 at 4.)

25. Also on November 1, 2018, Investigator Messina conducted a telephone interview with Neil Dye, Ms. Slaton's ex-husband. (Ex. A8 at 1-21; test. of Messina.) Mr. Dye reported that Ms. Slaton's excessive gambling during their marriage caused him to ultimately lose his home, his vehicles, and his retirement. He reported that Ms. Slaton also took money from her minor children to support her addictions. He also reported that he only filled one month of his 12-month prescription for opioid pain medication, and that Ms. Slaton filled all of the other months' prescriptions in his name for herself. (Ex. A8 at 3, 6-7, 12.)

26. Also on November 1, 2018, Investigator Messina conducted a telephone interview with James Slaton, Ms. Slaton's brother. (Ex. A9 at 1-16; test. of Messina.) James Slaton reported that, as of approximately June 19, 2018, he became the legal guardian of Ms. Slaton's three minor children. He also reported that Ms. Slaton took nearly \$70,000 of Mr. Dye's retirement funds. (Ex. A9 at 3, 9, 11.)

27. Also on November 1, 2018, Investigator Messina conducted a telephone interview with Robert Slaton, Ms. Slaton's father. (Ex. A10 at 1-18; test. of Messina.) Robert Slaton reported that Walmart records showed that Ms. Slaton had repeatedly filled Mr. Dye's monthly prescription for 100 full-strength OxyContin. (Ex. A10 at 4.)

28. On December 18, 2018, Ms. Slaton spoke to Investigator Messina via telephone and reported that, among other things, she had signed a release of information document with ADAPT. (See Ex. A4 at 5.)

29. On December 19, 2018, Board Investigator Dante Messina sent an email to Ms. Slaton requesting that she provide a copy of her work history and a written statement describing the alleged conduct that brought her to the Board's attention. (Ex. A2 at 1-2.) Later on December 19, 2018, Ms. Slaton responded to Investigator Messina's email. In the email, she listed her work history and wrote, in part:

Yes, as I have stated I did have an issue with pain medication over the past years, July of this year I entered into treatment and since I have remained sober. As of today I have 162 days clean from all mind altering substance[s]! I have an amazing support group to help me.

(*Id.* at 1.)

30. Also on December 19, 2018, Investigator Messina confirmed with an ADAPT employee (Rosa) that ADAPT had received a release of information document from Ms. Slaton. (Ex. A4 at 6.)

31. On January 8, 2019, Ms. Slaton participated in a telephone interview with

Investigator Messina. (Ex. A5 at 1-54; test. of Messina.) At the time of the interview, Ms. Slaton had nearly six months of sobriety. (See Ex. A5 at 15-16.) When Investigator Messina asked if she had ever diverted medication from work, or from coworkers, Ms. Slaton responded, “Absolutely not.” (*Id.* at 26.) When Investigator Messina questioned Ms. Slaton about an allegation that she was observed going through someone else’s pain pills at work, Ms. Slaton stated that such an incident “[a]bsolutely never” occurred. (*Id.* at 28.) Ms. Slaton also denied ever telling anyone at work that she was stealing medication. (See *id.* at 29.) With regard to her emergency hospitalization in 2015, Ms. Slaton told Investigator Messina that she had taken the prescribed muscle relaxant, Soma, which has since been put on her “allergy list.” (*Id.* at 29.) She reported that she only remembers taking one pill and then going to bed, and later being told that she had had a seizure. She denied taking a whole bottle of Soma, and suggested that she possibly had an allergic reaction to the single pill. (*Id.* at 29-30.) When Investigator Messina asked about statements she made to Ms. Rahimi on March 16, 2018 (*i.e.*, that she did not abuse or divert substances), Ms. Slaton admitted that she was in denial at the time she spoke with Ms. Rahimi and that although she was not using pain medications on March 16, 2018, she did have an addiction problem at the time. (*Id.* at 36-38.)

32. On January 9, 2019, Investigator Messina received documents from ADAPT. (See Ex. A4 at 6.) He determined that the records likely did not comprise all of Ms. Slaton’s records from her period of treatment. In particular, he felt that the records he received lacked documentation of the latter portion of her treatment (prior to her August 9, 2018 discharge from treatment). (Test. of Messina.)

33. On January 15, 2019, Investigator Messina informed Ms. Slaton via telephone that the Board wanted her to schedule a chemical dependency evaluation. Ms. Slaton agreed, and Investigation Messina subsequently provided her, via email, a list of Board-approved evaluators and requested that she undergo an evaluation by February 5, 2019. (Ex. A4 at 6.) Ms. Slaton did not participate in an evaluation by that date, at least in part because there are no approved evaluators in the Coos Bay/North Bend area, and attending an evaluation would have required her to travel outside of her geographic area, miss two work shifts, and pay for the cost of the evaluation.<sup>7</sup> (Test. of Slaton.)

34. On April 17, 2019, the Board issued a notice, proposing to revoke Ms. Slaton’s nursing assistant certificate. (Pleading P1.) In response, by letter dated May 1, 2019, Ms. Slaton requested a hearing and stated, in part:

First, I admit to the allegations against me including my dishonesty about diverting and abusing controlled substances between 2012 in July 2018. I was dishonest on my renewal application and did falsely answer questions regarding my addiction. I did have a substance abuse problem and sought in-patient treatment. I have been free of all mind altering substances since 10 of July 2018.

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<sup>7</sup> The Board modified this paragraph to reflect that the evidence indicates that Ms. Slaton did not participate in an evaluation. The omission of “not” appears to have been a scrivener’s error, as indicated by the surrounding text of the paragraph.

Next, when I renewed my license, I had already stopped using drugs but did still have an addiction problem. It was only through treatment that I realized the extent of my own addiction. Treatment has helped me understand my addictive tendencies and will continue to help me as I move further into my sobriety. I have a strong support system to keep me involved in my sobriety including a sobriety mentor and a strong group of friends and family who are supportive of me and my recovery. I have moved out of a toxic environment and have relocated to cut all ties with anyone who could negatively impact my recovery. In addition, I regularly attend Celebrate Recovery group meetings that help me connect with other supportive people who are themselves recovering from addiction issues.

Finally, I never endangered my patients and was careful not to work while under the influence of narcotics. I value my job, and as my attendance at Providence Medford Medical Center will demonstrate, my attendance, not my job performance, was affected by my addiction.

I certainly understand the depth of the issue, and I did violate many Oregon Administrative Rules and Oregon Revised Statutes. However, I am asking that the revocation be reconsidered and that I be given an opportunity to demonstrate my sobriety and maintain my job as a Certified Nursing Assistant. I will submit drug tests, take a chemical dependency evaluation, and provide any and all information that is requested of me.

I have fully cooperated with the investigation since I've started treatment and will fully cooperate with any requests that allow me to keep my Certified Nursing Certificate.

(Ex. A3 at 1-2.)

#### *Circumstances at the Time of the Hearing*

36. At the time of the hearing, Ms. Slaton had been sober since July 10, 2018, she spoke with her sobriety mentor at least every other day, and she participated in weekly Celebrate Recovery meetings online (due to Covid-19). (Test. of Slaton.)

