IN THE MATTER OF	§	**BEFORE THE TEXAS**
ADVANCED PRACTICE REGISTERED	§	
NURSE LICENSE NUMBER AP130232	§	
& REGISTERED NURSE LICENSE NUMBER 890276,	§	
ISSUED TO ANTOINETTE MICHELLE THOMPSON	§	**BOARD OF NURSING**

BOARD OF NURSING TEXAS

I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.

Executive Director of the Board

NUNC PRO TUNC ORDER OF THE BOARD

TO: Antoinette Michelle Thompson
c/o Taralynn Mackay, Attorney
P.O. Box 1137
Elgin, TX 78621

An Agreed Order was entered for ANTOINETE MICHELLE THOMPSON on August 10, 2021. The Agreed Order, however, failed to reference Ms. Thompson's advanced practice registered nurse license in the Order. Upon notice and hearing, administrative agencies, like the Courts, have the power to enter nunc pro tunc orders where it can be seen by reference to a record that what was intended to be entered, but was omitted by inadvertence or mistake, can be corrected upon satisfactory proof of its rendition provided that no intervening rights will be prejudiced. *Railroad Comm'n v. McClain*, 356 S.W.2d 330, 334 (Tex. App.--Austin 1962, no writ) (citing *Frankfort Ky. Nat. Gas Co. v. City of Frankfort*, 276 Ky. 199, 123 S.W.2d 270, 272).

The Executive Director, as agent of the Texas Board of Nursing, after review and due consideration of the record and the facts therein submits and enters the corrected Agreed Order. Respondent received due process regarding her license, was made aware of this error, and consented to this Nunc Pro Tunc Order through her counsel; therefore, her rights have not been prejudiced.

NOW, THEREFORE, IT IS ORDERED that the corrected Agreed Order is hereby approved and entered on the dates set forth below.

Order effective August 10, 2021.

Entered this 13th day of August, 2021.

BY: Katherine A. Thomas

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

BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of	§	AGREED ORDER
Advanced Practice Registered Nurse License	§	
Number AP130232	§	
& Registered Nurse License Number 890276	§	
issued to ANTOINETTE MICHELLE	§	
THOMPSON		

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of ANTOINETTE MICHELLE THOMPSON, Advanced Practice Registered Nurse License Number AP130232, and Registered Nurse License Number 890276, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may be subject to discipline pursuant to Section 301.452(b)(8), Texas Occupations Code.

Respondent waived notice and hearing and agreed to the entry of this Agreed Order approved by Katherine A. Thomas, MN, RN, FAAN, Executive Director, on June 22, 2021.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license(s).

2. Respondent waived notice and hearing, and agreed to the entry of this Agreed Order.

3. Respondent's license to practice as a professional nurse in the State of Texas is in current status. Respondent's license to practice as an advanced practice registered nurse in the State of Texas with authorization as a Family Nurse Practitioner is in current status with Prescription Authorization Number in current status.

4. Respondent received an Associate Degree in Nursing from Oklahoma City University, Oklahoma City, Oklahoma, on December 19, 2004. Respondent completed a Family Nurse Practitioner Program from University of South Alabama, Mobile, Alabama, on December 1, 2014. Respondent was licensed to practice professional nursing in the State of Texas on

December 4, 2015. Respondent was licensed to practice advanced practice registered nursing in the State of Texas with authorization as a Family Nurse Practitioner on February 5, 2016. Respondent was licensed to practice advanced practice registered nursing in the State of Texas with authorization as a Family Nurse Practitioner with Prescription Authorization on February 5, 2016.

5. Respondent's nursing employment history includes:

12/2015 – 04/2016	RN	Ponca City Urgent Care Ponca City, Oklahoma
04/2016 – 07/2016	RN	Franklin General Family Clinic North Iowa
06/2016 – 02/2017	RN	Emergency Physicians Medical Group Clinton, Iowa
06/2016 – Present	RN	Veterans Memorial Hospital Waukon, Iowa
09/2016 – 01/2019	RN	Barton Associates Ottumwa, Iowa
01/2017 – Present	RN	Apollo MD Des Moines, Iowa
01/2019 – Present	RN	Wapiti Medical Group Perry, Iowa

6. On or about August 10, 2020, your license to practice as a Registered Nurse and Advanced Practice Registered Nurse - Certified Nurse Practitioner was suspended for one (1) year by the Oklahoma Board of Nursing, Oklahoma City, Oklahoma. A copy of the Order is attached and incorporated by reference as part of this order.

7. On or about January 26, 2021, your license to practice as a Registered Nurse and Advanced Practice Registered Nurse - Certified Nurse Practitioner was suspended by the Georgia Board of Nursing, Macon, Georgia based on the 2020 Oklahoma Board of Nursing's Order. A copy of the Order is attached and incorporated by reference as part of this order.

8. On or about April 7, 2021, your license to practice as a Registered Nurse and Advanced Practice Registered Nurse - Certified Nurse Practitioner was placed on probation by the Board of Nursing of the State of Iowa based on the 2020 Oklahoma Board of Nursing's Order. A copy of the Order is attached and incorporated by reference as part of this order.

9. On or about May 4, 2021, Respondent was issued a Letter of Concern by the North Dakota Board of Nursing, Bismark, ND, based on the 2020 Oklahoma Board of Nursing's Order. A copy of the Letter of Concern is attached and incorporated by reference as part of this order.

10. In response to Findings of Fact Numbers Seven (7) through Nine (9) Respondent explains she has never worked in Texas and has no plans to work in Texas, but she understands she needs to enter into this order to resolve the allegations that originated in Oklahoma.

11. Formal Charges were filed on April 26, 2021.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient cause pursuant to Section 301.452(b)(8), Texas Occupations Code, to take disciplinary action against Advanced Practice Registered Nurse License Number AP130232, and Registered Nurse License Number 890276, heretofore issued to ANTOINETTE MICHELLE THOMPSON.

4. Pursuant to Section 301.463(d), Texas Occupations Code, this Agreed Order is a settlement agreement under Rule 408, Texas Rules of Evidence, in civil or criminal litigation.

TERMS OF ORDER

I. SANCTION AND APPLICABILITY

IT IS THEREFORE AGREED and ORDERED that RESPONDENT SHALL receive the sanction of **LIMITED LICENSE WITH STIPULATIONS** in accordance with the terms of this Order.

A. While under the terms of this Order, **RESPONDENT SHALL NOT provide direct patient care.** For the purposes of this Order, direct patient care involves the formation of a relationship between the nurse and the client, and includes, but is not limited to: teaching, counseling, assessing the client's needs and strengths, and providing skilled nursing care.

B. While under the terms of this Order, **RESPONDENT SHALL notify each present employer in nursing** and present each with a complete copy of this Order, including all attachments, if any, within five (5) days of receipt of this Order. While under the terms of this Order, **RESPONDENT SHALL notify all future employers in nursing** and present each with a complete copy of this Order, including all attachments, if any, prior to accepting an offer of employment.

C. This Order SHALL apply to any and all future licenses issued to RESPONDENT to practice nursing in the State of Texas.

D. This Order SHALL be applicable to RESPONDENT'S nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

E. Until successfully completed, RESPONDENT may not practice nursing in the State of Texas except in accordance with the terms of this Order.

F. As a result of this Order, RESPONDENT'S license(s) will be designated "single state" as applicable and RESPONDENT may not work outside the State of Texas in another nurse licensure compact party state using a Texas compact license.

II. COMPLIANCE WITH LAW

While under the terms of this Order, RESPONDENT agrees to comply in all respects with the Nursing Practice Act, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nursing Education, Licensure and Practice, 22 TEX. ADMIN. CODE §§211.1 *et seq.*, and this Agreed Order.

III. REMEDIAL EDUCATION COURSE(S)

In addition to any continuing education requirements the Board may require for licensure renewal, RESPONDENT SHALL successfully complete the following remedial education course(s) **within one (1) year of the effective date of this Order, unless otherwise specifically indicated**:

A Board-approved course in Texas nursing jurisprudence and ethics that shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's

Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft, and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. Home study and video programs will not be approved.

In order to receive credit for completion of this/these course(s), RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form or SHALL submit the continuing education certificate, as applicable, to the attention of Monitoring at the Board's office. RESPONDENT SHALL first obtain Board approval of any course prior to enrollment if the course is not being offered by a pre-approved provider. *Information about Board-approved courses and Verification of Course Completion forms are available from the Board at www.bon.texas.gov/compliance.*

IV. RESTORATION OF PATIENT CARE PRIVILEGES AND/OR UNENCUMBERED LICENSE(S)

SHOULD RESPONDENT desire to provide direct patient care, RESPONDENT SHALL petition the Board for such approval, at which time, the RESPONDENT MUST satisfy all then existing requirements for restoration of the privilege to provide direct patient care. Further, the Board may impose reasonable conditions that must be satisfied by the RESPONDENT before restoration of an unencumbered license, which, at a minimum, shall include the remedial education courses, work restrictions, supervised practice, and/or employer reporting which would have been requirements of this Agreed Order had the license(s) not been placed in limited status.

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RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Order. I have reviewed this Order. I neither admit nor deny the violation(s) alleged herein. By my signature on this Order, I agree to the entry of this Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order is subject to ratification by the Texas Board of Nursing and a copy of this Order will be mailed to me once the Order becomes effective. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including possible revocation of my license(s) and/or privileges to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 24 day of June, 2021.

ANTOINETTE MICHELLE THOMPSON,

RESPONDENT

Sworn to and subscribed before me this 24 day of June, 2021.

SEAL

JAMIE LEE RUMSEY
Commission Number 817662
My Commission Expires
June 21 2022

Notary Public in and for the State of Iowa

Approved as to form and substance.

Taralynn R. Mackay

Taralynn R. Mackay, Attorney for Respondent

Signed this 24th day of June, 2021.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 24th day of June 2021 by ANTOINETTE MICHELLE THOMPSON, Advanced Practice Registered Nurse License Number AP130232, and Registered Nurse License Number 890276, and said Agreed Order is final.

Effective this 10th day of August, 2021.

Katherine A. Thomas, MN, RN, FAAN
Executive Director on behalf
of said Board

BEFORE THE OKLAHOMA BOARD OF NURSING

IN THE MATTER OF ANTOINETTE MICHELLE THOMPSON, R.N., A.P.R.N.-C.N.P
LICENSE NO. R0082169 SINGLE-STATE LICENSE
LICENSE NO. 142312 MULTISTATE LICENSE (PSOR – IOWA)

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

This matter comes on for hearing before the Oklahoma Board of Nursing ("Board") on the 22nd day of July, 2020 at the location described in the final agenda posted on the Oklahoma Board of Nursing website, on the Cameron Building front entrance at 2915 N. Classen Blvd., Oklahoma City, Oklahoma and at the Board office, at 2915 N. Classen Blvd., Oklahoma City, Oklahoma, Suite 524. A quorum of members was present pursuant to 59 O.S. § 567.4(E).

The Complainant is represented by Debbie McKinney, Esq. and Antoinette Michelle Thompson, R.N. APRN-CNP ("Respondent") appeared in person with counsel, James M. Barber, Esq. at the hearing on this date.

The Board, after reviewing the pleadings, hearing and considering all of the evidence and being fully advised, finds by clear and convincing evidence and enters the following Findings of Fact, Conclusions of Law and Order ("Order").

JURISDICTION

This Order is issued pursuant to the Oklahoma Nursing Practice Act, 59 O.S. § 567.1, *et seq.*

FINDINGS OF FACT

The Board after hearing all the evidence presented hereby issues the following Findings of Fact established by clear and convincing evidence.

