In the Matter of	§	**BEFORE THE TEXAS**
Permanent Registered Nurse	§	
License Number 942577	§	**BOARD OF NURSING**
Issued to AMY CATHERINE-ORR SLEPICA,	§	
Respondent	§	**ELIGIBILITY AND**
		DISCIPLINARY COMMITTEE

ORDER OF THE BOARD

TO: Amy Slepica
20873 Hartford Way
Lakeville, MN 55044

During open meeting held in Austin, Texas, on May 14, 2019, the Texas Board of Nursing Eligibility and Disciplinary Committee (hereinafter "Committee") heard the above-styled case, based on the failure of the Respondent to appear as required by 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that notice of the facts or conduct alleged to warrant disciplinary action has been provided to Respondent in accordance with Texas Government Code § 2001.054(c) and Respondent has been given an opportunity to show compliance with all the requirements of the Nursing Practice Act, Chapter 301 of the Texas Occupations Code, for retention of Respondent's license(s) to practice nursing in the State of Texas.

The Committee finds that the Formal Charges were properly initiated and filed in accordance with section 301.458, Texas Occupations Code.

The Committee finds that after proper and timely Notice regarding the violations alleged in the Formal Charges was given to Respondent in this matter, Respondent has failed to appear in accordance with 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that the Board is authorized to enter a default order pursuant to Texas Government Code § 2001.056.

The Committee, after review and due consideration, adopts the proposed findings of fact and conclusions of law as stated in the Formal Charges which are attached hereto and incorporated by

reference for all purposes and the Staff's recommended sanction of revocation by default. This Order will be properly served on all parties and all parties will be given an opportunity to file a motion for rehearing [22 TEX. ADMIN. CODE § 213.16(j)]. All parties have a right to judicial review of this Order.

All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

NOW, THEREFORE, IT IS ORDERED that Permanent Registered Nurse License Number 942577, previously issued to AMY CATHERINE-ORR SLEPICA to practice nursing in the State of Texas be, and the same is/are hereby, REVOKED.

IT IS FURTHER ORDERED that this Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

Entered this 14th day of May, 2019

TEXAS BOARD OF NURSING

BY: Katherine A. Thomas

KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

Attachment: Formal Charges filed February 1, 2019

d17r(2019.03.19)

CERTIFICATE OF SERVICE

I hereby certify that on the 16 day of May, 2019, a true and correct copy of the foregoing DEFAULT ORDER was served and addressed to the following person(s), as follows:

Via USPS Certified Mail, Return Receipt Requested,
Copy Via USPS First Class Mail

Amy Slepica
20873 Hartford Way
Lakeville, MN 55044

BY: Katherine A. Thomas

KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

In the Matter of	§	
Permanent Registered Nurse	§	**BEFORE THE TEXAS**
License Number 942577	§	
Issued to AMY CATHERINE-ORR	§	
SLEPICA,	§	**BOARD OF NURSING**
Respondent		

FORMAL CHARGES

This is a disciplinary proceeding under Section 301.452(b), Texas Occupations Code. Respondent, AMY CATHERINE-ORR SLEPICA, is a Registered Nurse holding license number 942577 which is in current status at the time of this pleading.

Written notice of the facts and conduct alleged to warrant adverse licensure action was sent to Respondent at Respondent's address of record and Respondent was given opportunity to show compliance with all requirements of the law for retention of the license prior to commencement of this proceeding.

CHARGE I.

On or about December 6, 2018, Respondent received a Final Order from the Minnesota Board of Nursing, wherein her license to practice professional nursing was suspended. A copy of the Final Order dated December 6, 2018, is attached and incorporated by reference as part of this pleading.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(8), Texas Occupations Code.

NOTICE IS GIVEN that staff will present evidence in support of the recommended disposition of up to, and including, revocation of Respondent's license(s) and/or privilege(s) to practice nursing in the State of Texas pursuant to the Nursing Practice Act, Chapter 301, Texas Occupations Code and the Board's rules, 22 TEX. ADMIN. CODE §§ 213.27 - 213.33.

NOTICE IS GIVEN that all statutes and rules cited in these Charges are incorporated as part of this pleading and can be found at the Board's website, www.bon.texas.gov.

NOTICE IS GIVEN that, based on the Formal Charges, the Board will rely on the Disciplinary Matrix, located at 22 TEX. ADMIN. CODE §213.33(b), which can be found under the "Discipline & Complaints; Board Policies & Guidelines" section of the Board's website, www.bon.texas.gov.