37. Ms. Slaton received letters of professional support from Chelle McCoy Jermain, Amy Ristoff, Lisa DiSante, Lacey Taylor, Bobbi Agens, Rebecca Conlan, Christina Schlitter, Meghan Lane, Margaret Hubert, Heidi Long, Wendy Meri, and Laurie Gallo. These individuals attested to Ms. Slaton's excellent patient care, kindness and compassion, dependability and commitment, personal fortitude, moral character, determination to overcome her past, and honesty about her addiction. (See Exs. A10 and R1 through R11.)

#### *Additional Board Considerations*

38. There is no easy short-term fix for addiction and it does not turn "on" and "off."

(Test. of Blomquist.) Even if Ms. Slaton did not report to work while acutely intoxicated during the years she was actively abusing narcotic medications, her concentration and/or mood were likely affected by her use. (*Id.*)

39. At the time of the hearing, Ms. Slaton still had not undergone a substance abuse evaluation, as the Board requested in January 2019. (Test. of Slaton; *see* Ex. A4 at 6.) The Friday prior to the hearing, she had an evaluation scheduled through ADAPT with Lisa Jennings. However, she was unable to follow through with the evaluation because her mother had a high blood pressure episode that day and, as her mother's caregiver, she had to take care of her mother. (Test. of Slaton.)

40. At the time of the hearing, and continuing through at least June 2, 2020, ADAPT had a "release of information" document on file for Ms. Slaton. (*See* Ex. A16 at 1-2.) However, the document was unsigned by Ms. Slaton and therefore invalid. (*See id.*) To date, the Board has been unable to obtain a complete set of records regarding Ms. Slaton's ADAPT treatment. (Test. of Dante.)

41. The following risk factors are relevant when assessing the likelihood that Ms. Slaton will be successful in maintaining her recovery from substance abuse: the severity of her disorder; her six-year duration of use; that she did not complete a treatment program; and that she had no treatment plan after her discharge from residential treatment. (Test. of Blomquist.)

42. CNAs may have access to prescription medications in the workplace. (Test. of Messina.)

### CONCLUSIONS OF LAW

1. Between 2012 and July 2018, Ms. Slaton diverted and abused controlled substances on multiple occasions. This constitutes conduct unbecoming a nursing assistant under OAR 851-063-0090(1)(b), (7)(c), and (8)(i) and (j).

2. On or about June 21, 2017, Ms. Slaton submitted a renewal application to the Board that contained untruthful response to several questions. This constitutes conduct unbecoming a nursing assistant under OAR 851-063-0090(1)(b), (9)(a), and (10)(b).

3. On or about March 6, 2018, Ms. Slaton untruthfully denied diverting controlled substances or having a substance abuse issue, while speaking with Board staff regarding such issues. This constitutes conduct unbecoming a nursing assistant under OAR 851-063-0090(1)(b) and (10)(b).

4. The Board may revoke Ms. Slaton's nursing assistant certificate, pursuant to ORS 678.442(2)(b), (d), and (f).

### OPINION

The Board seeks to revoke Ms. Slaton's nursing assistant certificate on several grounds. ORS 678.442(2) provides the authority for the Board to take such action against a certificate holder and states, in part:

[T]he [B]oard may revoke or suspend a certificate issued under this section or may reprimand a nursing assistant for the following reasons:

\* \* \* \* \*

(b) Any willful fraud or misrepresentation in applying for or procuring a certificate or renewal thereof.

\* \* \* \* \*

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

\* \* \* \* \*

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

The Board must prove its allegations against Ms. Slaton by a preponderance of the evidence, and it must also establish that the proposed sanction (*i.e.*, revocation) 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).

### **1. Diverting and Abusing Controlled Substances**

The Board contends that on numerous occasions between 2012 and July 2018, Ms. Slaton diverted and abused controlled substances, thereby engaging in conduct unbecoming a nursing assistant under OAR 851-063-0090(1)(b), (7)(c), and (8)(i) and (j).

The previous version of OAR 851-063-0090 (effective September 30, 2010 through December 31, 2014) applies to the alleged conduct occurring from 2012 through December 2014, and defines conduct unbecoming a nursing assistant, in part:

A CNA \* \* \* who, in the performance of nursing related duties, may adversely affect the health, safety or welfare of the public, may be found guilty of conduct unbecoming a nursing assistant. Conduct unbecoming a nursing assistant includes but is not limited to:

(2) Conduct related to other federal or state statutes/rule violations:

\* \* \* \* \*

(h) Possessing, obtaining, attempting to obtain, furnishing or administering prescription or controlled drugs to any person, including self, except as directed by a person authorized by law to prescribe drugs; or

(i) Removing or attempting to remove drugs, supplies, property or money from the workplace without authorization.

\* \* \* \* \*

(7)(a) Use of drugs, alcohol or mind-altering substances to an extent or in a manner dangerous or injurious to the nursing assistant or others or to an extent that such use impairs the ability to conduct safely the duties of a nursing assistant[.]

Ms. Slaton denies ever diverting drugs from the workplace, and the record does not establish that she did so divert. Ms. Slaton concedes, however, that she excessively used and abused narcotic medications that were prescribed to her, and that she also obtained and used narcotic medications prescribed to others from 2012 through July 9, 2018. The Board has therefore proven that Ms. Slaton engaged in conduct unbecoming a nursing assistant under the previous version of OAR 851-063-0090(2)(h) and (7)(a), cited above, between 2012 and December 2014.

The current version of OAR 851-063-0090 (effective January 1, 2015) applies to the alleged conduct occurring from January 2015 to July 2018, and defines conduct unbecoming a nursing assistant, in part:

A CNA \* \* \* whose behavior fails to conform to the legal standard and accepted standards of the nursing assistant profession, or who may adversely affect the health, safety or welfare of the public, may be found guilty of conduct unbecoming a nursing assistant. Such conduct includes but is not limited to:

\* \* \* \* \*

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

\* \* \* \* \*

(7)(c) Using a prescription or non-prescription drug, alcohol, or a mind-altering substance to an extent or in a manner dangerous or injurious to the

nursing assistant or others, or to an extent that such use impairs the ability to perform the authorized duties safely.

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

\* \* \* \* \*

(i) Possessing, obtaining, attempting to obtain, furnishing or administering prescription or controlled drugs to any person, including self, except as directed by a LIP authorized by law to prescribe drugs;

(j) Unauthorized removal or attempted removal of any drugs, supplies, property, or money from any person or setting[.]

The undisputed record establishes that during the period January 2015 to July 9, 2018, Ms. Slaton excessively used and abused narcotic medications prescribed to her; she obtained and used narcotic medications prescribed for her then-husband by filling those prescriptions on a regular basis without his knowledge and consent; and she bought narcotic medications from other individuals for her own use. The Board has therefore proven that Ms. Slaton engaged in conduct unbecoming a nursing assistant under the current version of OAR 851-063-0090(1)(b), (7)(c), and (8)(i) and (j) between January 2015 and July 9, 2018.