1. Proper notice of this Hearing and the Complaint has been served on Respondent as required by law.

2. Respondent is licensed to practice registered nursing in the State of Oklahoma and is the holder of a single-state license, License No. R0082169 issued by the Oklahoma Board of Nursing. Respondent is nationally certified to practice as a Certified Nurse-Practitioner in Family, Certification No. F1214305 (expiration date December 22, 2024) in the specialty role of family/individual across the lifespan. OAC 485:10-15-4(a)(2). Respondent is licensed by the Board as an advanced practice registered nurse-certified nurse practitioner. Respondent's prescriptive authority recognition was issued on December 30, 2014 and placed on inactive on April 1, 2018. Respondent holds a registered nursing multistate license with her primary state of residence in Iowa, License No. 142312. Respondent's licensing history is attached to the Complaint and incorporated by reference as if set forth in full herein.

3. On June 3, 2020, Lisa Griffitts, R.N., Nurse Investigator of the Board, filed a Complaint against Respondent's single-state licenses to practice registered nursing and advanced practice registered nursing with prescriptive authority recognition and multistate licensure privilege to practice alleging facts that constitute violations of the Oklahoma Nursing Practice Act. The Complaint is incorporated by reference as if set forth in full herein.

4. On June 22, 2020, the Board received Respondent's Notice of Appearance and on June 23, 2020 the Board received Respondent's Response. The Response and Notice of Appearance are incorporated by reference as if set forth in full herein.

5. On or about September 27-28, 2015,[1] the Respondent while working as the sole healthcare provider during a twenty-four hour shift from 7 a.m. to 7 a.m. in the Emergency Department ("ED") at Mercy Hospital El Reno in El Reno, Oklahoma ("Mercy Hospital"), as an advanced

[1] Civil litigation was filed in Oklahoma Courts in both matters described in the Complaint paragraphs 3.a. and 3.b. The litigation occurred between June of 2016 through October of 2019.

practice registered nurse-certified nurse practitioner ("APRN-CNP"), certified in Family with prescriptive authority recognition, provided emergency care to Patient #1[2] who presented in the ED via ambulance at 4:19 p.m. with acute symptoms to include: shortness of breath, chest pain, tachycardia (140 beats per minute) and low oxygen saturation (88% on room air). While in the ED the Respondent fainted when she got up to go to the bathroom. At 7:41 p.m. Patient #1 reported that she had been involved in a motor vehicle accident ("MVA") 2-3 months earlier.[3] The Respondent provided care for Patient #1 outside the Respondent's scope of practice; accordingly, the Respondent failed to timely diagnose and treat Patient #1's Pulmonary Emboli. As more particularly described in the relevant Mercy Hospital medical records for Patient #1 attached as pages 24-45 to the Complaint and incorporated by reference as if set forth in full herein. At 3:08 a.m. on September 28, 2015, Patient #1 was transferred to the Oklahoma University Medical Center in Oklahoma City, Oklahoma ("OU Medical Center") arriving at 3:35 a.m. in respiratory distress where she was emergently intubated, cardiopulmonary resuscitation was performed, and Patient #1 was pronounced dead at 5:26 a.m. As more particularly described in the relevant OU Medical Center medical records for Patient #1 attached as pages 46-48 to the Complaint incorporated by reference as if set forth in full herein. Patient #1's autopsy results provide Probable Cause of Death was Acute Pulmonary Embolism, as described in the Medical Examiner's Autopsy Report attached as pages 49-50 to the Complaint and incorporated by reference as if set forth in full herein.

6. On or about January 22, 2016,[1] the Respondent, while working as an APRN-CNP with prescriptive authority recognition at Ponca City Urgent Care in Ponca City, Oklahoma ("Urgent

[2] At the time of the ED visit, Patient #1 was 19 years-old and reported being on birth control pills.
[3] The Respondent recorded a closed fracture of sternum for Patient #1 (due to MVA). (*See* pg. 41.)

Care"), failed to document a complete prescriber order when she documented on Patient #2's[4] Urgent Care Flowsheet under MEDS/INJ/PLAN: "Decadron, Benadryl" and "Give Benadryl 10ml" to Patient #2. The order was inappropriately delegated by the Respondent to a Phlebotomist who administered 500 mg of adult injectable Benadryl by mouth to Patient #2, instead of children's liquid Benadryl oral medication 50 mg and administered intravenous Decadron 10mg *by mouth* to Patient #2, instead of Decadron oral medication. After receiving the medications from the Phlebotomist, Patient #2 was discharged home. At 1:55 p.m. Patient #2 was taken to the ED at Alliance Health Ponca City, in Ponca City, Oklahoma ("Medical Center") after becoming stiff, incoherent and lethargic, experiencing seizures and hallucinating. Patient #2 was admitted to the Medical Center with a diagnosis of Anticholinergic effect of overdose of Benadryl. Patient #2 was discharged home on January 23, 2016. As more particularly described in the relevant medical records of Patient #2 attached as pages 51-60 and made a part hereof.

7. Lisa Griffitts, RN, Nurse Investigator, testified the order written by the Respondent for Patient #2 at the Urgent Care was not an appropriate order to prescribe a medication as the Respondent documented only "Decadron, Benadryl" "Give Benadryl 10ml". Ms. Griffitts testified the Respondent's order did not include the dose nor the route of the medication(s). Ms. Griffitts testified the Respondent requested a phlebotomist to administer the medications to Patient #2, an inappropriate delegation by the Respondent. Ms. Griffitts testified the Respondent informed Board staff during an investigative conference that the Urgent Care staff wore name tags with their titles. Ms. Griffitts testified when a licensed nurse is delegating the administration of medications, the licensed nurse is responsible to know if the staff being delegated to is authorized by law to

[4] At the time of the incident, Patient #2 was a child who presented to the Urgent Care at 10:32 a.m. with a rash that Patient #2 had for three days.

administer medications and if the staff is competent to administer medications. Ms. Griffitts testified the phlebotomist administered Benadryl 500 mg (20 times the 25 mg dose the Respondent stated she intended to be administered as described in a statement included with Patient #2's medical record) resulting in Patient #2 becoming lethargic, stiff, rigid, having seizure like activity and tachycardia. Ms. Griffitts testified that Patient #2 was admitted, a few hours after receiving the overdose of Benadryl, to a Hospital with a diagnosis of anticholinergic effect from the overdose of Benadryl and was discharged the following day. (Testimony of Lisa Griffitts, RN)

8. Belinda Lechtenberg, RN, APRN-CNS, certified in acute care, Clinical Director of Emergency Services at INTEGRIS Baptist Medical Center in Oklahoma City, Oklahoma, testified that the differences between advanced practice registered nurses certified in family and those certified in acute care include: education, training and practice. Ms. Lechtenberg testified that a patient with a pulmonary embolism is an acute care patient. Ms. Lechtenberg testified that an advanced practice registered nurse, certified in family, who assesses a patient with the signs and symptoms of a pulmonary embolism should move quickly to transfer the patient to an acute care facility with acute care healthcare provider(s), as the advanced practice registered nurse certified in family cannot safely practice outside her certification. Ms. Lechtenberg testified that Patient #1's use of birth control pills and a history of a recent motor vehicle accident placed her at a high risk for a pulmonary embolism. Ms. Lechtenberg testified her standard of care in 2015 for a patient with a suspected pulmonary embolism included a D-Dimer laboratory test and a CT scan. Patient #1's urine specimen on admission reported a presumptive positive for Methamphetamine and negative for Amphetamine. Ms. Lechtenberg testified she has never seen a presumptive positive laboratory test result nor has she seen a positive methamphetamine result and a negative amphetamine result in the same laboratory test results, as methamphetamine metabolizes to

amphetamine. Ms. Lechtenberg testified if she had received Patient #1's laboratory test results, as described herein, she would have questioned the Laboratory. Ms. Lechtenberg testified that if the Respondent had informed Dr. Valuck, a physician the Respondent contacted at the Oklahoma Heart Hospital in Oklahoma City, Oklahoma about Patient #1, of all of Patient #1's signs and symptoms, to include: tachycardia, tachypnea, shortness of breath, use of birth control pills, sudden onsite of chest pain, and a recent crush injury there might have been a different outcome for Patient #1. Ms. Lechtenberg testified that due to the Respondent's delays in the treatment of Patient #1, the Respondent jeopardized Patient #1's life, health and safety and exposed Patient #1 to risk of harm. (Testimony of Belinda Lechtenberg, RN, APRN-CNS)

9. Respondent testified her advanced practice registered nurse-certified nurse practitioner certification is family and the Respondent's employment at Mercy Hospital was her first position to work as an advanced practice registered nurse-certified nurse practitioner. Respondent testified that her qualifications to work at Mercy Hospital were based on her practice in emergency medicine as a registered nurse and as a paramedic and the Respondent felt qualified to work in emergency medicine. Respondent testified she was also qualified to work at Mercy Hospital as she had trained in the ED at Mercy Hospital with her supervising physician, Dr. Wilson for one month. Respondent testified that in her advanced practice registered nurse education, she did not receive education for acute care and did not attend clinical in an emergency department. Respondent testified she requested in her credentials application and was given acute care privileges at Mercy Hospital. In the Respondent's Request for Privileges for Mercy Hospital ("Request"), Respondent testified the Request included privileges the Respondent had not been educated on or trained for as an advanced practice registered nurse. Respondent testified she signed the Request stating she

was competent to perform the requested privileges. (State's Exhibit "1"; Testimony of Respondent)

10. Respondent testified Patient #1 was acutely ill when she arrived to the ED presenting with anxiety, shortness of breath, chest pain, tachycardia and low oxygenation; that Patient #1 did not tell the Respondent she was taking birth control pills but told an ED nurse; and that the Respondent did not learn about Patient #1's motor vehicle accident until much later after Patient #1's admission to the ED. Respondent testified she performed an assessment of Patient #1 and ordered basic laboratory tests for Patient #1's shortness of breath, history of asthma and noted Patient #1 was an athlete. Respondent testified it is not generally possible to have a laboratory test result positive for methamphetamine and negative for amphetamine in the same results report; however, Patient #1 tested positive for methamphetamine. Respondent testified she contacted Dr. Valuck about Patient #1, reporting her symptoms. In his deposition, Dr.Valuck testified that the Respondent only reported to him that Patient #1 had a positive test for Methamphetamine and had tachycardia. (State's Exhibit "2"; Testimony of Respondent)

11. Respondent testified that she agrees the order she wrote in Patient #2's medical record was an incomplete order, without the medication dosage and route. Respondent testified she does not have the authority to delegate medication administration to unlicensed personnel. Respondent testified she agrees that Patient #2 suffered an avoidable incident and was harmed. (Testimony of Respondent)

12. In considering the factors for the imposition of an administrative penalty, pursuant to 59 O.S. § 567.8(A)(2) and (J)(1) & (2) the Board finds that in addition to the violation(s) of the Oklahoma Nursing Practice Act by Respondent, the Board has considered those factors set forth in O.A.C. 485:10-11-2(c) of the Rules promulgated by the Oklahoma Board of Nursing, and relies

specifically on Factor Number **1:** evidence of actual or potential harm to patients, clients or the public; Factor Number **2:** the seriousness of the violation, including the nature, circumstances, extent and gravity of any prohibited acts, and the hazard or potential hazard created to the health, safety and welfare of the public; Factor Number **8:** the actual damages, physical or otherwise resulting from the violation and Factor Number **9:** the deterrent effect of the penalty imposed.

13. The Board finds there was clear and convincing evidence presented at the hearing on this date to support the allegations against the Respondent.

CONCLUSIONS OF LAW

1. The Board has jurisdiction to hear this matter pursuant to 59 O.S. § 567.1, *et seq.* and O.A.C. 485:10-11-1, *et seq.*, of the Rules promulgated by this Board.