Filed this 1 day of February, 2019

TEXAS BOARD OF NURSING

James W. Johnston, General Counsel
Board Certified - Administrative Law
Texas Board of Legal Specialization
State Bar No. 10838300
Jena Abel, Deputy General Counsel
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BEFORE THE MINNESOTA

BOARD OF NURSING

In the Matter of
Amy C. Orr, RN, LPN
(A/K/A Amy C. Slepica)
RN License No. 211417-2
LPN License No. 71064-6

STIPULATION AND
CONSENT ORDER

STIPULATION

Amy C. Orr, RN, LPN ("Licensee"), and the Minnesota Board of Nursing Review Panel ("Review Panel") agree the above-referenced matter may be resolved without trial of any issue or fact as follows:

I.

JURISDICTION

1. The Minnesota Board of Nursing ("Board") is authorized pursuant to Minnesota Statutes sections 148.171 to 148.285 to license and regulate advanced practice registered nurses, registered nurses, and licensed practical nurses and to take disciplinary action as appropriate.

2. Licensee holds licenses from the Board to practice professional and practical nursing in the State of Minnesota and is subject to the jurisdiction of the Board with respect to the matters referred to in this Stipulation and Consent Order.

II.

BACKGROUND

3. On January 25, 2018, Licensee and her attorney, Nathan Hansen, Hansen Law Office, North St. Paul, Minnesota, appeared before the Review Panel, composed of Bradley Haugen, Board member, and Mariclaire England, Nursing Practice Specialist for the Board, to discuss allegations made in a Notice of Conference dated November 9, 2017. Jennifer Middleton, Assistant Attorney General, represented the Review Panel at the Conference.

4. On October 16, 2018, Licensee and her attorney, Nathan Hansen, North St. Paul, Minnesota, and the Review Panel appeared before the Office of Administrative Hearings, to discuss the matter. Kathleen Ghreichi, Assistant Attorney General, represents the Review Panel in this matter.

III.

FACTS

5. The parties agree this Stipulation and Consent Order is based upon the following facts:

a. On September 30, 2015, Licensee met with a Review Panel pursuant to a Notice of Conference dated July 16, 2015, to discuss the termination of her first nursing employment from a hospital in Minneapolis, Minnesota, for the following: (1) Lack of improvement in performance despite several coaching incidents and warnings; (2) Serious errors in care and documentation, including medication errors, narcotic errors, and infusing errors; and (3) Reckless and unprofessional behavior.

b. By letter dated October 13, 2015, the Review Panel informed Licensee it had determined disciplinary action by the Board was not warranted, but the Board may re-evaluate should the Board receive a similar report in the future.

c. While Licensee was employed beginning May 4, 2015, as a registered nurse and working at a hospital in Shakopee, Minnesota, the following occurred:

1) On May 11, 2016, Licensee received coaching for failing to document input and output on a pediatric patient with an intravenous infusion ("IV"), failing to complete a provider notification related to pain management, and retiming medications to after the end of Licensee's shift.

2) On July 18, 2016, Licensee received coaching for failing to document and report to the patient's provider a 25 beat run of ventricular tachycardia on an orthopedics patient with an elevated blood pressure and history of blacking out and falling.

3) On April 19, 2017, Licensee received a verbal warning for documentation errors and omissions occurring on March 9, 2017, as follows:

a) Licensee did not note in the chart for reassessment that a patient had a skin injury caused by a tourniquet.

b) Licensee did not add a "LDA" skin group to the flowsheet for ongoing assessment.

c) Licensee did not complete a progress note mentioning that a follow up assessment was needed for the patient.

d) Licensee did not document that an IV was placed by anesthesia or that she conducted an ongoing overnight IV assessment in the patient's injured arm.

4) On May 16, 2017, Licensee received coaching for failing to complete five newborn tests and assessments during her shift.

5) On May 17, 2017, Licensee received a performance review. Licensee received an overall performance rating of "Needs Improvement."

6) On June 22, 2017, Licensee received a written warning for failing to execute a provider ordered heparin protocol for a patient on May 25, 2017, as follows:

a) Licensee acknowledged the order for the heparin protocol but failed to initiate it. The heparin protocol was started at 9:26 p.m. in the emergency department and was due for a re-draw in six hours.

b) Licensee failed to verify time of heparin infusion initiation.

c) Licensee failed to run the protocol to determine proper time required for an activated partial thromboplastin time ("aPTT") re-draw.

d) Licensee failed to order the aPTT lab when due at 3:30 a.m.

e) Licensee failed to discontinue or adjust the heparin drip at the proper time by not running the protocol.

f) When Licensee's failure to run the heparin protocol was discovered at 7:39 a.m., the patient's aPTT was drawn and was over 240, which was critically high. It took ten hours to reduce the patient's aPTT to a therapeutic level.

g) Licensee's error put the patient at a very high risk for bleeding and may have been prevented had the high level aPTT been discovered at 3:30 a.m.

