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| IN THE MATTER OF<br>PERMANENT REGISTERED NURSE<br>LICENSE NUMBER 800152 | §<br>§<br>§ | BEFORE THE TEXAS<br><br>BOARD OF NURSING |
| ISSUED TO<br>JAYME LYN FARRIS | §<br>§ | ELIGIBILITY AND<br><br>DISCIPLINARY COMMITTEE |



**ORDER OF THE BOARD**

TO: JAYME LYN FARRIS
265 RACHAL
BRIDGE CITY, TX 77611

During open meeting held in Austin, Texas, on **September 9, 2014**, the Texas Board of Nursing Eligibility and Disciplinary Committee (hereinafter "Committee") heard the above-styled case, based on the failure of the Respondent to appear as required by 22 TEX. ADMIN. CODE Ch. 213.

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

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

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

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

The Committee, after review and due consideration, adopts the proposed findings of fact and conclusions of law as stated in the Formal Charges which are attached hereto and incorporated by reference for all purposes and the Staff's recommended sanction of revocation by default. This Order will be properly served on all parties and all parties will be given an opportunity to file a motion for rehearing [22 TEX. ADMIN.CODE § 213.16(j)]. All parties have a right to judicial review of this Order.

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

NOW, THEREFORE, IT IS ORDERED that Permanent Registered Nurse License Number 800152, previously issued to JAYME LYN FARRIS, to practice nursing in the State of Texas be, and the same is/are hereby, REVOKED.

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

Entered this **9th day of September, 2014**.

TEXAS BOARD OF NURSING

BY: 

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

Attachment: Formal Charge filed June 12, 2014.

CERTIFICATE OF SERVICE

I hereby certify that on the ____ day of _____, 20___, a true and correct copy of the foregoing DEFAULT ORDER was served and addressed to the following person(s), as follows:

Via USPS Certified Mail, Return Receipt Requested
JAYME LYN FARRIS
265 RACHAL
BRIDGE CITY, TX 77611

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

| | | |
|---|---|---|
| **In the Matter of** | § | **BEFORE THE TEXAS** |
| **Permanent Registered Nurse** | § | |
| **License Number 800152** | § | |
| **Issued to JAYME LYN FARRIS,** | § | |
| **Respondent** | § | **BOARD OF NURSING** |

## FORMAL CHARGES

This is a disciplinary proceeding under Section 301.452(b), Texas Occupations Code. Respondent, JAYME LYN FARRIS, is a Registered Nurse holding License Number 800152, which is in delinquent status at the time of this pleading.

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

## CHARGE I.

On or about September 12, 2013, Respondent failed to comply with the Agreed Order issued to her on September 11, 2012, by the Texas Board of Nursing. Noncompliance is the result of her failure to comply with Stipulation Number One (1) of the Agreed Order which states, in pertinent part:

> (1) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in Texas nursing jurisprudence and ethics....

A copy of the September 11, 2012, Agreed Order, Findings of Fact, and Conclusions of Law is attached and incorporated, by reference, as part of this pleading.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1) and (10), Texas Occupations Code, and is a violation of 22 TEX. ADMIN. CODE §217.12(11)(B).

## CHARGE II.

On or about September 12, 2013, Respondent failed to comply with the Agreed Order issued to her on September 11, 2012, by the Texas Board of Nursing. Noncompliance is the result of her failure to comply with Stipulation Number Two (2) of the Agreed Order which states, in pertinent part:

> (2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in medication administration....

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1) and (10), Texas Occupations Code, and is a violation of 22 TEX. ADMIN. CODE §217.12(11)(B).

## CHARGE III.

On or about September 12, 2013, Respondent failed to comply with the Agreed Order issued to her on September 11, 2012, by the Texas Board of Nursing. Noncompliance is the result of her failure to comply with Stipulation Number Three (3) of the Agreed Order which states, in pertinent part:

> (3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing documentation....

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1) and (10), Texas Occupations Code, and is a violation of 22 TEX. ADMIN. CODE §217.12(11)(B).