2. The Board concludes Respondent failed to adequately care for patients or to conform to the minimum standards of acceptable nursing practice that, in the opinion of the Board, unnecessarily exposed a patient to risk of harm, which is in violation of 59 O.S. § 567.3(a)(6). and § 567.8(B)(3) as defined in the Rules promulgated Board, specifically, O.A.C. 485:10-11-1(b)(2) and 485:10-15-6(b)(3) and (4); is guilty of acts that jeopardized a patient's life, health or safety, which is in violation of 59 O.S. § 567.3(a)(6) and § 567.8(B)(8) as defined in the Rules promulgated Board, specifically, O.A.C. 485:10-11-1(b)(4)(A),(B) and (D) and 485:10-15-6(b)(3) and (4) and is guilty of unprofessional conduct, which is in violation of 59 O.S. § 567.3(a)(6) and § 567.8(B)(7) as defined in the Rules promulgated Board, specifically, O.A.C. 485:10-11-1(b)(3)(H) and 485:10-15-6(b)(3) and (4). Findings of Fact 3 and 5 through 11 of this Order.

3. Based on the evidence presented, the Board finds that Respondent's conduct is grounds to deny, revoke, suspend or discipline Respondent's license, to otherwise discipline applicants, to impose an administrative penalty, and to recover the costs of the investigation, all as provided in

59 O.S. § 567.8(A)(1), (2) & (3), (J)(1) & (2), (L) and (M), with reliance specifically on O.A.C. 485:10-11-2(c)(1), (2), (8) and (9) of the Rules promulgated by the Oklahoma Board of Nursing. Findings of Fact 3 and 5 through 11 of this Order.

4. This Order constitutes formal disciplinary action and Respondent's conduct as evidenced by this Order constitutes a disqualifying event with regard to Respondent's multistate licensure privilege as defined in eNLC Rules Section 100(6). 59 O.S. §567.21 Article III(d).

ORDER

IT IS THEREFORE ORDERED by the Board that the single-state licenses to practice as a registered nurse and as an advanced practice registered nurse-certified nurse practitioner with prescriptive authority recognition in the State of Oklahoma held by Respondent are hereby **severely reprimanded.**

IT IS FURTHER ORDERED by the Oklahoma Board of Nursing that all authority to practice issued by this Board including Respondent's single-state licenses to practice as a registered nurse and as an advanced practice registered nurse-certified nurse practitioner with prescriptive authority recognition in the State of Oklahoma; and Respondent's multistate license privilege to practice held by Antoinette Michelle Thompson, R.N./A.P.R.N.-C.N.P., are **suspended** for a period of **one (1) year** and that Respondent's licenses and multistate privilege to practice are disciplined as follows:

1. Respondent shall, **within ninety (90) days prior to reinstatement**, successfully complete a course on **Medication Administration, to include controlled dangerous substances.** Respondent shall obtain Board approval of the course prior to enrollment. Courses that exclusively include home study courses, video Programs, or Internet courses will not be approved. The target audience must include licensed nurses. The didactic portion of this course must be a minimum of

four (4) hours in length. The course must contain a minimum eight (8) hour classroom lab with a skills competency checklist component which is to be supervised by a registered nurse. The course's content must include a review of proper administration procedures for all standard routes, transcribing and processing physician orders, computation of drug dosages, the rights of medication administration, factors influencing the choice of route and adverse effects resulting from improper administration. The course description must indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. Respondent shall successfully complete both the didactic and classroom portions of the course to satisfy this requirement. Respondent shall cause the sponsoring institution to submit verification of Respondent's successful completion of the course to the Board office.

2. Respondent shall, **within ninety (90) days prior to reinstatement**, successfully complete a course on **Nursing Documentation**. Respondent shall obtain Board approval of the course prior to enrollment. Courses that exclusively include home study courses, video Programs, or Internet courses will not be approved. The target audience must include licensed nurses. The course must be a minimum of eight (8) hours in length. The course must contain content on the following: guidelines and processes for objective reporting and recording; legal guidelines for recording; methods of recording; methods of alternative record-keeping; computerized charting/documentation; and case studies with practical demonstration of documentation to be reviewed by a registered nurse for appropriateness. The course description must indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. Respondent shall cause the sponsoring institution to submit verification of Respondent's successful completion of the course to the Board office.

3. Respondent shall, **within ninety (90) days prior to reinstatement,** successfully complete a course on **Critical Thinking, to include moral reasoning.** Respondent shall obtain Board approval of the course prior to enrollment. Courses that exclusively include home study courses, video Programs, and Internet courses will not be approved. The target audience must include licensed nurses. The course must be a minimum of eight (8) contact hours in length. The course description must indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. The course must address how nurses use critical thinking skills to make patient care decisions based on the nursing process. Respondent shall cause the sponsoring institution to submit verification of Respondent's successful completion of the course to the Board office.

4. Respondent shall, **within ninety (90) days prior to reinstatement,** successfully complete a course in **The Roles and Responsibilities of the Advanced Practice Registered Nurse with and without Prescriptive Authority, to include all applicable state and federal regulations,** to include all applicable state and federal regulations. Respondent shall obtain Boards approval of the course prior to enrollment. Courses that exclusively include home study courses, video Programs, and Internet courses will not be approved. The target audience must include licensed nurses. The course must be a minimum of sixteen (16) contact hours in length. For approval the course content must include delegation, supervision, patient assessment, critical thinking, scope of practice of each discipline; and responsibilities related to reporting incidents. The course description must indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. Respondent shall cause the sponsoring institution to submit verification of Respondent's successful completion of the course to the Board office.

5. **Prior to reinstatement,** Respondent shall pay an administrative penalty payable to the Oklahoma Board of Nursing in the full amount of **$1,000.00**. Partial payments are not accepted. The administrative penalty shall be paid only by certified check and/or money order. Any application to reinstate Respondent's license(s) will not be considered until the administrative penalty is paid in full.

6. **Prior to reinstatement,** Respondent shall pay the cost of the investigation and prosecution of the disciplinary action payable to the Oklahoma Board of Nursing in the full amount of **$1,993.22.** Partial payments are not accepted. The cost of the investigation and prosecution shall be paid only by certified check and/or money order. Any application to reinstate Respondent's license(s) will not be considered until the cost of the investigation is paid in full.

7. **Upon reinstatement,** Respondent's license as an advanced practice registered nurse–certified nurse practitioner shall be placed on **probation for employment as an advanced practice registered nurse–certified nurse practitioner for 2880 cumulative worked hours to be completed in two years.**

8. The employment of Respondent during such probationary period shall be in a **hospital only**, under the supervision of not more than two (2) advanced practice registered nurses who will agree to comply with the Guidelines for Supervised Practice in effect at the time of reinstatement.

9. Respondent shall comply with the Oklahoma Board of Nursing Staff/Board Conferences Guidelines in effect at the time of reinstatement.

10. A copy of this Order and all attachments and amendments shall be furnished to each prospective employer and to supervising advanced practice registered nurse(s) while Respondent's single-state advanced practice registered nurse license is on probation.

11. The terms of the Order shall apply to the practice of nursing of any kind, including practice while enrolled in a nursing education program.

12. Upon reinstatement, Respondent shall notify the Board office within five (5) working days of any change of address, name or phone number.

13. Respondent shall comply in all respects with the Oklahoma Nursing Practice Act, 59 O.S. § 567.1, *et seq.*, the Rules of the Board found at Oklahoma Administrative Code Title 485 Chapters 1 and 10 and Guidelines relating to nursing education, licensure and practice and this Order.

14. Prior to the Respondent's successful completion of this Order, any violations of the Oklahoma Nursing Practice Act by the Respondent, except as set forth herein, may require Respondent's appearance before the Board to **Show Cause** why Respondent's license(s) should not be revoked or other such action taken as the Board deems necessary and proper.

IT IS FURTHER ORDERED that this Order shall be sent to Respondent at Respondent's most recent address of record on file with the Board. If this Order is returned with a notation by the United States Postal Service indicating that it is undeliverable for any reason, and the records of the Board indicate that the Board has not received any change of address since the Order was sent, this Order and any subsequent material relating to the same matter sent to Respondent's most recent address on file with the Board shall be deemed legally served for all purposes. See 59 O.S. § 567.8(P).

IT IS FURTHER ORDERED that any failure to comply with submission of documentation by third parties, including late reports, or unsatisfactory reports and/or other violations of the Oklahoma Nursing Practice Act by the Respondent, will require Respondent's appearance before the Informal Disposition Panel of the Board and/or the Board to Show Cause why Respondent's

license(s) should not be revoked or such other action taken as the Board deems necessary and proper.

IT IS FURTHER ORDERED that this Order shall become final after anticompetitive review, as applicable, and a determination by the Oklahoma Attorney General that the Order is in compliance with the Board's authority and mission to protect the public health, safety and welfare, and Respondent has been legally served with this Order as set forth in this Order.

IT IS FURTHER ORDERED that this Order constitutes disciplinary action by the Board and may be used in any subsequent hearings by the Board. In the event other misconduct by Respondent is reported to the Board, this Order may be used as evidence against Respondent to establish a pattern of behavior and for the purpose of proving additional acts of misconduct. Respondent's conduct as evidenced by this Order constitutes a disqualifying event with regard to Respondent's multistate licensure privilege as defined in eNLC Rules Section 100(6). 59 O.S. §567.21. Article III(d).

IT IS FURTHER ORDERED that, upon successful completion of all of the terms and conditions of Respondent's probation, such probation shall terminate without further Order of this Board.

OKLAHOMA BOARD OF NURSING

By: Kim Massey DNP, RN
Presiding Board Officer

KK:ad

BEFORE THE GEORGIA BOARD OF NURSING
STATE OF GEORGIA

IN THE MATTER OF:	*	
	*	
ANTOINETTE MICHELLE THOMPSON, RN	*	DOCKET NO.:
License No. RN255472,	*	
	*	
Respondent.	*	

PUBLIC CONSENT ORDER

By agreement of the Georgia Board of Nursing ("Georgia Board") and ANTOINETTE MICHELLE THOMPSON, RN, (hereinafter "Respondent"), the following disposition of this disciplinary matter is entered pursuant to the provisions of the Georgia Administrative Procedure Act, O.C.G.A § 50-13-13(a)(4), as amended.

FINDINGS OF FACT

1.

The Respondent is licensed to practice nursing as a registered professional nurse and is authorized to practice as an advanced practice nurse practitioner in the State of Georgia and was so licensed and authorized at all times relevant to the matters stated herein.

2.

Respondent is also licensed as a nurse in Oklahoma. On or about July 22, 2020, a hearing was held for the Matter of Antoinette Michelle Thompson before the Oklahoma Board of Nursing ("Oklahoma Board"). The Oklahoma Board, after hearing and considering all of the evidence, entered the Findings of Fact, Conclusions of Law and Order ("Oklahoma Order") based on allegations that Respondent failed to adequately care for patients or to conform to the minimum standards of acceptable nursing practice, and that Respondent jeopardized a patient's life, health or safety. Under the terms of the Oklahoma Order, Respondent's single-state licenses to practice as a registered nurse and as an advanced practice registered nurse-certified nurse practitioner with

prescriptive authority recognition in the State of Oklahoma and Respondent's multistate license privilege to practice are suspended for a period of **one (1) year beginning in July 2020.** Per the terms of the Oklahoma Order, Respondent's licenses and multistate privilege to practice are further disciplined as follows: completion of courses; payment of an administrative penalty in the amount of $1,000; payment of the cost of investigation and prosecution in the amount of $1,993.22; and imposition of probation and conditions should Respondent apply for reinstatement.

3.

Pursuant to the terms of the Oklahoma Order, Respondent has submitted documentation, satisfactory to the Oklahoma Board, of successful completion of the following continuing education courses: Nursing Documentation (8 hours), Critical Thinking to include Moral Reasoning (8 hours), Roles and Responsibilities of the APRN with and without Prescriptive Authority (16 hours) and Medication Administration to include Controlled Dangerous Substances (12 hours).