7) At an investigatory meeting held on June 19, 2017 to discuss the May 25, 2017 incident, Licensee stated she had acknowledged the order for the heparin protocol but must have missed the protocol follow up. Licensee stated she believed the redraw from heparin initiation was 8 hours rather than 6 hours. Licensee's employer indicated Licensee appeared unaware of the seriousness of this error.

8) On August 22, 2017, Licensee received a final written warning for a continuing pattern of substandard performance related to executing provider orders and entering true and correct documentation, as follows:

a) During Licensee's overnight shift on July 4, 2017:

i) Licensee documented that sequential compression devices ("SCD") for a high-risk stroke patient were on at 12:05 a.m., however, the SCDs had never been placed on the patient. The SCDs were placed by a nurse on the following shift. Licensee's failure to place the SCDs on the patient put the patient at a higher risk for a blood clot.

ii) Licensee acknowledged an in-patient order for an orthostatic blood pressure assessment to be done upon arrival. Licensee documented completing a general assessment at 12:04 a.m. and checking vital signs at 4:51 a.m. but did not complete the orthostatic blood pressure assessment during Licensee's eight hour shift. The oncoming nurse noted the patient had a significant blood pressure drop during the morning assessment.

b) On July 20, 2017, the following occurred:

i) Licensee acknowledged an admission "Do Not Resuscitate" ("DNR") order for a patient but failed to place the band on the patient identifying the DNR code status.

ii) Licensee acknowledged an admission order for an orthostatic blood pressure assessment every shift while awake for a patient at 10:44 p.m. Licensee charted taking the patient's vital signs at 10:57 p.m. but did not measure the patient's orthostatic blood pressure. Licensee administered medication to the patient at 11:28 p.m. but did not measure the patient's orthostatic blood pressure. The orthostatic blood pressure was not obtained during Licensee's shift.

9) An investigatory meeting was held on August 7, 2017 to address the incidents that occurred in July 2017.

a) Regarding the July 4, 2017 incident, Licensee stated she thought she had delegated the SCD placement to a nursing assistant. Licensee also reported the patient was uncooperative making the assessment difficult. However, a review of the patient's charts did not reveal any documentation that the patient showed any behavioral difficulties. Licensee also reported the patient was sleeping and Licensee had no opportunity to perform the assessment. However, Licensee documented completing a physical assessment and vital signs during her shift.

b) Regarding the July 20, 2017 incident, Licensee stated that the patient had been asleep and therefore she could not complete the assessment. However, Licensee documented completing a medication administration and vital signs for the patient during her shift.

10) On September 12, 2017, Licensee resigned her employment effective September 14, 2017.

d. At the conference with the Review Panel, and in her written response received January 11, 2018, Licensee stated the following:

1) Licensee admitted to a majority of the allegations.

2) Licensee attributed her practice concerns to difficulties working over-night shifts, indicating she did not experience the same issues when she worked day and evening shifts.

3) Licensee denied her physical or mental health conditions contributed to her practice deficiencies.

4) Licensee stated that she began using an organization sheet to assist her in her practice; nevertheless, the Panel noted that despite using the sheet, Licensee continued to make nursing errors, including missing cares and documentation.

e. The Review Panel requested Licensee and her attorney provide the Board a copy of her most recent performance review. Despite multiple requests by the Board, the performance review was not provided. At the October 16, 2018 mediation, Licensee provided the Board with a letter from her employer stating that her practice currently meets expectation.

f. Following the January 25, 2018 Conference, the Board requested Licensee's medical records, which indicate that Licensee has physical and mental health conditions.

IV.

LAWS

6. Licensee acknowledges the conduct described in section III. above constitutes a violation of Minnesota Statutes section 148.261, subdivision 1(5), (6), (9), (11), (16), (18), and (22) and justifies the disciplinary action described in section V. below.