## 2. Renewal Application

The Board also contends that on or about June 21, 2017, Ms. Slaton submitted a renewal application to the Board that contained untruthful responses to several questions, thereby engaging in conduct unbecoming a nursing assistant under OAR 851-063-0090(1)(b), (9)(a), and (10)(b). As relevant to this allegation, OAR 851-063-0090 defines conduct unbecoming a nursing assistant to include, in part:

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

\* \* \* \* \*

(9)(a) Resorting to fraud, misrepresentation, or deceit during the application process for licensure or certification, \* \* \* while obtaining \* \* \* renewal of licensure or certification; [and]

\* \* \* \* \*

(10)(b) Failing to answer truthfully and completely any question asked by the Board on an application for certification, renewal of certification, during the course of an investigation, or any other question asked by the Board[.]

The record does not establish that Ms. Slaton knew of the Board's investigation at the time she filled out the renewal application at issue and answered "no" to the question pertaining

to such investigations. However, the undisputed evidence establishes that Ms. Slaton intentionally failed to disclose her addiction to and misuse of narcotic medications on her Board renewal application by answering “no” to three questions pertaining to the use and misuse of drugs and alcohol and whether she had any physical, mental, or emotional conditions that could impair her ability to safely perform her nursing assistant duties. This constitutes conduct unbecoming a nursing assistant under OAR 851-063-0090(1)(b), (9)(a), and (10)(b).

### **3. False Statements to Board Staff**

The undisputed record establishes that when Ms. Slaton spoke to former Board Investigator Shanon Rahimi on March 16, 2018, Ms. Slaton untruthfully denied diverting controlled substances or having a substance abuse issue. These intentional misrepresentations constitute conduct unbecoming a nursing assistant under OAR 851-063-0090(1)(b) and (10)(b).

### **4. Sanction**

The Board seeks to revoke Ms. Slaton’s nursing assistant certificate, pursuant to ORS 678.442(2)(b), (d), and (f).

The Board argues that revocation of her certificate is necessary to protect the public, given her severe past substance abuse, her diversion of narcotics, the extended duration of her conduct, and the fact that she has not successfully completed a substance abuse treatment program. At hearing, the Board’s counsel also articulated the Board’s concern that Ms. Slaton would not disclose a relapse to the Board, if a relapse were to occur.

Ms. Slaton has maintained her sobriety since July 10, 2018. As evidence of her commitment to staying sober, she points to significant changes she made to ensure the success of her recovery—changes such as relocating to a new city and disassociating with her previous drug-using acquaintances. And, despite her lack of successful completion of a treatment program, she emphasized that she maintains regular contact with a recovery mentor and attends online 12-step meetings. Though admittedly a “bad addict,” she argues that her addiction did not affect her CNA work because she “did not take [her] addiction to work.” Testimony of Slaton. And, she contends that she can safely continue working as a CNA because her duties do not include actually handling narcotic medication.

The Board’s concerns about Ms. Slaton’s continued certification are reasonable. In weighing the relative risk of allowing Ms. Slaton to continue working as a certified nursing assistant against the potential harm posed to the public, the Board must consider certain measurable and demonstrative risk factors. Here, those risk factors include that her addiction was diagnosed as severe, her misuse of narcotics spanned an approximately six-year period, she did not complete her residential treatment program, and she did not engage in any outpatient treatment program thereafter. In addition, there are matters still unknown to the Board — including the substance of any treatment notes or recommendations made by ADAPT staff between July 18, 2018 (the date of her only documented treatment therapy note) and August 9, 2018 (the date of her abrupt discharge). And, even more significantly, she has not undergone a

current substance abuse evaluation, as requested by the Board, so that the Board might more accurately assess whether and to what extent she presently poses a risk to the public.

Contrasting with the above-described risk factors and the gaps in data (both historical and present) are Ms. Slaton's approximately 25 months of sobriety and her avowals to maintain that sobriety through largely self-directed means. Given that the violations proven in this case all relate (to varying degrees) to instances of dishonest and untruthful conduct by Ms. Slaton, her current declarations — which have not been corroborated by a substance abuse evaluator — regarding the maintenance of her sobriety are not sufficient to mitigate the Board's concerns.

The ALJ recognized Ms. Slaton's sobriety but also opined that it is within the Board's discretion to revoke her nursing assistant certificate and, on this record, the Board has demonstrated sufficient justification to do so.<sup>8</sup>

### **ORDER**

*Based on the foregoing, the Board orders as follows:*

Brandi Slaton's nursing assistant certificate is revoked.

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Kathleen Chinn, FNP-BC  
President, Oregon State Board of Nursing

### **APPEAL**

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.*

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<sup>8</sup> The Board modified this paragraph to clarify the language for the Board's decision.

**CERTIFICATE OF MAILING**

On September \_\_\_\_, 2020, I mailed the foregoing FINAL ORDER issued on this date in Agency Case No. 17-01516.

By: First Class Mail

Brandi Slaton  
90824 Windy Lane  
Coos Bay, OR 97420

By: Electronic Mail

Lauren E Rauch  
Assistant Attorney General  
Department of Justice  
1162 Court St NE  
Salem, OR 97301

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Dante Messina,  
Investigator  
Oregon State Board of Nursing

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Heather Spaulding, CNA** ) **PROBATION**  
)  
**Certificate No. 201010059CNA** ) **Reference No. 20-01013**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Certificate Holders. Heather Spaulding (CNA) was issued a Certified Nursing Assistant certificate by the Oregon State Board of Nursing (Board) on January 11, 2010.

On or about February 16, 2020, the Board received information that CNA had been arrested on April 9, 2019, for Failure to Carry/Present License, Driving while Under the Influence of Intoxicants and for Unlawful Possession of Methamphetamines. An investigation was opened into the matter.

Through the course of the Board's investigation, CNA admitted to using methamphetamines since 2017. Following CNA's arrest, CNA engaged in treatment and has remained clean and sober since April 10, 2019.

By the above actions, CNA is subject to discipline pursuant to ORS 678.442(2)(c)(f) and OAR 851-063-0090(1)(a), (7)(c) and (8)(i) which reads as follows:

ORS 678.442 Certification of nursing assistants; rules.

(2) In the manner prescribed in ORS chapter 183, the board may revoke or suspend a certificate issued under this section or may reprimand a nursing assistant for the following reasons:

(c) Impairment as defined in ORS 676.303.

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

OAR 851-063-0090 Conduct Unbecoming a Nursing Assistant

A CNA, regardless of job location, responsibilities, or use of the title "CNA," whose behavior fails to conform to the legal standard and accepted standards of the nursing assistant profession, or who may adversely affect the health, safety or welfare of the public, may be found guilty of conduct unbecoming a nursing assistant. Such conduct includes but is not limited to:

(1) Conduct, regardless of setting, related to general fitness to perform nursing assistant authorized duties:

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

(7) Conduct related to safe performance of authorized duties:

(c) Using a prescription or non-prescription drug, alcohol, or a mind-altering substance to an

extent or in a manner dangerous or injurious to the nursing assistant or others, or to an extent that such use impairs the ability to perform the authorized duties safely.