4.

Pursuant to O.C.G.A. § 43-1-19(a)(5), the Georgia Board may discipline a licensee who has had disciplinary action taken against him or her by any such lawful licensing authority other than the board.

5.

Respondent admits to the above-styled Findings of Fact and waives any further findings of fact not already contained in this Order.

CONCLUSIONS OF LAW

The action taken by the Oklahoma Board of Nursing constitutes sufficient grounds for the imposition of sanctions upon Respondent's license to practice nursing as a registered professional

nurse and as an advanced practice nurse practitioner in the State of Georgia, under O.C.G.A. Chapter 26, Title 43.

ORDER

The Georgia Board of Nursing, having considered all the facts and circumstances of this case, hereby orders and Respondent hereby agrees that the following sanctions shall be imposed upon Respondent's license to practice nursing as a registered professional nurse and upon Respondent's authorization for advanced practice, in the State of Georgia:

1.

The Respondent's license to practice nursing as a registered professional nurse and Respondent's authorization for advanced practice as a nurse practitioner in the State of Georgia shall be **suspended for twelve (12) months commencing on July 2020,** which is the effective date of the Oklahoma Order. During the period of suspension, the Respondent shall not engage in any activities constituting the practice of nursing in the state of Georgia. If Respondent practices nursing in the State of Georgia without the prior express written permission of the Board, Respondent's advanced practice authorization and her license to practice as a registered professional shall be subject to revocation, upon substantiation thereof. The Respondent also acknowledges and agrees that the Board shall show that Respondent's advanced practice authorization is suspended in the State of Georgia on the Board's data bank and may respond to public inquiries that Respondent's authorization is suspended in the State of Georgia.

2.

Respondent may not petition to have the suspension of her license lifted until July 22, 2021. At this time, Respondent may simultaneously apply for inactive status by submitting an application for inactive status and paying the required fees pursuant to Ga. Comp. R. & Regs 410-

6-.01(1). Respondent acknowledges that when considering her petition to lift, the Board has the authority to review any investigative file relating to the Respondent. The Board may also consider having Respondent appear before the Board or one of its committees prior to making a determination on Respondent's petition. **Respondent shall further meet the requirements of Ga. Comp. R & Regs 410-4-.01(1) at the time of her request to lift suspension.** Lifting of suspension and restoration of the Respondent's license shall be in the sole discretion of the Board. Respondent shall not practice as a registered professional nurse or as an advanced practice nurse practitioner in the State of Georgia until such time as the Board's website (www.sos.ga.gov/plb/nursing) has been updated to reflect that Respondent has an "active" license in the State of Georgia.

3.

Prior to the Board considering Respondent's petition to lift, Respondent shall submit to the Board a **fine in the amount of $500.00** for the disciplinary action by the Oklahoma Board. Such fine shall be payable by cashier's check or money order made payable to the Georgia Board of Nursing and shall be sent to the Professional Licensing Boards Division, Georgia Board of Nursing 237 Coliseum Drive, Macon, Georgia 31217. **Respondent's petition shall not be considered by the Board until such time as Respondent has fully satisfied this fine.**

4.

Upon receipt of Respondent's petition to lift to include evidence of her submission of the fine, the Board shall have discretion to lift Respondent's suspension. If Respondent submits an application for inactive licensure status at the time that she submits her petition to lift, the Board shall place Respondent's license in inactive status in lieu of considering the restoration of Respondent's license. Respondent may submit an application for reinstatement in the future

pursuant to Ga. Comp. R. & Regs 410-6-.01(1). Upon receipt of any reinstatement application, the Board shall have the discretion to place upon Respondent's Georgia nursing license any conditions that the Board deems necessary to protect the public. Should the Board determine that reasonable cause exists for maintaining the suspension of Respondent's license, the Board shall notify Respondent of its intent to extend the period of suspension, and Respondent may request a hearing as in a contested case.

5.

If the Respondent shall fail to abide by any state and federal laws relating to drugs and regulating the practice of nursing in the State of Georgia, the Rules and Regulations of the Georgia Board of Nursing, the terms of this Consent Order, or if it should appear from reports submitted to the Board that the Respondent is unable to practice as a registered professional nurse or advanced practice nurse practitioner with reasonable skill and safety, Respondent's license may be further sanctioned or revoked, upon substantiation thereof.

6.

Approval of this Consent Order by the Georgia Board of Nursing shall in no way be construed as condoning the Respondent's conduct, and shall not be construed as a waiver of any of the lawful rights possessed by the Board.

7.

The Respondent acknowledges that she has read this Consent Order and understands its contents. The Respondent understands that Respondent has the right to a hearing in this matter, and freely, knowingly and voluntarily waives such right by entering into this Consent Order. The Respondent understands that this Consent Order will not become effective until approved by the Georgia Board of Nursing and docketed by the Division Director, Professional Licensing Boards

Division. The Respondent further understands and agrees that the Board shall have the authority to review the investigative file and all relevant evidence in considering this Consent Order. The Respondent understands that this Consent Order, once approved and docketed, shall constitute a **PUBLIC RECORD**, evidencing disciplinary action by the Board. However, if the Consent Order is not approved, it shall not constitute an admission against interest in this proceeding or prejudice the Board's ability to adjudicate this matter. The Respondent understands that, by entering into this Consent Order, Respondent may not be eligible for a multistate license. The Respondent hereby consents to the terms and sanctions contained herein.

(Signatures on the following page)

Approved this 15th day of January, 2021.

GEORGIA BOARD OF NURSING

BY: _____
DARRELL W. THOMPSON, RN, DNP, ACNP-BC, FNP-BC
President

ATTEST: _____
LA TRENDA TYLER-JONES, Director
Professional Licensing Boards Division

CONSENTED TO: _____
ANTOINETTE MICHELLE THOMPSON
Respondent

Respondent swore to and subscribed before me this 22 day of December, 2020.

_____
NOTARY PUBLIC
My commission expires: 2023

ANDREA S. YOUNG
Commission Number 826994
My Commission Expires
October 20, 2023

BEFORE THE BOARD OF NURSING

OF THE STATE OF IOWA

IN THE MATTER OF: ANTOINETTE THOMPSON 5223 Windsor Court Pleasant Hill, IA 50327 Certificate and License Nos. A142312, and 142312 RESPONDENT.	)	CASE NO. 20-266 **SETTLEMENT AGREEMENT AND FINAL ORDER**

1. In accordance with Iowa Code sections 17A.12(5) and 272C.3(4) and 655 IAC 20.24, the Iowa Board of Nursing (Board) and Antoinette Thompson , Respondent, enter into the following Settlement Agreement and Final Order to settle a contested case currently pending before the Board.

2. The Board filed a Notice of Hearing and Statement of Charges on January 20, 2021. The Board has jurisdiction over the parties and the subject matter of these proceedings.

3. The Board's approval of this Order shall constitute a **FINAL ORDER** of the Board.

IT IS THEREFORE ORDERED:

4. Respondent will immediately return all physical license's to the Board office.

5. Respondent's license/s to practice nursing in the state of Iowa will be placed on **PROBATION** for a period of (12) twelve months commencing upon receipt of this Order. Respondent will satisfy applicable administrative licensing requirements and pay any

fees due. The license will indicate the license is conditional and future license/s issued by the Board during the term of this sanction are subject to the conditions imposed by this Order. (Only those months in which Respondent maintains a minimum of forty-eight (48) hours of nursing employment will be acceptable toward completion of this requirement. This obligation must be fulfilled prior to (18) eighteen months from the date the Order is approved. Any future licenses that may be issued by the Board during the term of this sanction shall also be subjected to the conditions imposed by this Order.

During the period of probation:

6. Respondent will contact the case manager **within ten (10) calendar days** of entering the probation period of this Order and each month thereafter. Written notice of any change of address, phone number or employment shall be submitted within five (5) days of the event.

7. Within thirty (30) days of being placed on probation, Respondent shall meet in person with their case manager at the Board office at the case manager's request.

8. Respondent will obtain case manager approval for each work environment that requires licensure as a nurse or involves direct patient care, and immediately submit a copy of this document to the employer for review. Respondent's job-site supervisor will provide the case manager with a monthly report describing Respondent's activities and level of competence as well as ability to professionally interact with patients and coworkers. Respondent will abide by any work place practice restrictions imposed by the employer and consistently maintain acceptable standards of performance. Respondent shall not work in home health.

9. Upon receipt of the Order, Respondent shall immediately notify all current nursing employers of this Order.

10. While on probation, Respondent shall disclose this Order to all future nursing employers before commencing employment.

11. Respondent will submit to a medical, mental health and/or substance abuse evaluation, when determined appropriate by the case manager, based on information received by the Board indicating noncompliance with this Order. The evaluation is to be accomplished within thirty (30) days from the date of written notification to do so, and must be completed by a Board-approved evaluator. Respondent will ensure that a copy of the evaluation is sent directly to the case manager as soon as it is available.

12. Respondent agrees to sign all necessary release forms that may be required to obtain information related to case monitoring and/or compliance with the provisions of this Order.

13. Respondent will assume responsibility for all expenses incurred in order to comply with the conditions and requirements imposed by this Order.

14. Respondent agrees that an agent of the Board may make unscheduled visits to determine compliance with this Order.

15. Should Respondent violate the terms of this Order, the Board may initiate action to revoke or suspend Respondent's license, or to impose other licensee discipline as authorized by Iowa Code chapters 147, 152, and 272C, and 655 IAC chapter 4.

16. Respondent's practice privileges pursuant to the provisions of the Nurse Licensure Compact are suspended for the duration of this sanction.

17. Respondent acknowledges that the allegations contained in the Statement of Charges, if proven in a contested case proceeding, would constitute grounds for the discipline agreed to in this Order.

18. The Respondent does not admit the allegations contained in this Order and enters into this Order for the sole purpose of resolving this matter to avoid the burden, expense, delay, and uncertainties of a contested case hearing.

19. Execution of this Order constitutes the resolution of a contested case. Respondent has a right to hearing before the Board on the charges, but Respondent waives the right to hearing and all attendant rights, including the right to appeal or seek judicial review of the Board's action, by freely and voluntarily entering into this Order. Once entered, this Order shall have the force and effect of a disciplinary order entered following a contested case hearing.

20. Respondent is fully aware of the right to be represented by counsel in this matter.

21. Respondent agrees that the State's counsel may present this Order to the Board and may have *ex parte* communications with the Board while presenting it.

22. This Order is subject to approval by a majority of the full Board. If the Board fails to approve this Order, it shall be of no force or effect to either party.

23. Respondent understands the Board is required by federal law to report any adverse action to the National Practitioner Data Bank.

24. Respondent understands this Order, when fully executed, is a public record and is available for inspection and copying in accordance with the requirements of Iowa Code chapters 22 and 272C.

25. This Order shall be part of Respondent's permanent record and shall be considered by the board in determining the nature and severity of any disciplinary action to be imposed in the event of any future violations.

3-12-21
Date

Antoinette Thompson
Respondent

This Settlement Agreement and Final Order is approved by the Board on this 7 TH DAY OF APR 202

Mark G. Odden, BSN, MBA, CRNA, ARNP
Chairperson
Iowa Board of Nursing

Copies to:

Assistant Attorney General
Department of Justice
Hoover Building, 2nd Floor
Des Moines, IA 50319

NORTH DAKOTA BOARD OF NURSING

919 S 7th Street, Suite 504, Bismarck, ND 58504-5881
Telephone: (701) 527-5212 Fax: (701) 328-9785
Web Site Address: www.ndbon.org

May 4, 2021

ANTOINETTE THOMPSON
@TONIENORMAN@YAHOO.COM

Dear Ms. Thompson:

The Compliance Advisory Council (Council) of the North Dakota Board of Nursing has reviewed the investigative case regarding the NURSYS Speed Memos received in the Board office regarding the Oklahoma Board of Nursing suspending your nursing license in July 2020, the Georgia Board of Nursing suspending your license in January 2021, and the Iowa Board of Nursing placing your license on probation in April 2021. Rather than recommending disciplinary action against your license, the Council has directed that you receive a **Letter of Concern**. In addition to this Letter of Concern, the Council has directed you pay an administrative fee of $100 due to the Board office **by June 4, 2021.** You can pay this fee by sending a check or money order to the address below, or by emailing compliance@ndbon.org to set up a time to pay by card over the phone.