A. Stayed Suspension

7. The Board hereby **SUSPENDS** Licensee's licenses to practice professional and practical nursing. The suspension is **STAYED** so long as Licensee complies with the following requirements:

B. Limitations on Licenses

8. The Board places the following **LIMITATIONS** on Licensee's licenses:

a. Licensee may not perform any nursing duties except at her current employment (Optum Health) and during the clinical component of a nurse refresher course.

b. Licensee must be supervised by a registered nurse.

C. Removal of Limitations

9. The limitation in paragraph 9.a. above will be administratively removed upon completion of the nurse refresher course and written notification to Licensee by the Board of the removal of the limitation.

10. The remaining limitations in paragraphs 9.b. above will be administratively removed upon completion of 2,000 hours of employment as a registered nurse and written notification to Licensee by the Board of the removal of the limitations.

D. Conditions on Licenses

11. The Board places the following **CONDITIONS** on Licensee's licenses:

a. Refresher Course. Within six months of the date of this Order, Licensee must submit to the Board evidence of successful completion of a nurse refresher course with a supervised clinical component. Licensee must submit written documentation, such as measurable learning objectives and qualifications of the instructor, in order to receive advance approval from Board staff of classes that Licensee takes in fulfillment of this condition. Licensee is responsible for the cost of the refresher course. The refresher course must meet the continuing nursing education requirements found in Minnesota Rules 6310.2800, subpart 3. Licensee must submit verification of participation for any course taken in fulfillment of this requirement. Licensee must cause to be submitted to the Board a report from an instructor in the nurse refresher course, addressing Licensee's performance during the clinical component of the refresher course, including an evaluation of Licensee's nursing skills, level of knowledge, and ability to safely practice nursing. The report must also include any recommendations for additional education.

b. Self-Report. Licensee must submit a report to the Board every three months. Each report must provide and address:

1) Licensee's job title, dates of employment, work schedule, and the employer's name for every employment Licensee has held during the preceding three months;

2) Licensee's physical and mental health status, treatment plan, medications, and compliance with treatment;

3) Licensee's future plans in nursing; and

4) Any other information Licensee believes would assist the Board in its ultimate review of this matter.

c. Report From Nursing Supervisor. If Licensee is employed in nursing or in any health care or residential care setting, Licensee must cause to be submitted to the Board a report from her supervisor. The report must be submitted every three months. Each report must provide and address:

1) In the first report, verification Licensee's supervisor has received and reviewed a copy of this Order;

2) The date of Licensee's employment;

3) Licensee's attendance and reliability;

4) Licensee's ability to carry out assigned functions, and if any performance deficiencies are identified, the actions taken to address them;

5) Licensee's ability to handle stress;

6) Licensee's compliance with the limitations;

7) Number of hours Licensee worked during the reporting period; and

8) Any other information the supervisor believes would assist the Board in its ultimate review of this matter.

d. Participation in HPSP. Within 14 days of this Order, Licensee must contact the Health Professionals Services Program ("HPSP") at (651) 642-0487 to complete an intake interview and submit enrollment forms. Licensee is then required to sign a minimum 24-month Participation Agreement with the HPSP no later than 60 days following the date of this

Order. Licensee must comply with and successfully complete all terms of her HPSP Participation Agreement.

e. Mental Health Evaluation. Within two months of the date of this Order, Licensee must undergo a mental health evaluation performed by a mental health professional as defined in Minnesota Statutes sections 245.462, subdivision 18. Licensee must submit, or cause to be submitted, the credentials of the evaluator for review and pre-approval by Board staff for purposes of this evaluation. The evaluation must include the Minnesota Multiphasic Personality Inventory ("MMPI") or an equivalent personality inventory. Licensee is responsible for the cost of the evaluation. The results must be sent directly to the Board and must provide and address:

1) Verification the evaluator has reviewed a copy of this Order and any evaluation or treatment records deemed pertinent by the Board or the evaluator prior to the evaluation;

2) Diagnosis and any recommended treatment plan;

3) Interpretation of Licensee's MMPI test;

4) Licensee's ability to handle stress;

5) Recommendations for additional evaluation or treatment; and

6) Any other information the evaluator believes would assist the Board in its ultimate review of this matter.

f. Compliance With Evaluator's Recommendations. Licensee must comply promptly with any recommendations for additional evaluation and treatment made by the mental health evaluator.

g. Waivers. If requested by the Board at any time while this Order is in effect, Licensee must complete and sign health records waivers supplied by the Board to allow representatives of the Board to discuss Licensee's case with and to obtain written evaluations and reports and copies of all of Licensee's health and mental health records from her physician, mental health professional, or others from whom Licensee has sought or obtained treatment, support, or assistance.

h. Additional Information. Licensee must provide any additional relevant information reasonably requested by the Board.