## CHARGE IV.

On or about September 12, 2013, Respondent failed to comply with the Agreed Order issued to her on September 11, 2012, by the Texas Board of Nursing. Noncompliance is the result of her failure to comply with Stipulation Number Four (4) of the Agreed Order which states, in pertinent part:

> (4) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the course "Sharpening Critical Thinking Skills,"...

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1) and (10), Texas Occupations Code, and is a violation of 22 TEX. ADMIN. CODE §217.12(11)(B).

NOTICE IS GIVEN that staff will present evidence in support of the recommended disposition of up to, and including, revocation of Respondent's license/s to practice nursing in the State of Texas pursuant to the Nursing Practice Act, Chapter 301, Texas Occupations Code and the Board's rules, 22 Tex. Admin. Code §§ 213.27 - 213.33. Additionally, staff will seek to impose on Respondent the administrative costs of the proceeding pursuant to Section 301.461, Texas Occupations Code. The cost of proceedings shall include, but is not limited to, the cost paid by the Board to the State Office of Administrative Hearings and the Office of the Attorney General or other Board counsel for legal and investigative services, the cost of a court reporter and witnesses, reproduction of records, Board staff time, travel, and expenses. These shall be in an amount of at least one thousand two hundred dollars ($1200.00).

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

NOTICE IS GIVEN that, based on the Formal Charges, the Board will rely on the Disciplinary Matrix, which can be found at www.bon.texas.gov/disciplinaryaction/discp-matrix.html.

NOTICE IS ALSO GIVEN that Respondent's past disciplinary history, as set out below and described in the Order(s) which is/are attached and incorporated by reference as part of these charges, will be offered in support of the disposition recommended by staff: Agreed Order dated September 11, 2012.

Filed this 12 day of June, 2014.

TEXAS BOARD OF NURSING

James W. Johnston, General Counsel
Board Certified - Administrative Law
Texas Board of Legal Specialization
State Bar No. 10838300
Jena Abel, Assistant General Counsel
State Bar No. 24036103
John R. Griffith, Assistant General Counsel
State Bar No. 24079751
Robert Kyle Hensley, Assistant General Counsel
State Bar No. 50511847
John F. Legris, Assistant General Counsel
State Bar No. 00785533
John Vanderford, Assistant General Counsel
State Bar No. 24086670

333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-6811
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Attachments: Agreed Order dated September 11, 2012.

D/2014.05.23

BEFORE THE TEXAS BOARD OF NURSING

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| | | |
|---|---|---|
| In the Matter of | § | AGREED |
| Registered Nurse License Number 800152 | § | |
| issued to JAYME LYN FARRIS | § | ORDER |

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of JAYME LYN FARRIS, Registered Nurse License Number 800152, 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) and 301.453, Texas Occupations Code. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order offered on July 16, 2012, by Katherine A. Thomas, MN, RN, FAAN, Executive Director, subject to ratification by the Board.

## 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 representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order.

3. Respondent is currently licensed to practice professional nursing in the State of Texas.

4. Respondent received an Associate Degree in Nursing from Des Moines Area Community College, Boone, Iowa on May 1, 1999. Respondent was licensed to practice professional nursing in the State of Texas on May 4, 2011.

5. Respondent's professional nursing employment history is unknown.

6. On or about December 7, 2011, Respondent's license to practice nursing in the State of Louisiana was Summarily Suspended by the Louisiana State Board of Nursing, Baton Rouge, Louisiana. A copy of the letter which summarily suspended Respondent's Louisiana nursing

license and complaint dated December 7, 2011, is attached and incorporated, by reference, as part of this Order.

7. On or about February 14, 2012, Respondent's summary suspension of her license to practice nursing in the State of Louisiana, as outlined in Finding of Fact Number Six (6), was continued by the Louisiana State Board of Nursing, Baton Rouge, Louisiana. A copy of the Findings of Fact, Conclusions of Law, and Final Order dated February 17, 2012, is attached and incorporated, by reference, as part of this Order.