The Council is also requiring you provide the North Dakota Board of Nursing with reports of any non-compliance with the Iowa Settlement Agreement and Final Order finalized in April 2021. Please submit notification of successful completion of your Iowa sanctions upon completion of your probationary period. Any reported issues of non-compliance with the Iowa sanctions will be reviewed by the Council for consideration of disciplinary action.

A letter of concern does *not* involve disciplinary action against your license but is meant to convey the concerns of the Council regarding your nursing role and the importance of ensuring you are practicing nursing in compliance with NDCC 43-12.1, Nurse Practices Act.

Thank you for your cooperation during the investigation. Please respond to this email with any questions.

North Dakota Board of Nursing
Compliance Advisory Council
919 S. 7th Street, Suite 504
Bismarck, ND 58504
compliance@ndbon.org
Phone: 701-527-5212

BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of	§	AGREED ORDER
Registered Nurse License Number 890276	§	
issued to ANTOINETTE MICHELLE	§	
THOMPSON	§	

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of ANTOINETTE MICHELLE THOMPSON, Registered Nurse License Number 890276, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may be subject to discipline pursuant to Section 301.452(b)(8), Texas Occupations Code.

Respondent waived notice and hearing and agreed to the entry of this Agreed Order approved by Katherine A. Thomas, MN, RN, FAAN, Executive Director, on June 22, 2021.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license(s).

2. Respondent waived notice and hearing, and agreed to the entry of this Agreed Order.

3. Respondent's license to practice as a professional nurse in the State of Texas is in current status.

4. Respondent received an Associate Degree in Nursing from Oklahoma City University, Oklahoma City, Oklahoma, on December 19, 2004. Respondent was licensed to practice professional nursing in the State of Texas on December 4, 2015.

5. Respondent's nursing employment history includes:

12/2015 – 04/2016	RN	Ponca City Urgent Care Ponca City, Oklahoma

Respondent's nursing employment history continued:

04/2016 – 07/2016	RN	Franklin General Family Clinic North Iowa
06/2016 – 02/2017	RN	Emergency Physicians Medical Group Clinton, Iowa
06/2016 – Present	RN	Veterans Memorial Hospital Waukon, Iowa
09/2016 – 01/2019	RN	Barton Associates Ottumwa, Iowa
01/2017 – Present	RN	Apollo MD Des Moines, Iowa
01/2019 – Present	RN	Wapiti Medical Group Perry, Iowa

6. On or about August 10, 2020, your license to practice as a Registered Nurse and Advanced Practice Registered Nurse - Certified Nurse Practitioner was suspended for one (1) year by the Oklahoma Board of Nursing, Oklahoma City, Oklahoma. A copy of the Order is attached and incorporated by reference as part of this order.

7. On or about January 26, 2021, your license to practice as a Registered Nurse and Advanced Practice Registered Nurse - Certified Nurse Practitioner was suspended by the Georgia Board of Nursing, Macon, Georgia based on the 2020 Oklahoma Board of Nursing's Order. A copy of the Order is attached and incorporated by reference as part of this order.

8. On or about April 7, 2021, your license to practice as a Registered Nurse and Advanced Practice Registered Nurse - Certified Nurse Practitioner was placed on probation by the Board of Nursing of the State of Iowa based on the 2020 Oklahoma Board of Nursing's Order. A copy of the Order is attached and incorporated by reference as part of this order.

9. On or about May 4, 2021, Respondent was issued a Letter of Concern by the North Dakota Board of Nursing, Bismark, ND, based on the 2020 Oklahoma Board of Nursing's Order. A copy of the Letter of Concern is attached and incorporated by reference as part of this order.

10. In response to Findings of Fact Numbers Seven (7) through Nine (9) Respondent explains she has never worked in Texas and has no plans to work in Texas, but she understands she needs to enter into this order to resolve the allegations that originated in Oklahoma.

11. Formal Charges were filed on April 26, 2021.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient cause pursuant to Section 301.452(b)(8), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 890276, heretofore issued to ANTOINETTE MICHELLE THOMPSON.

4. Pursuant to Section 301.463(d), Texas Occupations Code, this Agreed Order is a settlement agreement under Rule 408, Texas Rules of Evidence, in civil or criminal litigation.

TERMS OF ORDER

I. SANCTION AND APPLICABILITY

IT IS THEREFORE AGREED and ORDERED that RESPONDENT SHALL receive the sanction of **LIMITED LICENSE WITH STIPULATIONS** in accordance with the terms of this Order.

A. While under the terms of this Order, **RESPONDENT SHALL NOT provide direct patient care.** For the purposes of this Order, direct patient care involves the formation of a relationship between the nurse and the client, and includes, but is not limited to: teaching, counseling, assessing the client's needs and strengths, and providing skilled nursing care.

B. While under the terms of this Order, **RESPONDENT SHALL notify each present employer in nursing** and present each with a complete copy of this Order, including all attachments, if any, within five (5) days of receipt of this Order. While under the terms of this Order, **RESPONDENT SHALL notify all future**

employers in nursing and present each with a complete copy of this Order, including all attachments, if any, prior to accepting an offer of employment.

C. This Order SHALL apply to any and all future licenses issued to RESPONDENT to practice nursing in the State of Texas.

D. This Order SHALL be applicable to RESPONDENT'S nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

E. Until successfully completed, RESPONDENT may not practice nursing in the State of Texas except in accordance with the terms of this Order.

F. As a result of this Order, RESPONDENT'S license(s) will be designated "single state" as applicable and RESPONDENT may not work outside the State of Texas in another nurse licensure compact party state using a Texas compact license.

II. COMPLIANCE WITH LAW

While under the terms of this Order, RESPONDENT agrees to comply in all respects with the Nursing Practice Act, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nursing Education, Licensure and Practice, 22 TEX. ADMIN. CODE §§211.1 *et seq.*, and this Agreed Order.

III. REMEDIAL EDUCATION COURSE(S)

In addition to any continuing education requirements the Board may require for licensure renewal, RESPONDENT SHALL successfully complete the following remedial education course(s) **within one (1) year of the effective date of this Order, unless otherwise specifically indicated**:

A Board-approved course in Texas nursing jurisprudence and ethics that shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft, and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. Home study and video programs will not

be approved. Due to the COVID-19 pandemic, this course can be obtained online until the course returns to in person only.

In order to receive credit for completion of this/these course(s), RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form or SHALL submit the continuing education certificate, as applicable, to the attention of Monitoring at the Board's office. RESPONDENT SHALL first obtain Board approval of any course prior to enrollment if the course is not being offered by a pre-approved provider. *Information about Board-approved courses and Verification of Course Completion forms are available from the Board at www.bon.texas.gov/compliance.*

IV. RESTORATION OF PATIENT CARE PRIVILEGES AND/OR UNENCUMBERED LICENSE(S)

SHOULD RESPONDENT desire to provide direct patient care, RESPONDENT SHALL petition the Board for such approval, at which time, the RESPONDENT MUST satisfy all then existing requirements for restoration of the privilege to provide direct patient care. Further, the Board may impose reasonable conditions that must be satisfied by the RESPONDENT before restoration of an unencumbered license, which, at a minimum, shall include the remedial education courses, work restrictions, supervised practice, and/or employer reporting which would have been requirements of this Agreed Order had the license(s) not been placed in limited status.

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RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Order. I have reviewed this Order. I neither admit nor deny the violation(s) alleged herein. By my signature on this Order, I agree to the entry of this Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order is subject to ratification by the Texas Board of Nursing and a copy of this Order will be mailed to me once the Order becomes effective. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including possible revocation of my license(s) and/or privileges to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 24 day of June, 2021.

ANTOINETTE MICHELLE THOMPSON,

RESPONDENT

Sworn to and subscribed before me this 24 day of June, 2021.

SEAL

Notary Public in and for the State of Iowa

JAMIE LEE RUMSEY
Commission Number 817582
My Commission Expires
June 21 2022

Approved as to form and substance.

Taralynn R. Mackay, Attorney for Respondent

Signed this 24th day of June, 2021.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 24th day of June, 2021, by ANTOINETTE MICHELLE THOMPSON, Registered Nurse License Number 890276, and said Agreed Order is final.

Effective this 10th day of August, 2021.

Katherine A. Thomas, MN, RN, FAAN
Executive Director on behalf
of said Board

BEFORE THE OKLAHOMA BOARD OF NURSING

IN THE MATTER OF ANTOINETTE MICHELLE THOMPSON, R.N., A.P.R.N.-C.N.P
LICENSE NO. R0082169 SINGLE-STATE LICENSE
LICENSE NO. 142312 MULTISTATE LICENSE (PSOR – IOWA)

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

This matter comes on for hearing before the Oklahoma Board of Nursing ("Board") on the 22nd day of July, 2020 at the location described in the final agenda posted on the Oklahoma Board of Nursing website, on the Cameron Building front entrance at 2915 N. Classen Blvd., Oklahoma City, Oklahoma and at the Board office, at 2915 N. Classen Blvd., Oklahoma City, Oklahoma, Suite 524. A quorum of members was present pursuant to 59 O.S. § 567.4(E).

The Complainant is represented by Debbie McKinney, Esq. and Antoinette Michelle Thompson, R.N. APRN-CNP ("Respondent") appeared in person with counsel, James M. Barber, Esq. at the hearing on this date.

The Board, after reviewing the pleadings, hearing and considering all of the evidence and being fully advised, finds by clear and convincing evidence and enters the following Findings of Fact, Conclusions of Law and Order ("Order").

JURISDICTION

This Order is issued pursuant to the Oklahoma Nursing Practice Act, 59 O.S. § 567.1, *et seq.*

FINDINGS OF FACT

The Board after hearing all the evidence presented hereby issues the following Findings of Fact established by clear and convincing evidence.

1. Proper notice of this Hearing and the Complaint has been served on Respondent as required by law.

2. Respondent is licensed to practice registered nursing in the State of Oklahoma and is the holder of a single-state license, License No. R0082169 issued by the Oklahoma Board of Nursing. Respondent is nationally certified to practice as a Certified Nurse-Practitioner in Family, Certification No. F1214305 (expiration date December 22, 2024) in the specialty role of family/individual across the lifespan. OAC 485:10-15-4(a)(2). Respondent is licensed by the Board as an advanced practice registered nurse-certified nurse practitioner. Respondent's prescriptive authority recognition was issued on December 30, 2014 and placed on inactive on April 1, 2018. Respondent holds a registered nursing multistate license with her primary state of residence in Iowa, License No. 142312. Respondent's licensing history is attached to the Complaint and incorporated by reference as if set forth in full herein.

3. On June 3, 2020, Lisa Griffitts, R.N., Nurse Investigator of the Board, filed a Complaint against Respondent's single-state licenses to practice registered nursing and advanced practice registered nursing with prescriptive authority recognition and multistate licensure privilege to practice alleging facts that constitute violations of the Oklahoma Nursing Practice Act. The Complaint is incorporated by reference as if set forth in full herein.

4. On June 22, 2020, the Board received Respondent's Notice of Appearance and on June 23, 2020 the Board received Respondent's Response. The Response and Notice of Appearance are incorporated by reference as if set forth in full herein.