12. While this Order is in effect, Licensee must notify each present and future nursing supervisor of this Order within ten days of the date of the order or commencing employment. Licensee must provide the supervisor with a copy of the entire signed Order.

E. Removal of Stayed Suspension

13. The stayed suspension of Licensee's license will be administratively removed after at least 24 months from the date of this Order, upon completion of 2,000 hours of nursing employment, and upon the HPSP's written notification to the Board of Licensee's successful completion of the terms of the Participation Agreement. The removal is effective upon written notification to Licensee by the Board of the removal of the stayed suspension.

VI.

CONSEQUENCES FOR NONCOMPLIANCE OR ADDITIONAL VIOLATIONS

14. It is Licensee's responsibility to ensure all payments, reports, evaluations, and documentation required to be filed with the Board pursuant to this Stipulation and Consent Order or the HPSP pursuant to Licensee's Participation Agreement are timely filed by those preparing the report, evaluation, or documentation. Failure to file payments, reports, evaluations, and documentation on or before their due date is a violation of this Stipulation and Consent Order.

A. Noncompliance With Requirements for Stayed Suspension

15. If the Review Panel has probable cause to believe Licensee has failed to comply with or has violated any of the requirements for staying the suspension as outlined in paragraphs 8, 11, and 12 above or has failed to comply with the Participation Agreement, the Review Panel may remove the stayed suspension pursuant to the procedures outlined in paragraph 16 below, with the following additions and exceptions:

a. If the HPSP discharges Licensee from the program for any reason other than Licensee's successful completion of the terms of the Participation Agreement, there will be

a presumption of a preponderance of the evidence that Licensee has failed to comply with the requirement(s) for staying the suspension.

b. The removal of the stayed suspension will take effect upon service of an Order of Removal of Stayed Suspension ("Order of Removal"). Licensee agrees that the Review Panel is authorized to issue an Order of Removal, which will remain in effect and will have the full force and effect of an order of the Board until the Board makes a final determination pursuant to the procedures outlined in paragraph 16 below. The Order of Removal will confirm the Review Panel has probable cause to believe Licensee has failed to comply with or has violated one or more of the requirements for staying the suspension of Licensee's license. Licensee further agrees an Order of Removal issued pursuant to this paragraph will be deemed a public document under the Minnesota Government Data Practices Act. Licensee waives any right to a conference or hearing before removal of the stayed suspension.

c. The Review Panel will schedule the hearing pursuant to paragraph 16.a. below to be held within 60 days of the notice.

B. Noncompliance With Stipulation and Consent Order

16. If Licensee fails to comply with or violates this Stipulation and Consent Order the Review Panel may, in its discretion, seek additional discipline either by initiating a contested case proceeding pursuant to Minnesota Statutes chapter 14 or by bringing the matter directly to the Board pursuant to the following procedure:

a. The Review Panel will schedule a hearing before the Board. At least 20 days before the hearing, the Review Panel will mail Licensee a notice of the violation(s) alleged by the Review Panel. In addition, the notice will designate the time and place of the hearing. Within ten days after the notice is mailed, Licensee will submit a written response to the allegations. If Licensee does not submit a timely response to the Board, the allegations may be deemed admitted.

b. The Review Panel, in its discretion, may schedule a conference with Licensee prior to the hearing before the Board to discuss the allegations and to attempt to resolve the allegations through agreement.

c. Prior to the hearing before the Board, the Review Panel and Licensee may submit affidavits and written argument in support of their positions. At the hearing, the Review Panel and Licensee may present oral argument. Argument will not refer to matters outside the record. The evidentiary record will be limited to the affidavits submitted prior to the hearing and this Stipulation and Consent Order. Unless stated otherwise in this Stipulation and Consent Order, the Review Panel will have the burden of proving by a preponderance of the evidence that a violation has occurred. If Licensee has failed to submit a timely response to the allegations, Licensee may not contest the allegations, but may present argument concerning the appropriateness of additional discipline. Licensee waives a hearing before an administrative law judge, discovery, cross-examination of adverse witnesses, and other procedures governing hearings pursuant to Minnesota Statutes chapter 14.