8. Regarding the conduct outlined in the Louisiana State Board of Nursing actions, as outlined in Findings of Fact Numbers Six (6) and Seven (7), Respondent states that she did waste the narcotics correctly. She states that there was a blue bin and a black bin for wasting medications and that sometimes it was confusing as to which bin to use to waste. She states that she did not document on the computer correctly the amount that was wasted. She states that she had never used that kind of system to waste or pull meds or even chart so it was rather confusing to her to start with. Respondent states that the computer screen had pop-ups that would read "cannot calculate correct dose to waste", "consult pharmacy", and she would hit the okay button and it would go back to the rest of the meds she needed to pull for her patients.

   Respondent states that the charting system was confusing for her, and they told her she had to document every 2 hours on each of her patients and most of the time she wouldn't even get to sit down to chart for the first time until after midnight for the 7p-7a shift she worked.

   Respondent states that she did not respond to the allegations because she started her new job in Texas where she lives and wants to continue to work. She states that she wasn't even planing on renewing her Louisiana license, and she has no intention of ever working there again. She states that when this happened she took it as a her sign to go back to long-term or skilled nursing which is what she is used to, what she knows and loves best.

9. On or about April 4, 2012, Respondent presented for a chemical dependency evaluation by Kit. W. Harrison, Ph.D. Dr. Harrison concludes that Respondent demonstrates chronic problems associated with stress arising out of both domestic and occupational factors. Dr. Harrison states that although these issues would place her at heightened risk for developing sporadic substance abuse problems, there are few or no significant clinical evidence indicators that she currently demonstrates substance abuse or dependence. Dr. Harrison states that there is ample support for problems with planning and executive functioning, organizational skill problems, which may have contributed to her occupational problems and allegations.

   Dr. Harrison states that Respondent would benefit from continuing education for documentation, monitoring and supervision on charting and information technology, and training for compensatory strategies for the enhancement of cognitive aspects of her work. Dr. Harrison adds that Respondent would seemingly benefit from stress management services, and she may wish to seek additional testing for memory concerns. Dr. Harrison

adds that Respondent voluntarily submitted a specimen for a drug screen on April 4, 2012, which resulted negative.

10. The Board finds that there exists serious risks to public health and safety as a result of impaired nursing care due to intemperate use of controlled substances or chemical dependency.

11. Formal Charges were filed on January 4, 2012.

12. Formal Charges were mailed to Respondent on January 5, 2012.

## 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 800152, heretofore issued to JAYME LYN FARRIS, including revocation of Respondent's license(s) to practice nursing in the State of Texas.

## ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that RESPONDENT SHALL receive the sanction of WARNING WITH STIPULATIONS, and RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.1 *et seq.* and this Order.

IT IS FURTHER AGREED and ORDERED that, while under the terms of this Order, this Order SHALL apply to any and all future licenses issued to Respondent to practice nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable

to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that while Respondent's license(s) is/are encumbered by this Order, Respondent may not work outside the State of Texas pursuant to a nurse licensure compact privilege without the written permission of the Texas Board of Nursing and the Board of Nursing in the party state where Respondent wishes to work.

IT IS FURTHER AGREED that:

(1) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in Texas nursing jurisprudence and ethics. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include nurses. It 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. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.texas.gov/disciplinaryaction/stipscourses.html.*

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully

complete a course in medication administration. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include Nurses. The didactic portion of this course shall be a minimum of six (6) hours in length. The course shall contain a minimum twenty-four (24) hour clinical component which is to be provided by the same Registered Nurse who provides the didactic portion of this course. The clinical component SHALL focus on tasks of medication administration only. In order for the course to be approved, the course's content shall include: a review of proper administration procedures for all standard routes; computation of drug dosages; the five (5) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper administration. The course description shall 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 clinical portions of the course to satisfy this stipulation. RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form, provided by the Board, to the office of the Board to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.texas.gov/disciplinaryaction/stipscourses.html.*