5. On or about September 27-28, 2015,[1] the Respondent while working as the sole healthcare provider during a twenty-four hour shift from 7 a.m. to 7 a.m. in the Emergency Department ("ED") at Mercy Hospital El Reno in El Reno, Oklahoma ("Mercy Hospital"), as an advanced

[1] Civil litigation was filed in Oklahoma Courts in both matters described in the Complaint paragraphs 3.a. and 3.b. The litigation occurred between June of 2016 through October of 2019.

practice registered nurse-certified nurse practitioner ("APRN-CNP"), certified in Family with prescriptive authority recognition, provided emergency care to Patient #1[2] who presented in the ED via ambulance at 4:19 p.m. with acute symptoms to include: shortness of breath, chest pain, tachycardia (140 beats per minute) and low oxygen saturation (88% on room air). While in the ED the Respondent fainted when she got up to go to the bathroom. At 7:41 p.m. Patient #1 reported that she had been involved in a motor vehicle accident ("MVA") 2-3 months earlier.[3] The Respondent provided care for Patient #1 outside the Respondent's scope of practice; accordingly, the Respondent failed to timely diagnose and treat Patient #1's Pulmonary Emboli. As more particularly described in the relevant Mercy Hospital medical records for Patient #1 attached as pages 24-45 to the Complaint and incorporated by reference as if set forth in full herein. At 3:08 a.m. on September 28, 2015, Patient #1 was transferred to the Oklahoma University Medical Center in Oklahoma City, Oklahoma ("OU Medical Center") arriving at 3:35 a.m. in respiratory distress where she was emergently intubated, cardiopulmonary resuscitation was performed, and Patient #1 was pronounced dead at 5:26 a.m. As more particularly described in the relevant OU Medical Center medical records for Patient #1 attached as pages 46-48 to the Complaint incorporated by reference as if set forth in full herein. Patient #1's autopsy results provide Probable Cause of Death was Acute Pulmonary Embolism, as described in the Medical Examiner's Autopsy Report attached as pages 49-50 to the Complaint and incorporated by reference as if set forth in full herein.

6. On or about January 22, 2016,[1] the Respondent, while working as an APRN-CNP with prescriptive authority recognition at Ponca City Urgent Care in Ponca City, Oklahoma ("Urgent

[2] At the time of the ED visit, Patient #1 was 19 years-old and reported being on birth control pills.
[3] The Respondent recorded a closed fracture of sternum for Patient #1 (due to MVA). (*See* pg. 41.)

Care"), failed to document a complete prescriber order when she documented on Patient #2's[4] Urgent Care Flowsheet under MEDS/INJ/PLAN: "Decadron, Benadryl" and "Give Benadryl 10ml" to Patient #2. The order was inappropriately delegated by the Respondent to a Phlebotomist who administered 500 mg of adult injectable Benadryl by mouth to Patient #2, instead of children's liquid Benadryl oral medication 50 mg and administered intravenous Decadron 10mg *by mouth* to Patient #2, instead of Decadron oral medication. After receiving the medications from the Phlebotomist, Patient #2 was discharged home. At 1:55 p.m. Patient #2 was taken to the ED at Alliance Health Ponca City, in Ponca City, Oklahoma ("Medical Center") after becoming stiff, incoherent and lethargic, experiencing seizures and hallucinating. Patient #2 was admitted to the Medical Center with a diagnosis of Anticholinergic effect of overdose of Benadryl. Patient #2 was discharged home on January 23, 2016. As more particularly described in the relevant medical records of Patient #2 attached as pages 51-60 and made a part hereof.

7. Lisa Griffitts, RN, Nurse Investigator, testified the order written by the Respondent for Patient #2 at the Urgent Care was not an appropriate order to prescribe a medication as the Respondent documented only "Decadron, Benadryl" "Give Benadryl 10ml". Ms. Griffitts testified the Respondent's order did not include the dose nor the route of the medication(s). Ms. Griffitts testified the Respondent requested a phlebotomist to administer the medications to Patient #2, an inappropriate delegation by the Respondent. Ms. Griffitts testified the Respondent informed Board staff during an investigative conference that the Urgent Care staff wore name tags with their titles. Ms. Griffitts testified when a licensed nurse is delegating the administration of medications, the licensed nurse is responsible to know if the staff being delegated to is authorized by law to

[4] At the time of the incident, Patient #2 was a child who presented to the Urgent Care at 10:32 a.m. with a rash that Patient #2 had for three days.

administer medications and if the staff is competent to administer medications. Ms. Griffitts testified the phlebotomist administered Benadryl 500 mg (20 times the 25 mg dose the Respondent stated she intended to be administered as described in a statement included with Patient #2's medical record) resulting in Patient #2 becoming lethargic, stiff, rigid, having seizure like activity and tachycardia. Ms. Griffitts testified that Patient #2 was admitted, a few hours after receiving the overdose of Benadryl, to a Hospital with a diagnosis of anticholinergic effect from the overdose of Benadryl and was discharged the following day. (Testimony of Lisa Griffitts, RN)

8. Belinda Lechtenberg, RN, APRN-CNS, certified in acute care, Clinical Director of Emergency Services at INTEGRIS Baptist Medical Center in Oklahoma City, Oklahoma, testified that the differences between advanced practice registered nurses certified in family and those certified in acute care include: education, training and practice. Ms. Lechtenberg testified that a patient with a pulmonary embolism is an acute care patient. Ms. Lechtenberg testified that an advanced practice registered nurse, certified in family, who assesses a patient with the signs and symptoms of a pulmonary embolism should move quickly to transfer the patient to an acute care facility with acute care healthcare provider(s), as the advanced practice registered nurse certified in family cannot safely practice outside her certification. Ms. Lechtenberg testified that Patient #1's use of birth control pills and a history of a recent motor vehicle accident placed her at a high risk for a pulmonary embolism. Ms. Lechtenberg testified her standard of care in 2015 for a patient with a suspected pulmonary embolism included a D-Dimer laboratory test and a CT scan. Patient #1's urine specimen on admission reported a presumptive positive for Methamphetamine and negative for Amphetamine. Ms. Lechtenberg testified she has never seen a presumptive positive laboratory test result nor has she seen a positive methamphetamine result and a negative amphetamine result in the same laboratory test results, as methamphetamine metabolizes to

amphetamine. Ms. Lechtenberg testified if she had received Patient #1's laboratory test results, as described herein, she would have questioned the Laboratory. Ms. Lechtenberg testified that if the Respondent had informed Dr. Valuck, a physician the Respondent contacted at the Oklahoma Heart Hospital in Oklahoma City, Oklahoma about Patient #1, of all of Patient #1's signs and symptoms, to include: tachycardia, tachypnea, shortness of breath, use of birth control pills, sudden onsite of chest pain, and a recent crush injury there might have been a different outcome for Patient #1. Ms. Lechtenberg testified that due to the Respondent's delays in the treatment of Patient #1, the Respondent jeopardized Patient #1's life, health and safety and exposed Patient #1 to risk of harm. (Testimony of Belinda Lechtenberg, RN, APRN-CNS)

9. Respondent testified her advanced practice registered nurse-certified nurse practitioner certification is family and the Respondent's employment at Mercy Hospital was her first position to work as an advanced practice registered nurse-certified nurse practitioner. Respondent testified that her qualifications to work at Mercy Hospital were based on her practice in emergency medicine as a registered nurse and as a paramedic and the Respondent felt qualified to work in emergency medicine. Respondent testified she was also qualified to work at Mercy Hospital as she had trained in the ED at Mercy Hospital with her supervising physician, Dr. Wilson for one month. Respondent testified that in her advanced practice registered nurse education, she did not receive education for acute care and did not attend clinical in an emergency department. Respondent testified she requested in her credentials application and was given acute care privileges at Mercy Hospital. In the Respondent's Request for Privileges for Mercy Hospital ("Request"), Respondent testified the Request included privileges the Respondent had not been educated on or trained for as an advanced practice registered nurse. Respondent testified she signed the Request stating she

was competent to perform the requested privileges. (State's Exhibit "1"; Testimony of Respondent)

10. Respondent testified Patient #1 was acutely ill when she arrived to the ED presenting with anxiety, shortness of breath, chest pain, tachycardia and low oxygenation; that Patient #1 did not tell the Respondent she was taking birth control pills but told an ED nurse; and that the Respondent did not learn about Patient #1's motor vehicle accident until much later after Patient #1's admission to the ED. Respondent testified she performed an assessment of Patient #1 and ordered basic laboratory tests for Patient #1's shortness of breath, history of asthma and noted Patient #1 was an athlete. Respondent testified it is not generally possible to have a laboratory test result positive for methamphetamine and negative for amphetamine in the same results report; however, Patient #1 tested positive for methamphetamine. Respondent testified she contacted Dr. Valuck about Patient #1, reporting her symptoms. In his deposition, Dr.Valuck testified that the Respondent only reported to him that Patient #1 had a positive test for Methamphetamine and had tachycardia. (State's Exhibit "2"; Testimony of Respondent)

11. Respondent testified that she agrees the order she wrote in Patient #2's medical record was an incomplete order, without the medication dosage and route. Respondent testified she does not have the authority to delegate medication administration to unlicensed personnel. Respondent testified she agrees that Patient #2 suffered an avoidable incident and was harmed. (Testimony of Respondent)

12. In considering the factors for the imposition of an administrative penalty, pursuant to 59 O.S. § 567.8(A)(2) and (J)(1) & (2) the Board finds that in addition to the violation(s) of the Oklahoma Nursing Practice Act by Respondent, the Board has considered those factors set forth in O.A.C. 485:10-11-2(c) of the Rules promulgated by the Oklahoma Board of Nursing, and relies

specifically on Factor Number **1:** evidence of actual or potential harm to patients, clients or the public; Factor Number **2:** the seriousness of the violation, including the nature, circumstances, extent and gravity of any prohibited acts, and the hazard or potential hazard created to the health, safety and welfare of the public; Factor Number **8:** the actual damages, physical or otherwise resulting from the violation and Factor Number **9:** the deterrent effect of the penalty imposed.

13. The Board finds there was clear and convincing evidence presented at the hearing on this date to support the allegations against the Respondent.

CONCLUSIONS OF LAW

1. The Board has jurisdiction to hear this matter pursuant to 59 O.S. § 567.1, *et seq.* and O.A.C. 485:10-11-1, *et seq.*, of the Rules promulgated by this Board.

2. The Board concludes Respondent failed to adequately care for patients or to conform to the minimum standards of acceptable nursing practice that, in the opinion of the Board, unnecessarily exposed a patient to risk of harm, which is in violation of 59 O.S. § 567.3(a)(6). and § 567.8(B)(3) as defined in the Rules promulgated Board, specifically, O.A.C. 485:10-11-1(b)(2) and 485:10-15-6(b)(3) and (4); is guilty of acts that jeopardized a patient's life, health or safety, which is in violation of 59 O.S. § 567.3(a)(6) and § 567.8(B)(8) as defined in the Rules promulgated Board, specifically, O.A.C. 485:10-11-1(b)(4)(A),(B) and (D) and 485:10-15-6(b)(3) and (4) and is guilty of unprofessional conduct, which is in violation of 59 O.S. § 567.3(a)(6) and § 567.8(B)(7) as defined in the Rules promulgated Board, specifically, O.A.C. 485:10-11-1(b)(3)(H) and 485:10-15-6(b)(3) and (4). Findings of Fact 3 and 5 through 11 of this Order.

3. Based on the evidence presented, the Board finds that Respondent's conduct is grounds to deny, revoke, suspend or discipline Respondent's license, to otherwise discipline applicants, to impose an administrative penalty, and to recover the costs of the investigation, all as provided in

59 O.S. § 567.8(A)(1), (2) & (3), (J)(1) & (2), (L) and (M), with reliance specifically on O.A.C. 485:10-11-2(c)(1), (2), (8) and (9) of the Rules promulgated by the Oklahoma Board of Nursing. Findings of Fact 3 and 5 through 11 of this Order.