d. Licensee's correction of a violation prior to the conference, hearing, or meeting of the Board may be taken into account by the Board but will not limit the Board's authority to impose discipline for the violation. A decision by the Review Panel not to seek discipline when it first learns of a violation will not waive the Review Panel's right to later seek discipline for that violation, either alone or in combination with other violations, at any time while Licensee's license is suspended or the suspension is stayed.

e. Following the hearing, the Board will deliberate confidentially. If the allegations are not proved, the Board will dismiss the allegations. If a violation is proved, the Board may impose additional discipline, including additional requirements for the stayed suspension, removal of the stayed suspension, an additional period of suspension, or revocation of Licensee's license.

f. Nothing herein will limit the Review Panel's or the Board's right to temporarily suspend Licensee's license pursuant to Minnesota Statutes section 148.262,

subdivision 3, based on a violation of this Stipulation and Consent Order or based on conduct of Licensee not specifically referred to herein. Similarly, nothing herein will limit the Review Panel's or the Board's right to automatically suspend Licensee's license pursuant to Minnesota Statutes section 148.262, subdivision 2.

VII.

ADDITIONAL INFORMATION

17. In the event Licensee should leave Minnesota to reside or to practice outside of the state, Licensee will give the Board written notification of the new location, as well as dates of departure and return. Periods of residency and practice outside of Minnesota will not apply to the reduction of any period of Licensee's suspension or stayed suspension in Minnesota unless Licensee demonstrates that the practice in another state conforms completely with this Stipulation and Consent Order. If Licensee leaves the state, the terms of this order continue to apply unless waived in writing.

18. Licensee waives the contested case hearing and all other procedures before the Board to which Licensee may be entitled under the Minnesota and United States constitutions, statutes, or rules.

19. Licensee waives any claims against the Board, the Minnesota Attorney General, the State of Minnesota, and their agents, employees, and representatives related to the investigation of the conduct herein, or the negotiation or execution of this Stipulation and Consent Order, which may otherwise be available to Licensee.

20. This Stipulation and Consent Order, the files, records, and proceedings associated with this matter will constitute the entire record and may be reviewed by the Board in its consideration of this matter.

21. Either party may seek enforcement of this Stipulation and Consent Order in any appropriate civil court.

22. Licensee has read, understands, and agrees to this Stipulation and Consent Order and has voluntarily signed the Stipulation and Consent Order. Licensee is aware this Stipulation

and Consent Order must be approved by the Board before it goes into effect. The Board may either approve the Stipulation and Consent Order as proposed, approve it subject to specified change, or reject it. If the changes are acceptable to Licensee, the Stipulation and Consent Order will take effect and the order as modified will be issued. If the changes are unacceptable to Licensee or the Board rejects the Stipulation and Consent Order, it will be of no effect except as specified in the following paragraph.

23. Licensee agrees that if the Board rejects this Stipulation and Consent Order or a lesser remedy than indicated in this settlement, and this case comes again before the Board, Licensee will assert no claim that the Board was prejudiced by its review and discussion of this Stipulation and Consent Order or of any records relating to it.

24. This Stipulation and Consent Order does not limit the Board's authority to proceed against Licensee by initiating a contested case hearing or by other appropriate means on the basis of any act, conduct, or admission of Licensee which constitutes grounds for disciplinary action and which is not directly related to the specific facts and circumstances set forth herein.

VIII.

DATA PRACTICES NOTICES

25. This Stipulation and Consent Order constitutes disciplinary action by the Board and is classified as public data pursuant to Minnesota Statutes section 13.41, subdivision 5. Data regarding this action will be provided to data banks as required by Federal law or consistent with Board policy. While this Stipulation and Consent Order is in effect, information obtained by the Board pursuant to this Order is considered active investigative data on a licensed health professional, and as such, is classified as confidential data pursuant to Minnesota Statutes section 13.41, subdivision 4.

26. This Stipulation contains the entire agreement between the parties, there being no other agreement of any kind, verbal or otherwise, which varies this Stipulation.

CONSENT:

BOARD OF NURSING

REVIEW PANEL

AMY C. ORR (SLEPICA), RN, LPN
Licensee

Dated: Oct. 16th, 2018

BRADLEY HAUGEN
Board Member

Dated: 12-6-18, 2018

ORDER

Upon consideration of the Stipulation, the Board hereby **SUSPENDS** Licensee's licenses. The Board **STAYS** the suspension so long as Licensee complies with the requirements outlined in the Stipulation and adopts all other terms of the Stipulation on this 6th day of December, 2018.

MINNESOTA BOARD
OF NURSING

SURITY A. BREKKEN
Executive Director