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

(i) Possessing, obtaining, attempting to obtain, furnishing or administering prescription or controlled drugs to any person, including self, except as directed by a LIP authorized by law to prescribe drugs;

CNA admits that the above allegations occurred and constitute violations of the Nurse Practice Act. CNA 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 CNA:

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

Certificate Holder shall comply with the following terms and conditions of probation:

- 1) Certificate Holder shall not violate the Nurse Practice Act (ORS 678) or the rules adopted thereunder.
- 2) Certificate Holder shall have thirty-six (36) months from Board's acceptance of this Stipulated Order to complete twenty-four (24) months of monitored practice.
- 3) Certificate Holder shall notify Board staff, in writing, prior to any change of address or employment setting during the probation period.
- 4) Certificate Holder shall maintain an active certificate.
- 5) Certificate Holder shall inform Board staff in advance of any absences from Oregon and/or any move from Oregon to another licensing jurisdiction. If Certificate Holder leaves the state and is unable to work in the state of Oregon, Certificate Holder's probationary status will be re-evaluated.
- 6) Certificate Holder shall appear in person or by phone, to designated Board staff for interviews on a monthly basis during the probationary period. Frequency of contact may be reviewed and revised periodically at the discretion of Board staff.

7) Certificate Holder shall notify Board staff of any citations, arrests, or convictions for any offense, whether felony, misdemeanor, violation, or citation within seven (7) days of the occurrence.

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

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

10) Certificate Holder shall work under the direct observation of another licensed healthcare professional, functioning at a higher level of licensure 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 Certificate Holder's work and provide assistance and who has taken the required Board approved Monitor/Supervisor training. Certificate Holder shall be employed in a setting where Certificate Holder's 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, Certificate Holder may be restricted from performing the duties of a nursing assistant.

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

12) Certificate Holder shall notify Board staff when there is a change in status of employment, including resignations and terminations.

13) Certificate Holder shall not work in any work setting when on-site monitoring is not available. This generally includes home health agencies, traveling agencies, float pools, temporary agencies, assisted living facilities, adult foster care, independent consulting contracts, home hospice, and night shifts outside of acute care settings.

14) Certificate Holder shall not be approved for enrollment in clinical practicum hours for the purpose of obtaining an additional degree or license.

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

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

17) Certificate Holder shall abstain from the use of intoxicating, mind altering, or potentially addictive drugs, both over-the-counter and prescription drugs, and alcohol while participating in the Board's random urine drug testing program, except as provided in **Section 19** below. Certificate Holder shall avoid any over the counter products and food items containing alcohol, marijuana and poppy seeds.

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

19) Certificate Holder shall cease performing the duties of a nursing assistant upon the occurrence of a relapse, or at the request of Board staff because of a relapse or relapse behavior. The performance of nursing assistant duties may resume only when approved in writing by Board staff, in consultation with Certificate Holder's employer.

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

21) Certificate Holder 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.

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

Certificate Holder 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.

Certificate Holder understands that in the event Certificate Holder engages in future conduct resulting in violations of the terms of this Stipulated Order and/or the Nurse Practice Act, the Board may take further disciplinary action against Certificate Holder's certificate, up to and including revocation of Certificate Holder's certification to perform the duties of a Certificate Holder.

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

Certificate Holder understands that by signing this Stipulated Order, Certificate Holder waives the right to an administrative hearing under ORS 183.310 to 183.540. Certificate Holder acknowledges that no promises, representations, duress or coercion have been used to induce Certificate Holder to sign this Stipulated Order.

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

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

IT IS SO AGREED:

---

Heather Spaulding, CNA

---

Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Kathleen Chinn, FNP-BC  
Board President

\_\_\_\_\_  
Date

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SIGNATURES & DATED COPY ON FILE IN BOARD OFFICE

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Patricia Twombly, LPN** ) **PROBATION**  
 )  
 ) **Reference No. 19-01512**

---

The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Patricia Twombly (Licensee) was issued a Licensed Practical Nurse License by the Oregon State Board of Nursing on May 1, 2014.

On or about April 16, 2018, Licensee was reported to the Board for alleged impairment in the workplace. The Board opened an investigation into the matter.

II.

On April 10, 2019, the Board approved entry into the Health Professional Services Program (HPSP) for four years of monitoring to include toxicology testing.

The Board has received Substantial Non-Compliance Reports for use of substances not authorized per the HPSP contract. Licensee has received positive toxicology results while in the HPSP.

By the above actions, Licensee is subject to discipline pursuant to:

**ORS 676.200 Board participation in program; rules.**

(1)(a) A health profession licensing board that is authorized by law to take disciplinary action against licensees may adopt rules opting to participate in the impaired health professional program established under ORS 676.190 and may contract with or designate one or more programs to deliver therapeutic services to its licensees which read as follows:

(3) A board that participates in the impaired health professional program shall review reports received from the program. If the board finds that a licensee is substantially noncompliant with a diversion agreement entered into under ORS 676.190, the board may suspend, restrict, modify or revoke the licensee's license or end the licensee's participation in the impaired health professional program.

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

(e) Impairment as defined in ORS 676.303.

(f) Conduct derogatory to the standards of nursing.

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

**678.112 Impaired health professional program.** Persons licensed to practice nursing who elect not to participate in the impaired health professional program established under ORS 676.190 or who fail to comply with the terms of participation shall be reported to the Oregon State Board of Nursing for formal disciplinary action under ORS 678.111. [1991 c.193 §2; 2007 c.335 §1; 2009 c.697 §7; 2009 c.756 §§32,94]

**851-045-0070 Conduct Derogatory to the Standards of Nursing Defined**

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

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

(e) Failing to comply with the terms and conditions of Health Professionals' Services Program agreements.

**851-070-0100 Substantial Non-Compliance Criteria**

(1) The HPSP will report substantial non-compliance to the Board within one business day after the HPSP learns of non-compliance, including but not limited to information that a licensee:

(d) Received a positive toxicology test result as determined by federal regulations pertaining to drug testing or self report of unauthorized substance use;

(1) Violated any terms of the monitoring agreement;

(2) The Board, upon being notified of a licensee's substantial non-compliance will investigate and determine the appropriate sanction, which may include a limitation of licensee's practice and any other sanction, up to and including termination from the HPSP and formal discipline.

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 Licensed Practical Nurse License of Patricia Twombly 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's acceptance of this Order to complete twenty-four (24) months of monitored practice.
- 3) Licensee shall notify Board staff, in writing, prior to any change of address or employment setting during the probation period.
- 4) Licensee shall maintain an active license.
- 5) Licensee shall inform Board staff in advance of any absences from Oregon and/or any move from Oregon to another licensing jurisdiction. If Licensee leaves the state and is unable to practice in the state of Oregon, Licensee's probationary status will be re-evaluated.
- 6) Licensee shall appear in person or by phone, to designated Board staff for interviews on a monthly basis during the probationary period. Frequency of contact may be reviewed and revised periodically at the discretion of Board staff.
- 7) Licensee shall notify Board staff of any citations, arrests, or convictions for any offense, whether felony, misdemeanor, violation, or citation within seven (7) days of the occurrence.
- 8) Licensee will not look for, accept, or begin a new nursing position without prior 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 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 perform the duties of a nurse.