4. This Order constitutes formal disciplinary action and Respondent's conduct as evidenced by this Order constitutes a disqualifying event with regard to Respondent's multistate licensure privilege as defined in eNLC Rules Section 100(6). 59 O.S. §567.21 Article III(d).

ORDER

IT IS THEREFORE ORDERED by the Board that the single-state licenses to practice as a registered nurse and as an advanced practice registered nurse-certified nurse practitioner with prescriptive authority recognition in the State of Oklahoma held by Respondent are hereby **severely reprimanded**.

IT IS FURTHER ORDERED by the Oklahoma Board of Nursing that all authority to practice issued by this Board including Respondent's single-state licenses to practice as a registered nurse and as an advanced practice registered nurse-certified nurse practitioner with prescriptive authority recognition in the State of Oklahoma; and Respondent's multistate license privilege to practice held by Antoinette Michelle Thompson, R.N./A.P.R.N.-C.N.P., are **suspended** for a period of **one (1) year** and that Respondent's licenses and multistate privilege to practice are disciplined as follows:

1. Respondent shall, **within ninety (90) days prior to reinstatement**, successfully complete a course on **Medication Administration, to include controlled dangerous substances.** Respondent shall obtain Board approval of the course prior to enrollment. Courses that exclusively include home study courses, video Programs, or Internet courses will not be approved. The target audience must include licensed nurses. The didactic portion of this course must be a minimum of

four (4) hours in length. The course must contain a minimum eight (8) hour classroom lab with a skills competency checklist component which is to be supervised by a registered nurse. The course's content must include a review of proper administration procedures for all standard routes, transcribing and processing physician orders, computation of drug dosages, the rights of medication administration, factors influencing the choice of route and adverse effects resulting from improper administration. The course description must indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. Respondent shall successfully complete both the didactic and classroom portions of the course to satisfy this requirement. Respondent shall cause the sponsoring institution to submit verification of Respondent's successful completion of the course to the Board office.

2. Respondent shall, **within ninety (90) days prior to reinstatement**, successfully complete a course on **Nursing Documentation**. Respondent shall obtain Board approval of the course prior to enrollment. Courses that exclusively include home study courses, video Programs, or Internet courses will not be approved. The target audience must include licensed nurses. The course must be a minimum of eight (8) hours in length. The course must contain content on the following: guidelines and processes for objective reporting and recording; legal guidelines for recording; methods of recording; methods of alternative record-keeping; computerized charting/documentation; and case studies with practical demonstration of documentation to be reviewed by a registered nurse for appropriateness. The course description must indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. Respondent shall cause the sponsoring institution to submit verification of Respondent's successful completion of the course to the Board office.

3. Respondent shall, **within ninety (90) days prior to reinstatement,** successfully complete a course on **Critical Thinking, to include moral reasoning.** Respondent shall obtain Board approval of the course prior to enrollment. Courses that exclusively include home study courses, video Programs, and Internet courses will not be approved. The target audience must include licensed nurses. The course must be a minimum of eight (8) contact hours in length. The course description must indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. The course must address how nurses use critical thinking skills to make patient care decisions based on the nursing process. Respondent shall cause the sponsoring institution to submit verification of Respondent's successful completion of the course to the Board office.

4. Respondent shall, **within ninety (90) days prior to reinstatement,** successfully complete a course in **The Roles and Responsibilities of the Advanced Practice Registered Nurse with and without Prescriptive Authority, to include all applicable state and federal regulations,** to include all applicable state and federal regulations. Respondent shall obtain Boards approval of the course prior to enrollment. Courses that exclusively include home study courses, video Programs, and Internet courses will not be approved. The target audience must include licensed nurses. The course must be a minimum of sixteen (16) contact hours in length. For approval the course content must include delegation, supervision, patient assessment, critical thinking, scope of practice of each discipline; and responsibilities related to reporting incidents. The course description must indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. Respondent shall cause the sponsoring institution to submit verification of Respondent's successful completion of the course to the Board office.

5. **Prior to reinstatement**, Respondent shall pay an administrative penalty payable to the Oklahoma Board of Nursing in the full amount of **$1,000.00**. Partial payments are not accepted. The administrative penalty shall be paid only by certified check and/or money order. Any application to reinstate Respondent's license(s) will not be considered until the administrative penalty is paid in full.

6. **Prior to reinstatement,** Respondent shall pay the cost of the investigation and prosecution of the disciplinary action payable to the Oklahoma Board of Nursing in the full amount of **$1,993.22**. Partial payments are not accepted. The cost of the investigation and prosecution shall be paid only by certified check and/or money order. Any application to reinstate Respondent's license(s) will not be considered until the cost of the investigation is paid in full.

7. **Upon reinstatement**, Respondent's license as an advanced practice registered nurse–certified nurse practitioner shall be placed on **probation for employment as an advanced practice registered nurse–certified nurse practitioner for 2880 cumulative worked hours to be completed in two years**.

8. The employment of Respondent during such probationary period shall be in a **hospital only**, under the supervision of not more than two (2) advanced practice registered nurses who will agree to comply with the Guidelines for Supervised Practice in effect at the time of reinstatement.

9. Respondent shall comply with the Oklahoma Board of Nursing Staff/Board Conferences Guidelines in effect at the time of reinstatement.

10. A copy of this Order and all attachments and amendments shall be furnished to each prospective employer and to supervising advanced practice registered nurse(s) while Respondent's single-state advanced practice registered nurse license is on probation.

11. The terms of the Order shall apply to the practice of nursing of any kind, including practice while enrolled in a nursing education program.

12. Upon reinstatement, Respondent shall notify the Board office within five (5) working days of any change of address, name or phone number.

13. Respondent shall comply in all respects with the Oklahoma Nursing Practice Act, 59 O.S. § 567.1, *et seq.*, the Rules of the Board found at Oklahoma Administrative Code Title 485 Chapters 1 and 10 and Guidelines relating to nursing education, licensure and practice and this Order.

14. Prior to the Respondent's successful completion of this Order, any violations of the Oklahoma Nursing Practice Act by the Respondent, except as set forth herein, may require Respondent's appearance before the Board to **Show Cause** why Respondent's license(s) should not be revoked or other such action taken as the Board deems necessary and proper.

IT IS FURTHER ORDERED that this Order shall be sent to Respondent at Respondent's most recent address of record on file with the Board. If this Order is returned with a notation by the United States Postal Service indicating that it is undeliverable for any reason, and the records of the Board indicate that the Board has not received any change of address since the Order was sent, this Order and any subsequent material relating to the same matter sent to Respondent's most recent address on file with the Board shall be deemed legally served for all purposes. See 59 O.S. § 567.8(P).

IT IS FURTHER ORDERED that any failure to comply with submission of documentation by third parties, including late reports, or unsatisfactory reports and/or other violations of the Oklahoma Nursing Practice Act by the Respondent, will require Respondent's appearance before the Informal Disposition Panel of the Board and/or the Board to Show Cause why Respondent's

license(s) should not be revoked or such other action taken as the Board deems necessary and proper.

IT IS FURTHER ORDERED that this Order shall become final after anticompetitive review, as applicable, and a determination by the Oklahoma Attorney General that the Order is in compliance with the Board's authority and mission to protect the public health, safety and welfare, and Respondent has been legally served with this Order as set forth in this Order.

IT IS FURTHER ORDERED that this Order constitutes disciplinary action by the Board and may be used in any subsequent hearings by the Board. In the event other misconduct by Respondent is reported to the Board, this Order may be used as evidence against Respondent to establish a pattern of behavior and for the purpose of proving additional acts of misconduct. Respondent's conduct as evidenced by this Order constitutes a disqualifying event with regard to Respondent's multistate licensure privilege as defined in eNLC Rules Section 100(6). 59 O.S. §567.21. Article III(d).

IT IS FURTHER ORDERED that, upon successful completion of all of the terms and conditions of Respondent's probation, such probation shall terminate without further Order of this Board.

OKLAHOMA BOARD OF NURSING

By: Kim Massey DNP, RN
Presiding Board Officer

KK:ad

BEFORE THE GEORGIA BOARD OF NURSING
STATE OF GEORGIA

IN THE MATTER OF:	*		
	*		
ANTOINETTE MICHELLE THOMPSON, RN	*	DOCKET NO.:	JAN 2 6 2021
License No. RN255472,	*		2021-0058
	*		DOCKET NUMBER
Respondent.	*		

PUBLIC CONSENT ORDER

By agreement of the Georgia Board of Nursing ("Georgia Board") and ANTOINETTE MICHELLE THOMPSON, RN, (hereinafter "Respondent"), the following disposition of this disciplinary matter is entered pursuant to the provisions of the Georgia Administrative Procedure Act, O.C.G.A § 50-13-13(a)(4), as amended.

FINDINGS OF FACT

1.

The Respondent is licensed to practice nursing as a registered professional nurse and is authorized to practice as an advanced practice nurse practitioner in the State of Georgia and was so licensed and authorized at all times relevant to the matters stated herein.

2.

Respondent is also licensed as a nurse in Oklahoma. On or about July 22, 2020, a hearing was held for the Matter of Antoinette Michelle Thompson before the Oklahoma Board of Nursing ("Oklahoma Board"). The Oklahoma Board, after hearing and considering all of the evidence, entered the Findings of Fact, Conclusions of Law and Order ("Oklahoma Order") based on allegations that Respondent failed to adequately care for patients or to conform to the minimum standards of acceptable nursing practice, and that Respondent jeopardized a patient's life, health or safety. Under the terms of the Oklahoma Order, Respondent's single-state licenses to practice as a registered nurse and as an advanced practice registered nurse-certified nurse practitioner with

prescriptive authority recognition in the State of Oklahoma and Respondent's multistate license privilege to practice are suspended for a period of **one (1) year beginning in July 2020.** Per the terms of the Oklahoma Order, Respondent's licenses and multistate privilege to practice are further disciplined as follows: completion of courses; payment of an administrative penalty in the amount of $1,000; payment of the cost of investigation and prosecution in the amount of $1,993.22; and imposition of probation and conditions should Respondent apply for reinstatement.

3.

Pursuant to the terms of the Oklahoma Order, Respondent has submitted documentation, satisfactory to the Oklahoma Board, of successful completion of the following continuing education courses: Nursing Documentation (8 hours), Critical Thinking to include Moral Reasoning (8 hours), Roles and Responsibilities of the APRN with and without Prescriptive Authority (16 hours) and Medication Administration to include Controlled Dangerous Substances (12 hours).

4.

Pursuant to O.C.G.A. § 43-1-19(a)(5), the Georgia Board may discipline a licensee who has had disciplinary action taken against him or her by any such lawful licensing authority other than the board.

5.

Respondent admits to the above-styled Findings of Fact and waives any further findings of fact not already contained in this Order.

CONCLUSIONS OF LAW

The action taken by the Oklahoma Board of Nursing constitutes sufficient grounds for the imposition of sanctions upon Respondent's license to practice nursing as a registered professional

nurse and as an advanced practice nurse practitioner in the State of Georgia, under O.C.G.A. Chapter 26, Title 43.

ORDER

The Georgia Board of Nursing, having considered all the facts and circumstances of this case, hereby orders and Respondent hereby agrees that the following sanctions shall be imposed upon Respondent's license to practice nursing as a registered professional nurse and upon Respondent's authorization for advanced practice, in the State of Georgia:

1.