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing documentation. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home

study courses and video programs will not be approved. The course shall be a minimum of six (6) hours in length of classroom time. In order for the course to be approved, the target audience shall include Nurses. The course shall include content on the following: nursing standards related to accurate and complete documentation; legal guidelines for recording; methods and processes of recording; methods of alternative record-keeping; and computerized documentation. RESPONDENT SHALL cause the instructor to submit a Verification of Course Completion form, provided by the Board, to the Board's office to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.texas.gov/disciplinaryaction/stipscourses.html.*

(4) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the course "Sharpening Critical Thinking Skills," a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension. In order to receive credit for completion of this program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.texas.gov/disciplinaryaction/stipscourses.html.*

**IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF**

SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR ONE (1) YEAR(S) OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWELVE (12) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) OR A VOCATIONAL NURSE (LVN) LICENSE, AS APPROPRIATE, WILL NOT APPLY TO THIS STIPULATION PERIOD:

(5) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the stipulations on RESPONDENT'S license(s). RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each present employer within five (5) days of receipt of this Order. RESPONDENT SHALL notify all future employers in nursing of this Order of the Board and the stipulations on RESPONDENT'S license(s). RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each future employer prior to accepting an offer of employment.

(6) RESPONDENT SHALL CAUSE each present employer in nursing to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within five (5) days of employment as a nurse.

(7) RESPONDENT SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse, who is on the premises. The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to

provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years experience in the same or similar practice setting to which the Respondent is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(8) RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month period for one (1) year(s) of employment as a nurse.

(9) RESPONDENT SHALL abstain from the consumption of alcohol, Nubain, Stadol, Dalgan, Ultram, or other synthetic opiates, and/or the use of controlled substances, except as prescribed by a licensed practitioner for a legitimate purpose. If prescribed, RESPONDENT SHALL CAUSE the licensed practitioner to submit a written report identifying the medication, dosage and the date the medication was prescribed. The report shall be submitted directly to the office of the Board by the prescribing practitioner, within ten (10) days of the date of the prescription. **In the event that prescriptions for controlled substances are required for periods of two (2) weeks or longer, the Board may require and RESPONDENT SHALL submit to a pain management and/or chemical dependency evaluation by a Board approved evaluator. The performing evaluator must submit a written report meeting the Board's requirements to the Board's office within thirty (30) days from the Board's request.**

(10) RESPONDENT SHALL submit to random periodic screens for controlled substances, tramadol hydrochloride (Ultram), and alcohol. For the first three (3) month period,

random screens shall be performed at least once per week. For the next three (3) month period, random screens shall be performed at least twice per month. For the next six (6) month period, random screens shall be performed at least once per month. All random screens SHALL BE conducted through urinalysis. Screens obtained through urinalysis are the sole method accepted by the Board.

Specimens shall be screened for at least the following substances:

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|---|---|
| Amphetamines | Meperidine |
| Barbiturates | Methadone |
| Benzodiazepines | Methaqualone |
| Cannabinoids | Opiates |
| Cocaine | Phencyclidine |
| Ethanol | Propoxyphene |
| tramadol hydrochloride (Ultram) | |

A Board representative may appear at the RESPONDENT'S place of employment at any time during the stipulation period and require RESPONDENT to produce a specimen for screening.

All screens shall be properly monitored and produced in accordance with the Board's policy on Random Drug Testing. A complete chain of custody shall be maintained for each specimen obtained and analyzed. RESPONDENT SHALL be responsible for the costs of all random drug screening during the stipulation period.

Any positive result for which the nurse does not have a valid prescription or failure to report for a drug screen, which may be considered the same as a positive result, will be regarded as non-compliance with the terms of this Order and may subject the nurse to further disciplinary action including EMERGENCY SUSPENSION pursuant to Section 301.4551, Texas Occupations Code, or REVOCATION of Respondent's license(s) and nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S license(s) to practice nursing in the State of Texas and RESPONDENT shall be eligible for nurse licensure compact privileges, if any.

## RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. I waive representation by counsel. 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 Findings of Fact, Conclusions of Law, 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 Board. When this Order is ratified, the terms of this Order become effective, and a copy will be mailed to me. 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 revocation of my license(s) to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 13 day of August 2012

Jayme Lyn Farris

JAYME LYN FARRIS, RESPONDENT

Sworn to and subscribed before me this 13 day of August, 2012.

SEAL

KARI TAYLOR
Notary Public, State of Texas
My Commission Expires
March 13, 2013

Kari Taylor

Notary Public in and for the State of Texas

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 13th day of August, 2012, by JAYME LYN FARRIS, Registered Nurse License Number 800152, and said Order is final.

Effective this 11th day of September, 2012.

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

LOUISIANA STATE BOARD OF NURSING
BATON ROUGE, LOUISIANA

| IN THE MATTER OF: | | |
|---|---|---|
| JAYME REEVES FARRIS | * | FINAL ORDER |
| 265 RACHAL | * | |
| BRIDGE CITY, TX 77611 | * | |
| RESPONDENT | | |

The Louisiana State Board of Nursing, having set a hearing to determine whether cause exists under La. R.S. 37:911, et seq., to revoke or suspend or otherwise discipline the RN license of JAYME REEVES FARRIS ["Respondent"] held said hearing on February 14, 2012, pursuant to applicable Louisiana laws and regulations.

A quorum of the Board was present. Celia Cangelosi, attorney, represented the Board and served as counsel to the President. E. Wade Shows, attorney, served as prosecuting attorney for the Board. Respondent was not present and was not represented by counsel at this hearing.

Testimony and other evidence were received by the Board, and as a result thereof, the Board makes the following findings of fact and conclusion of law.

## FINDINGS OF FACT

### JURISDICTION

1. On July 13, 2010, Respondent was licensed by endorsement to practice as a Registered Nurse in Louisiana.

### PRIOR BOARD ACTION

2. On December 7, 2011, Respondent's license was summarily suspended, as the public health, safety and welfare imperatively required emergency action. The notice of license summary suspension was sent by certified mail, return receipt requested, to Respondent's address of record; the returned receipt was signed but not dated.

### LEGAL FILINGS AND NOTICES

3. On September 21, 2011, a demand letter was sent by certified mail, return receipt requested, to Respondent's address of record; the returned receipt was signed on October 11, 2011.

4. On October 18, 2011, a request was sent to Respondent to attend an informal conference set for October 26, 2011; the returned receipt was signed on October 22, 2011.

5. On October 27, 2011, a demand letter was sent by certified mail, return receipt requested, to Respondent's address of record; the returned receipt was signed on October 31, 2011.

6. On December 7, 2011, along with the notice letter regarding license summary suspension, formal charges were filed; charges and notice of charges and hearing were sent to Respondent's address of record by certified mail, return receipt requested; the returned receipt was signed but not dated.

7. On December 19, 2011, board office received from Respondent the RN license and a Response Form advising that Respondent will not appear at the board hearing on February 14, 2012.

LOUISIANA STATE BOARD OF NURSING
BATON ROUGE, LOUISIANA

| IN THE MATTER OF: | | |
|---|---|---|
| JAYME REEVES FARRIS | * | FINAL ORDER |
| 265 RACHAL | * | |
| BRIDGE CITY, TX 77611 | * | |
| RESPONDENT | | |

CURRENT CHARGES

8. Between June 5, 2011, and July 28, 2011, while employed as a Registered Nurse at West Calcasieu Cameron Parish Hospital in Sulphur, Louisiana, Respondent demonstrated narcotic discrepancies by removing narcotic medications (Ativan, Dilaudid, Morphine) then failing to document waste or otherwise account for the remaining medication not administered; by removing medication earlier than ordered; and by documenting administration of medication prior to removal of the medication. Specifically,

   a. On June 5, 2011, for shift of 1900 (7:00PM) to 0700 (7:00 AM) for Patient # 1 (TS) who had orders for Ativan (Lorazepam) 1 mg IV every 6 hours as needed for anxiety, Respondent:
      - At 2208 removed Lorazepam 2 mg; at 2200 documented administration of Lorazepam 1 mg on the MAR, but failed to waste or otherwise account for the remaining 1 mg.