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

13) Licensee shall not work in any practice setting when on-site monitoring is not available. This generally includes home health agencies, traveling agencies, 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 participate in and comply with any treatment recommendations set forth by a third party evaluator approved by the Board. Within fourteen (14) days of completing treatment, Licensee shall submit to Board staff a copy of Licensee's completion certificate or discharge summary. Licensee shall attend Narcotics Anonymous (NA), Alcoholics Anonymous (AA) or similar recovery program on a weekly basis and provide proof of attendance to Board staff. Licensee shall sign any release of information necessary to allow Board staff to communicate with Licensee's treatment provider and release Licensee's treatment records to the Board.

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

18) Licensee shall abstain from using alcohol and/or other intoxicating, mind altering, or potentially addictive drugs, including over-the-counter or prescription drugs while participating in the Board's random urine drug testing program, except as provided in **Section (19)** below. Licensee shall avoid any over-the-counter products and food items containing alcohol, marijuana and poppy seeds.

19) Licensee may take medication for a documented medical condition, provided that Licensee obtains such medication only by a legal prescription written by a person authorized by law to write such a prescription. Licensee will notify Board staff within 72 hours in the event Licensee is prescribed such medication, and shall sign a release of information authorizing the

prescribing person to communicate with Board staff about Licensee's medical condition. Licensee shall produce the medical records pertaining to the medical condition and medication use. Licensee will discard any unused prescription medications when it is no longer needed or expired.

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

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

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

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

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

Licensee understands that in the event Licensee engages in future conduct resulting in violations the terms of this Stipulated Order and/or the Nurse Practice Act, 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 its approval and is subject to the Board's confirmation.

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

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

IT IS SO AGREED:

\_\_\_\_\_  
Patricia Twombly, LPN

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Kathleen Chinn, FNP-BC  
Board President

\_\_\_\_\_  
Date

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**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Barbara Vinyard, CNA** ) **REPRIMAND WITH CONDITION**  
)  
**Certificate No. 201604592CMA,** ) **Reference No. 20-00651**  
**000034486CNA** )

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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 (CNA) and Certified Medication Aides (CMA). The Board issued Barbara Vinyard (Certificate Holder) a CNA certificate on April 14, 1996, and a CMA certificate on June 29, 2016.

On or about December 19, 2019, the Board received information that Certificate Holder was investigated by DHS for an incident on August 26, 2019, in which she was allegedly verbally abusive toward two residents at a nursing facility where she was employed. It was alleged that Certificate Holder used vulgar language while communicating with the residents, and threatened to withhold assistance if the residents weren't cooperative. Certificate Holder stated that she did not intend to offend or intimidate the residents by her actions or speech and regrets her conduct.

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

**ORS 678.442 Certification of nursing assistants; rules.**

(2) In the manner prescribed in ORS chapter 183, the board may revoke or suspend a certificate issued under this section or may reprimand a nursing assistant for the following reasons:

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

**OAR 851-063-0090 Conduct Unbecoming a Nursing Assistant**

A CNA, regardless of job location, responsibilities, or use of the title "CNA," whose behavior fails to conform to the legal standard and accepted standards of the nursing assistant profession, or who may adversely affect the health, safety or welfare of the public, may be found guilty of conduct unbecoming a nursing assistant. 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 assistant performance of duties. Actual injury need not be established;

**(3) Conduct related to client safety and integrity:**

(g) Failing to respect the dignity and rights of the person receiving nursing services, regardless of social or economic status, age, race, religion, sex, sexual orientation, national origin, nature of health needs, other physical attributes, or disability[.]

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

**That the Nursing Assistant Certificate of Barbara Vinyard be reprimanded with the following condition: that Barbara Vinyard successfully complete two (2) Board-approved continuing education courses on professional communication with residents and patient rights within thirty (60) days of this Order.**

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

Certificate Holder understands that in the event she engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against her certificate/s, up to and including revocation of her certificate to practice as a Certified Nursing Assistant and/or Certified Medication Aide.

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

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

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

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

\_\_\_\_\_  
Barbara Vinyard, CNA

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Kathleen Chinn, FNP-BC  
Board President

\_\_\_\_\_  
Date

CERTIFICATE HOLDER: PLEASE RETURN ALL PAGES OF THIS STIPULATED ORDER AFTER SIGNING

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Denise Wagner, LPN** ) **REPRIMAND OF LICENSE**  
)  
**License No. 092003128LPN** ) **Reference No. 20-01217**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Practical Nurse Licenses. Denise Wagner (Licensee) was issued a Practical Nurse License by the Board on December 04, 1992.

On or about June 3, 2020, the Board received information that Licensee engaged in unacceptable behavior toward a co-worker which was perceived as threatening. A review of Licensee's personnel file showed she has been counseled previously about her behavior toward coworkers.

Licensee completed continuing education on how to effectively navigate and negotiate conflict with co-workers.

By the above actions, Licensee is subject to discipline pursuant to ORS 678.111(1)(f) and OAR 851-045-0070(6)(a) which read as follows:

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

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

(f) Conduct derogatory to the standards of nursing.

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

**(6) Conduct related to co-workers and health care team members:**

(a) Engaging in violent, abusive or threatening behavior towards a co-worker.

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 Practical Nurse License of Denise Wagner 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 she engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against her license, up to and including revocation of her license to practice as a Licensed Practical Nurse.

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

Licensee understands that by signing this Stipulated Order, she 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 her to sign this Order.

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

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

\_\_\_\_\_  
Denise Wagner, LPN

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Kathleen Chinn, FNP-BC  
Board President

\_\_\_\_\_  
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**  
**Crystal Whited, RN** ) **VOLUNTARY SURRENDER**  
)  
**License No. 201243520RN** ) **Reference No. 21-00143**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Crystal Whited (Licensee) was issued a Registered Nurse License by the Board on November 01, 2012.

On July 8, 2020, the Board accepted a signed Stipulated Order for a suspension followed by probation from Licensee. Licensee was given credit for time served on the Interim Consent Order. The Board had received information that Licensee had been suspended from work pending the completion of an investigation into allegations of diversion. The allegations of diversion were not founded by the employer. The Board received additional complaints regarding Licensee being admitted to the hospital. Records obtained during the investigation showed that Licensee tested positive for THC and Methamphetamine. In April 2019, the Board received information that Licensee was arrested for Criminal Trespass in the First Degree and Theft in the Third Degree. In August 2019, Licensee pled guilty to Criminal Trespass in the First Degree and was sentenced to 24 months of bench probation.

After beginning probation, Licensee was contacted about activating her lab account in order to participate and comply with the Board's random urine drug testing program which is a condition of her probation. Licensee notified Board staff that she has decided to surrender her license.

By the above actions, Licensee is subject to discipline pursuant to ORS 678.111 (1) (f) and OAR 851-045-0070 (10) (d) which read as follows:

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

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

(f) Conduct derogatory to the standards of nursing.

OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined:

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

- (10) Conduct related to the licensee's relationship with the Board:
- (d) Violating the terms and conditions of a Board order.