The Respondent's license to practice nursing as a registered professional nurse and Respondent's authorization for advanced practice as a nurse practitioner in the State of Georgia shall be **suspended for twelve (12) months commencing on July 2020,** which is the effective date of the Oklahoma Order. During the period of suspension, the Respondent shall not engage in any activities constituting the practice of nursing in the state of Georgia. If Respondent practices nursing in the State of Georgia without the prior express written permission of the Board, Respondent's advanced practice authorization and her license to practice as a registered professional shall be subject to revocation, upon substantiation thereof. The Respondent also acknowledges and agrees that the Board shall show that Respondent's advanced practice authorization is suspended in the State of Georgia on the Board's data bank and may respond to public inquiries that Respondent's authorization is suspended in the State of Georgia.

2.

Respondent may not petition to have the suspension of her license lifted until July 22, 2021. At this time, Respondent may simultaneously apply for inactive status by submitting an application for inactive status and paying the required fees pursuant to Ga. Comp. R. & Regs 410-

6-.01(1). Respondent acknowledges that when considering her petition to lift, the Board has the authority to review any investigative file relating to the Respondent. The Board may also consider having Respondent appear before the Board or one of its committees prior to making a determination on Respondent's petition. **Respondent shall further meet the requirements of Ga. Comp. R & Regs 410-4-.01(1) at the time of her request to lift suspension.** Lifting of suspension and restoration of the Respondent's license shall be in the sole discretion of the Board. Respondent shall not practice as a registered professional nurse or as an advanced practice nurse practitioner in the State of Georgia until such time as the Board's website (www.sos.ga.gov/plb/nursing) has been updated to reflect that Respondent has an "active" license in the State of Georgia.

3.

Prior to the Board considering Respondent's petition to lift, Respondent shall submit to the Board a **fine in the amount of $500.00** for the disciplinary action by the Oklahoma Board. Such fine shall be payable by cashier's check or money order made payable to the Georgia Board of Nursing and shall be sent to the Professional Licensing Boards Division, Georgia Board of Nursing 237 Coliseum Drive, Macon, Georgia 31217. **Respondent's petition shall not be considered by the Board until such time as Respondent has fully satisfied this fine.**

4.

Upon receipt of Respondent's petition to lift to include evidence of her submission of the fine, the Board shall have discretion to lift Respondent's suspension. If Respondent submits an application for inactive licensure status at the time that she submits her petition to lift, the Board shall place Respondent's license in inactive status in lieu of considering the restoration of Respondent's license. Respondent may submit an application for reinstatement in the future

pursuant to Ga. Comp. R. & Regs 410-6-.01(1). Upon receipt of any reinstatement application, the Board shall have the discretion to place upon Respondent's Georgia nursing license any conditions that the Board deems necessary to protect the public. Should the Board determine that reasonable cause exists for maintaining the suspension of Respondent's license, the Board shall notify Respondent of its intent to extend the period of suspension, and Respondent may request a hearing as in a contested case.

5.

If the Respondent shall fail to abide by any state and federal laws relating to drugs and regulating the practice of nursing in the State of Georgia, the Rules and Regulations of the Georgia Board of Nursing, the terms of this Consent Order, or if it should appear from reports submitted to the Board that the Respondent is unable to practice as a registered professional nurse or advanced practice nurse practitioner with reasonable skill and safety, Respondent's license may be further sanctioned or revoked, upon substantiation thereof.

6.

Approval of this Consent Order by the Georgia Board of Nursing shall in no way be construed as condoning the Respondent's conduct, and shall not be construed as a waiver of any of the lawful rights possessed by the Board.

7.

The Respondent acknowledges that she has read this Consent Order and understands its contents. The Respondent understands that Respondent has the right to a hearing in this matter, and freely, knowingly and voluntarily waives such right by entering into this Consent Order. The Respondent understands that this Consent Order will not become effective until approved by the Georgia Board of Nursing and docketed by the Division Director, Professional Licensing Boards

Division. The Respondent further understands and agrees that the Board shall have the authority to review the investigative file and all relevant evidence in considering this Consent Order. The Respondent understands that this Consent Order, once approved and docketed, shall constitute a **PUBLIC RECORD**, evidencing disciplinary action by the Board. However, if the Consent Order is not approved, it shall not constitute an admission against interest in this proceeding or prejudice the Board's ability to adjudicate this matter. The Respondent understands that, by entering into this Consent Order, Respondent may not be eligible for a multistate license. The Respondent hereby consents to the terms and sanctions contained herein.

(Signatures on the following page)

Approved this 15th day of January, 2021.

GEORGIA BOARD OF NURSING

BY: _____
DARRELL W. THOMPSON, RN, DNP, ACNP-BC, FNP-BC
President

ATTEST: _____
LA TRENDA TYLER-JONES, Director
Professional Licensing Boards Division

CONSENTED TO: _____
ANTOINETTE MICHELLE THOMPSON
Respondent

Respondent swore to and subscribed before me this 22 day of December, 2020.

_____
NOTARY PUBLIC
My commission expires: 2023

ANDREA S. YOUNG
Commission Number 826994
My Commission Expires
October 20, 2023

BEFORE THE BOARD OF NURSING

OF THE STATE OF IOWA

IN THE MATTER OF: ANTOINETTE THOMPSON 5223 Windsor Court Pleasant Hill, IA 50327 Certificate and License Nos. A142312, and 142312 RESPONDENT.	)	CASE NO. 20-266 **SETTLEMENT AGREEMENT AND FINAL ORDER**

1. In accordance with Iowa Code sections 17A.12(5) and 272C.3(4) and 655 IAC 20.24, the Iowa Board of Nursing (Board) and Antoinette Thompson , Respondent, enter into the following Settlement Agreement and Final Order to settle a contested case currently pending before the Board.

2. The Board filed a Notice of Hearing and Statement of Charges on January 20, 2021. The Board has jurisdiction over the parties and the subject matter of these proceedings.

3. The Board's approval of this Order shall constitute a **FINAL ORDER** of the Board.

IT IS THEREFORE ORDERED:

4. Respondent will immediately return all physical license's to the Board office.

5. Respondent's license/s to practice nursing in the state of Iowa will be placed on **PROBATION** for a period of (12) twelve months commencing upon receipt of this Order. Respondent will satisfy applicable administrative licensing requirements and pay any

fees due. The license will indicate the license is conditional and future license/s issued by the Board during the term of this sanction are subject to the conditions imposed by this Order. (Only those months in which Respondent maintains a minimum of forty-eight (48) hours of nursing employment will be acceptable toward completion of this requirement. This obligation must be fulfilled prior to (18) eighteen months from the date the Order is approved. Any future licenses that may be issued by the Board during the term of this sanction shall also be subjected to the conditions imposed by this Order.

During the period of probation:

6. Respondent will contact the case manager **within ten (10) calendar days** of entering the probation period of this Order and each month thereafter. Written notice of any change of address, phone number or employment shall be submitted within five (5) days of the event.

7. Within thirty (30) days of being placed on probation, Respondent shall meet in person with their case manager at the Board office at the case manager's request.

8. Respondent will obtain case manager approval for each work environment that requires licensure as a nurse or involves direct patient care, and immediately submit a copy of this document to the employer for review. Respondent's job-site supervisor will provide the case manager with a monthly report describing Respondent's activities and level of competence as well as ability to professionally interact with patients and coworkers. Respondent will abide by any work place practice restrictions imposed by the employer and consistently maintain acceptable standards of performance. Respondent shall not work in home health.

9. Upon receipt of the Order, Respondent shall immediately notify all current nursing employers of this Order.

10. While on probation, Respondent shall disclose this Order to all future nursing employers before commencing employment.

11. Respondent will submit to a medical, mental health and/or substance abuse evaluation, when determined appropriate by the case manager, based on information received by the Board indicating noncompliance with this Order. The evaluation is to be accomplished within thirty (30) days from the date of written notification to do so, and must be completed by a Board-approved evaluator. Respondent will ensure that a copy of the evaluation is sent directly to the case manager as soon as it is available.

12. Respondent agrees to sign all necessary release forms that may be required to obtain information related to case monitoring and/or compliance with the provisions of this Order.

13. Respondent will assume responsibility for all expenses incurred in order to comply with the conditions and requirements imposed by this Order.

14. Respondent agrees that an agent of the Board may make unscheduled visits to determine compliance with this Order.

15. Should Respondent violate the terms of this Order, the Board may initiate action to revoke or suspend Respondent's license, or to impose other licensee discipline as authorized by Iowa Code chapters 147, 152, and 272C, and 655 IAC chapter 4.

16. Respondent's practice privileges pursuant to the provisions of the Nurse Licensure Compact are suspended for the duration of this sanction.

17. Respondent acknowledges that the allegations contained in the Statement of Charges, if proven in a contested case proceeding, would constitute grounds for the discipline agreed to in this Order.

18. The Respondent does not admit the allegations contained in this Order and enters into this Order for the sole purpose of resolving this matter to avoid the burden, expense, delay, and uncertainties of a contested case hearing.

19. Execution of this Order constitutes the resolution of a contested case. Respondent has a right to hearing before the Board on the charges, but Respondent waives the right to hearing and all attendant rights, including the right to appeal or seek judicial review of the Board's action, by freely and voluntarily entering into this Order. Once entered, this Order shall have the force and effect of a disciplinary order entered following a contested case hearing.

20. Respondent is fully aware of the right to be represented by counsel in this matter.

21. Respondent agrees that the State's counsel may present this Order to the Board and may have *ex parte* communications with the Board while presenting it.

22. This Order is subject to approval by a majority of the full Board. If the Board fails to approve this Order, it shall be of no force or effect to either party.

23. Respondent understands the Board is required by federal law to report any adverse action to the National Practitioner Data Bank.

24. Respondent understands this Order, when fully executed, is a public record and is available for inspection and copying in accordance with the requirements of Iowa Code chapters 22 and 272C.

25. This Order shall be part of Respondent's permanent record and shall be considered by the board in determining the nature and severity of any disciplinary action to be imposed in the event of any future violations.

3-12-21
Date

Antoinette Thompson
Respondent

This Settlement Agreement and Final Order is approved by the Board on this 7 TH DAY OF APR 202

Mark G. Odden, BSN, MBA, CRNA, ARNP
Chairperson
Iowa Board of Nursing

Copies to:

Assistant Attorney General
Department of Justice
Hoover Building, 2nd Floor
Des Moines, IA 50319

NORTH DAKOTA BOARD OF NURSING

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Web Site Address: www.ndbon.org

May 4, 2021

ANTOINETTE THOMPSON
@TONIENORMAN@YAHOO.COM

Dear Ms. Thompson:

The Compliance Advisory Council (Council) of the North Dakota Board of Nursing has reviewed the investigative case regarding the NURSYS Speed Memos received in the Board office regarding the Oklahoma Board of Nursing suspending your nursing license in July 2020, the Georgia Board of Nursing suspending your license in January 2021, and the Iowa Board of Nursing placing your license on probation in April 2021. Rather than recommending disciplinary action against your license, the Council has directed that you receive a **Letter of Concern**. In addition to this Letter of Concern, the Council has directed you pay an administrative fee of $100 due to the Board office **by June 4, 2021.** You can pay this fee by sending a check or money order to the address below, or by emailing compliance@ndbon.org to set up a time to pay by card over the phone.

The Council is also requiring you provide the North Dakota Board of Nursing with reports of any non-compliance with the Iowa Settlement Agreement and Final Order finalized in April 2021. Please submit notification of successful completion of your Iowa sanctions upon completion of your probationary period. Any reported issues of non-compliance with the Iowa sanctions will be reviewed by the Council for consideration of disciplinary action.

A letter of concern does *not* involve disciplinary action against your license but is meant to convey the concerns of the Council regarding your nursing role and the importance of ensuring you are practicing nursing in compliance with NDCC 43-12.1, Nurse Practices Act.

Thank you for your cooperation during the investigation. Please respond to this email with any questions.

North Dakota Board of Nursing
Compliance Advisory Council
919 S. 7th Street, Suite 504
Bismarck, ND 58504
compliance@ndbon.org
Phone: 701-527-5212