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

**That the voluntary surrender of the Registered Nurse license of Crystal Whited be accepted. If, after a minimum of three years, Ms. Whited wishes to reinstate their Registered Nurse license, Crystal Whited may submit an application to the Board to request reinstatement.**

Licensee agrees that they will not practice as a Registered Nurse 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, **Crystal Whited** 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 has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Voluntary Surrender.

\_\_\_\_\_  
Crystal Whited, RN

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Kathleen Chinn, FNP-BC  
Board President

\_\_\_\_\_  
Date

PLEASE RETURN ALL PAGES OF THIS STIPULATED ORDER AFTER SIGNING

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

IN THE MATTER OF: ) **FINAL ORDER**  
)  
**TAMIKA WINTER,** ) OAH Case No. 2019-ABC-03378  
**pka Tamika Hall Nicholson** ) Agency Case No. 19-01398  
)

On September 9, 2020, the Board reviewed the Proposed Order issued by ALJ Fair. After considering the record, the Board adopts the Proposed Order as the Final Order and denies Ms. Winter's Practical Nurse License application as explained below.

**HISTORY OF THE CASE**

On November 15, 2019, the Oregon State Board of Nursing (Board) issued Tamika Winter, pka Tamika Hall Nicholson,<sup>1</sup> a Notice of Proposed Denial of Practical Nurse License. On December 13, 2019, Ms. Winter requested a hearing.

On December 16, 2019, the Board referred the matter to the Office of Administrative Hearings (OAH). The OAH assigned Administrative Law Judge (ALJ) Samantha A. Fair to preside at hearing. On February 28, 2020, ALJ Fair convened a prehearing conference. Ms. Winter appeared. Senior Assistant Attorney General (AAG) Raul Ramirez appeared on the Board's behalf. Britney Noel also appeared on behalf of the Board. ALJ Fair scheduled an in-person hearing for July 1 and 2, 2020, and set deadlines for the submission of witness lists and exhibits.

On March 23, 2020, Ms. Winter requested that she appear by telephone for the hearing. On March 24, 2020, ALJ Fair granted Ms. Winter's request.

On May 20, 2020, the Board filed a Motion for Qualified Protective Order and Qualified Protective Order Limiting Use and Disclosure. On May 22, 2020, the OAH issued the Qualified Protective Order Limiting Use and Disclosure.

In response to the coronavirus pandemic, on June 15, 2020, ALJ Fair converted the hearing to a telephone hearing with the consent of the Board.

ALJ Fair convened a telephone hearing on July 1, 2020. Ms. Winter appeared and testified on her own behalf. The Board appeared and was represented by AAG Ramirez. Leslie Kilborn, a Board investigator, appeared and testified on behalf of the Board. The Board also

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<sup>1</sup> At the time of the filing of the application, Ms. Winter's name was Tamika Hall Nicholson. (Ex. A7 at 1.) Subsequently, she changed her last name to Winter. (Test. of Winter.)

called Ms. Winter as a witness. ALJ Fair left the record open for the Board to submit an audio copy of Exhibit A10.<sup>2</sup> The record closed on July 7, 2017, after receipt of Exhibit A12 (the audio copy of Exhibit A10).

## EXCEPTIONS

On August 13, 2020, the Board received notice of an ex-parte communication from ALJ Fair. The ex-parte communication was an email from Ms. Winter to ALJ Fair dated August 13, 2020 that did not copy the Board or Board counsel. The Board considers Ms. Winter's ex-parte communication as exceptions to the proposed order and addresses them as follows:

### Exceptions were not filed in a timely manner

The proposed order notified Ms. Winter of her right to file exceptions within 10 days of service of the proposed order and provided instructions on how to file exceptions. The proposed order was served electronically on Ms. Winter on the date the proposed order was issued, July 29, 2020. Ms. Winter had previously consented on May 20, 2020 to accept service of all correspondence from OAH by email only because of the Covid-19 pandemic. As a result, the deadline for filing exceptions with the Board was August 10, 2020. The exceptions received on August 13, 2020 are therefore untimely.

### Exceptions are not persuasive even if considered

Even if the Board considers the exceptions as timely, the Board finds the exceptions unpersuasive and they provide no basis to change the outcome in the case. Ms. Winter alleges in her exceptions that the proposed order is unfair and biased. The record indicates that ALJ Fair's proposed order was properly based on evidence in the record.

Ms. Winter also alleges ALJ Fair should not have allowed evidence after "the deadline," presumably referring to the exhibit filing deadline. ALJ Fair left the hearing record open to receive an audio recording of Ms. Winter's board interview, a transcript of which was already in the record.

In determining that the untimely exceptions are not persuasive and therefore do not affect the outcome, the Board cannot consider what appears to be Ms. Winter's attempt to offer (as exceptions) new evidence regarding the demand for nurses during the Covid-19 pandemic.

## ISSUES

1. Whether Ms. Winter engaged in fraud or misrepresentation or was untruthful on her application for licensure or during the course of a Board investigation. ORS 678.111(1)(c) and (f); OAR 851-045-0070(1)(b) and (10)(b).
2. Whether the Board should deny Ms. Winter's application for licensure. ORS 678.111.

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<sup>2</sup> Exhibit A10 was a transcript of Ms. Kilborn's August 28, 2019 interview of Ms. Winter.

## EVIDENTIARY RULINGS

Exhibits A1 through A12, offered by the Board, were admitted into the record without objection.

## FINDINGS OF FACT

1. Ms. Winter is a licensed practical nurse (LPN) in Georgia. She has been licensed by Georgia since May 5, 2017. (Ex A7 at 3; test. of Winter.) She has worked as a charge nurse at the Brian Center since October 2017. (Exs. A7 at 3; A9 at 1-2.) Ms. Winter has performed well as a nurse at the Brian Center and has not received any disciplinary action against her Georgia licensure. (Test. of Winter.)

2. On February 15, 2002, Ms. Winter was charged with criminal damage to property and trafficking in illegal drugs in Georgia. She was sentenced on the criminal damage offense and the drug charge was dismissed. (Ex. A5 at 4-6.)

3. On November 18, 2007, Ms. Winter was cited for disorderly conduct in Ashburn, Georgia. On January 8, 2008, she was convicted of the charge and fined \$298. (Ex. A2 at 1.)

4. On March 22, 2008, Ms. Winter was charged with theft in Ashburn, Georgia, and was convicted of that charge on May 13, 2008. (Ex. A5 at 6-7.)

5. On March 11, 2009, Ms. Winter was arrested for giving a false name and false date of birth, driving without a license and driving with no insurance in Dooly County, Georgia. (Ex. A3 at 1, 3-5.) At the time the police officer stopped her vehicle, Ms. Winter provided him her sister's name and date of birth as her own.<sup>3</sup> (Ex. A3 at 4.) On January 10, 2010, she pled no contest to the charges of giving a false name and false date of birth and driving with no insurance and was fined \$1,555. The charge of driving without a license was dismissed. (Ex. A3 at 7.)

6. On February 13, 2014, Ms. Winter was arrested and jailed for aggravated assault in Crisp County, Georgia, following a fight as she entered her car. After reviewing the evidence, the district attorney did not file any charges against Ms. Winter. (Exs. A5 at 8; A10 at 38-39, 42-43; test. of Winter.)

7. On July 11, 2014, Ms. Winter was arrested and jailed for obstruction and disorderly conduct in Ashburn, Georgia.<sup>4</sup> (Exs. A4 at 1; A10 at 26.)

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<sup>3</sup> Ms. Winter disputed the police officer's account in her testimony. However, the Board agrees with ALJ Fair's finding that her testimony was unpersuasive based upon her subsequent plea to the charge; the police officer's accurate identification of the sister's full name (including the middle name) and her date of birth, which he could only have received from Ms. Winter; and her lack of clear recollection. During her testimony, Ms. Winter frequently responded with qualifiers, such as "may have," "can't remember," and "can't say," which demonstrated her lack of clear recollection of past events.

<sup>4</sup> The records were unclear as to any final disposition in this case. (Exs. A4 at 2; A5 at 9.)

8. On January 21, 2016, in preparation for her LPN application with Georgia, Ms. Winter obtained a copy of her criminal history through the Georgia Crime Information Center. (Ex. A5 at 2; test. of Winter.)

9. On May 30, 2017, Ms. Winter was arrested for possession of marijuana with intent to distribute in Cartersville, Georgia. (Ex. A11 at 1-3.)

10. On April 19, 2019, Ms. Winter filed an online application for licensure as a LPN (Application) with the Board. (Ex. A7.) The Application included a series of disclosure questions for the applicant to complete. (Ex. A7 at 2-3.) The Application's Question 3 and Ms. Winter's response were, as follows:

3. Other than a traffic ticket, have you ever been arrested, cited, or charged with an offense?

Response: 3. Yes

Explanation: My most recent charge will be exonerated on April 30, 2019. I do have a record but all charges and arrests were 7-10 years ago before I became a nurse.

(Ex. A7 at 2.) Ms. Winter utilized the same criminal history record that she had obtained in January 2016 to respond to the Application's disclosure questions. (Test. of Winter.) The criminal history record included both 2014 arrests. (Ex. A5 at 8-9.)

11. Prior to submitting the Application, Ms. Winter checked the authorization statement, which stated:

I understand I have a duty to provide the Oregon State Board of Nursing with any updates to information required in this application while it is pending. I hereby certify that I have read this application, and that the information provided is true and correct. I have personally completed this application. I am aware that falsifying an application, supplying misleading information or withholding information is grounds for denial or discipline of license/certification. I am aware that the Oregon State Board of Nursing will conduct criminal records checks through the Oregon Law Enforcement Data System (LEDS) and the Federal Bureau of Investigation (FBI).

(Ex. A7 at 3-4.)

12. On May 30, 2019, while police were investigating a domestic complaint in Bartow County, Georgia, Ms. Winter arrived and proceeded to scream and yell at a 14-year-old child. The police repeatedly told her to stop yelling and sit in her car. Despite repeated requests by the police, Ms. Winter refused to provide her name. The police arrested Ms. Winter for disorderly

conduct and failure to appear. (Ex. A6 at 2, 4.) After her arrest, the police took her to jail, where she was booked and had her mug shot taken. She was subsequently released the following morning after posting bail. (Test. of Winter.)

13. On June 11, 2019, the Board sent a letter to Ms. Winter, advising her that it had opened an investigation into her Application. In the letter, the Board requested that she provide a written statement, “detailing each of your arrests, including citations issued in lieu of an arrest. Include the dates, locations, your actions that led up to the arrest, and the outcome of the criminal charges.” (Ex. A8 at 1.)

14. On June 23, 2019, Ms. Winter provided the Board a written statement. Ms. Winter disclosed her July 11, 2014 arrest for obstruction of an officer but noted the arrest date as July 11, 2015 in her written statement. She provided the following explanation of the 2014 arrest:

My fifth arrest was willful obstruction of an officer on July 11, 2015. I was never taken to court for this charge. Nothing ever came of it. I was never prosecuted for it. I was never placed on probation for it. I think that the statue [*sic*] limit of time to take me to court for it expired. Im not exactly sure.

(Ex. A9 at 1.) In her written statement, Ms. Winter noted that her 2017 drug charge was dismissed on May 14, 2019, and she was “exonerated.” (Ex. A9 at 1.) In her written statement, Ms. Winter did not disclose her 2007 and 2019 disorderly conduct arrests and her 2014 aggravated assault arrest. (Ex. A9 at 1.) She did not disclose her 2019 disorderly conduct arrest because she was afraid it would interfere with her ability to get the Oregon license. (Test. of Winter.) Sometime after filing her written statement, Ms. Winter forwarded a copy of her criminal history record that she had obtained in 2016 to the Board. (Test. of Winter and Kilborn.)

15. On August 28, 2019, the Board’s investigator interviewed Ms. Winter. (Ex. A10 at 1.) At the beginning of the interview, the investigator informed Ms. Winter of the following:

As an LPN applicant in Oregon you’re bound by the rules in the Nurse Practice Act, and some of those rules apply to this conversation today and this investigation that are very important, and one of them is that when I ask you questions, you need to be truthful in your statements to me. Failure to do so is a violation of the Nurse Practice Act and, of course, I’d have to report that the board.

(Ex. A10 at 3.)

16. During the course of the interview, Ms. Winter informed the investigator that, during the March 2009 encounter, she gave her name to the police officer, not her sister’s name, and that she was only convicted of the charge of driving without a license. (Ex. A10 at 20-23.)

17. During the course of the interview, Ms. Winter informed the investigator that her

2017 arrest was her last arrest. (Exs. A10 at 33; A12; test. of Winter and Kilborn.) After that answer, the investigator and Ms. Winter had the following exchange:

Investigator: So it looks like you - - there's another arrest on May 30 - - May 31, 2019.

Winter: May 31, 2018?

Investigator: '19, yeah.

Winter: For what?

Investigator: Let's see. Disorderly conduct.

Winter: Oh, crap. Yeah. That one. I'm sorry. I'm sorry.

(Ex. A10 at 33.)

18. On September 1998, the Board adopted a Fitness to Practice Interpretive Statement (Statement), which was last reviewed in August 2018. In the Statement, the Board stated, in part:

**Falsification of documents or deception/lying outside of the workplace, including falsification of an application for licensure or certification to the Board or lying during the course of an investigation, raises concern about the applicant's propensity to lie and the likelihood that such conduct could continue into the practice of nursing or performance of authorized duties of the nursing assistant.**

\* \* \* \* \*

**Failing to disclose on an application for licensure/certification:**

Every Board application, including application for renewal, has a series of disclosure questions. The applicant/licensee/certificate holder must answer all of these questions truthfully[.]

(Ex. A1 at 1; emphasis in original.) The Board also needs honesty and accuracy from its applicants in order to properly assess any filed applications. The Board has serious concerns about any applicant's or licensee's furnishing of false information because nurses work with vulnerable populations that must be protected. (Test. of Kilborn.)

**CONCLUSIONS OF LAW**

1. Ms. Winter engaged in fraud, misrepresentation and was untruthful on her application

for licensure and during the course of a Board investigation.

2. The Board should deny Ms. Winter's application for licensure.

### OPINION

The Board seeks to deny Ms. Winter's application based on allegations that she was dishonest on her application and during the Board's investigation. Because this is an application proceeding, Ms. Winter has the burden to establish, by a preponderance of the evidence, her eligibility for licensure. *Sobel v. Board of Pharmacy*, 130 Or App 374, 380 (1994) (applicants have the burden of establishing their eligibility by a preponderance of the evidence); *Dixon v. Board of 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).

#### Conduct During Application and Investigation Process

ORS 678.111(1) provides, in part:

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

\* \* \* \* \*

(c) Any willful fraud or misrepresentation in applying for or procuring a license or renewal thereof.

\* \* \* \* \*

(f) Conduct derogatory to the standards of nursing[.]

OAR 851-045-0070 provides, in 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:

(1) Conduct related to general fitness to practice 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 Board on an application for licensure or during the course of an investigation or any other question asked by the Board[.]

On April 19, 2019, Ms. Winter submitted the Application to the Board, seeking licensure as a practical nurse. In that Application, she disclosed that "all charges and arrests were 7-10 years ago." Exhibit A7 at 2. If her statement was true, then her most recent arrests would have occurred no later than 2012. However, Ms. Winter was arrested twice in 2014, once for an aggravated assault and once for a disorderly conduct, and she was arrested in 2017 for possession of marijuana with intent to distribute. Therefore, the information she provided on her Application was not truthful.

In the Application, she noted that her most recent charge would be exonerated at the end of April 2019. Ms. Winter was clearly alluding to the 2017 arrest when she included this statement in her answer. However, she failed to note the 2017 arrest date of "the most recent charge." Exhibit A7 at 2. Instead, her complete answer indicated that this most recent charge would have been the result of an arrest that was at least seven years old. Ms. Winter's answer, made when she was specifically thinking of the recent 2017 arrest, was deliberately deceptive in an attempt to convince the Board that she had lived without any allegations of criminal behavior for almost a decade.

During her testimony, Ms. Winter suggested that she simply forgot about her 2014 arrests. However, her testimony was unpersuasive as both of those arrests resulted in her being jailed, which are memorable events, as well as occurring within a few months of each other and just a few years before the filing of her Application. Additionally, Ms. Winter utilized the criminal history record she obtained in 2016 when she completed the Application. Because that record included the two 2014 arrests and she indicated that her last arrest occurred prior to 2012, her answers on the Application were false and clearly intended to conceal the full extent of her criminal history from the Board.

The statute and administrative rule do not provide any definitions for "willful," "fraud" or "misrepresentation." Therefore, the dictionary definition is used to provide guidance. "Fraud" means "an instance or act of trickery or deceit \* \* \* an intentional misrepresentation \* \* \* for the purpose of inducing another in reliance upon it to part with some valuable thing \* \* \*."

*Webster's Third New Int'l Dictionary* 904 (unabridged ed 2002). A "misrepresentation" is an

untrue, inaccurate or misleading representation. *Id.* at 1445. “Willful” means done deliberately or not accidental. *Id.* at 2617. As shown above, the evidence established that Ms. Winter deliberately failed to truthfully answer Question 3 on the Application. Thus, when Ms. Winter chose to conceal her 2014 and 2017 arrests, she deliberately made an untrue and misleading representation to the Board in an effort to obtain a nursing license from the Board. Ms. Winter engaged in willful fraud and misrepresentation in applying for a nursing license and conduct derogatory to the standards of nursing, in violation of ORS 678.111(1)(c) and (f) and OAR 851-045-0070(1)(b). In addition, because she failed to answer the Application’s Question 3 truthfully and completely, Ms. Winter also violated OAR 851-045-0070(10)(b).

As part of the Board’s investigation of Ms. Winter’s Application, the Board’s investigator requested Ms. Winter to provide a written statement regarding her entire arrest history. In response to the investigator’s request, Ms. Winter failed to include her 2014 aggravated assault arrest and her 2007 disorderly conduct arrest and conviction, even though they appeared on the 2016 criminal history she had previously obtained. Finally, she also failed to include any mention of her 2019 disorderly conduct arrest that had occurred less than a month prior to her producing the written statement for the Board. During the hearing, she acknowledged that she failed to include the 2019 disorderly conduct arrest because she believed it would negatively impact her ability to obtain an Oregon nursing license, which would also be a reason for her other omissions. On August 28, 2019, during an interview conducted by the Board’s investigator, Ms. Winter falsely claimed that she had no other arrests since the 2017 drug arrest, in another attempt to conceal the truth of her criminal history from the Board. Because Ms. Winter made false statements during the Board’s investigation in an attempt to induce the Board to issue her a nursing license, Ms. Winter engaged in conduct derogatory to nursing by demonstrating incidents of dishonesty, misrepresentation and fraud and failing to answer truthfully and completely the investigator’s questions, in violation of ORS 678.111(1)(f) and OAR 851-045-0070(1)(b) and (10)(b).

### Denial of Application

Pursuant to ORS 678.111(1), the Board has the authority to deny a license for violations of its statutes and administrative rules. As shown above, the Board established that Ms. Winter violated ORS 678.111(1)(c) and (f) and OAR 851-045-0070(1)(b) and (10)(b), by providing fraudulent and misleading information to the Board on multiple occasions throughout the application and investigatory process. The Board has the authority to deny Ms. Winter’s Application.

For the Board to effectively fulfill its oversight role of licensees, the Board needs to rely on the honesty of its licensees in their interactions with the Board. As Ms. Winter demonstrated during the application and investigatory process for this license, the Board would not be able to rely on her to provide it honest and accurate information. Even after warning her of the requirement that she be truthful on the Application and in the investigatory interview, Ms. Winter still provided false information to the Board. Ms. Winter’s prior work history does not outweigh the Board’s legitimate concerns regarding her persistent and deliberate lack of veracity in her interactions with the Board. Therefore, based upon her repeated violations of the Board’s statutes and administrative rules and the Board’s inability to rely on the accuracy of Ms. Winter’s

statements, the Board has determined it should deny Ms. Winter's Application. Each distinct violation committed by Ms. Winter serves as a separate and independent basis for the Board to deny her Application.<sup>5</sup>

### ORDER

Based on the foregoing, the Board orders as follows:

Tamika Winter's application for a practical nurse license is denied based on her violations of ORS 678.111(1)(c) and (f) and OAR 851-045-0070(1)(b) and (10)(b).

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Kathleen Chinn, FNP-BC  
Board President

### APPEAL

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.*

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<sup>5</sup> The Board modified this paragraph in connection with Ms. Winter's work history and to clarify the language for the Board's decision.

**CERTIFICATE OF MAILING**

On September\_\_\_\_, 2020, I mailed the foregoing **FINAL ORDER** issued on this date in OAH Case No. 2019-ABC-03378

By: First Class Mail

Tamika Winter  
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Hillsboro, OR 97124

By: Electronic Mail

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Leslie Kilborn  
Investigator, Oregon State Board of Nursing