   b. On June 7, 2011, for shift of 1900 (7:00PM) to 0700 (7:00 AM) for Patient # 2 (MC) who had orders for Ativan (Lorazepam) 1 mg IV every 6 hours as needed for anxiety, Respondent:
      - At 2056 removed Lorazepam 2 mg; at 2200 documented administration of Lorazepam 1 mg on the MAR; but failed to waste or otherwise account for the remaining 1 mg.

   c. On June 19, 2011, for scheduled shift of 1900 (7:00PM) to 0700 (7:00 AM) for Patient # 3 (MM) who had orders for Morphine 2 mg IV every 4 hours as needed for pain, Respondent:
      a. At 0048 removed Morphine 10 mg and at 0145 and at 0545 documented administration of Morphine 2 mg on the MAR, but failed to waste or otherwise account for the remaining 6 mg.

   d. On June 19, 2011, for scheduled shift of 1900 (7:00PM) to 0700 (7:00 AM) for Patient # 4 (EY) who had orders for Ativan (Lorazepam) 0.5 mg to 1 mg IVP every 2 hours as needed for signs and symptoms of anxiety, Respondent:
      - At 2320 removed Lorazepam 2 mg and at 2200 (80 minutes prior to removal) documented the administration of Lorazepam 1 mg on the MAR, but failed to waste or otherwise account for the remaining 1 mg; and
      - At 0039 removed Lorazepam 2 mg and at 0045 documented the administration of Lorazepam 1 mg on the MAR, but failed to waste or otherwise account for the remaining 1 mg.

   e. On June 19, 2011, for scheduled shift of 1900 (7:00PM) to 0700 (7:00 AM) for Patient # 5 (MS) who had orders for Morphine 2 mg IV every 4 hours as needed for pain, Respondent:
      - At 0518 removed Morphine 10 mg and at 0545 documented the administration of Morphine 2 mg on the MAR, but failed to waste or otherwise account for the remaining 8 mg.

   f. On June 27, 2011, for scheduled shift of 1900 (7:00PM) to 0700 (7:00 AM) for Patient # 6 (TC) who had orders for Ativan (Lorazepam) 1 mg IV every 6 hours as needed for agitation, Respondent:

- At 0035 removed Lorazepam 2 mg and at 0040 documented the administration of Lorazepam 1 mg on the MAR, but failed to waste or otherwise account for the remaining 1 mg.

g. On July 12, 2011, for scheduled shift of 1900 (7:00PM) to 0700 (7:00 AM) for Patient # 7 (KA) who had orders for Dilaudid (Hydromorphone 0.5 mg IV every 4 hours as needed for pain, Respondent:
- At 0122 removed Hydromorphone 2 mg and at 0130 documented the administration of Dilaudid 0.5 mg on the MAR, but failed to waste or otherwise account for the remaining 1.5 mg.

h. On July 16, 2011 and July 17, 2011, on the shift from 1900 (7:00PM) to 0700 (7:00 AM) for Patient # 8 (EM) who had orders for Dilaudid (Hydromorphone 1mg IV every 4 hours as needed for pain, Respondent:
July 16, 2011,
- At 2349 removed Hydromorphone 2 mg and at 0000 documented the administration of Hydromorphone 1 mg on the MAR, but failed to waste or otherwise account for the remaining 1 mg; and
- At 0446 removed Hydromorphone 2 mg and at 0500 documented the administration of Hydromorphone 1 mg on the MAR, but failed to waste or otherwise account for the remaining 1 mg.

July 17, 2011,
- At 2028 removed Hydromorphone 2 mg and at 2030 documented the administration of Hydromorphone 1 mg on the MAR, but failed to waste or otherwise account for the remaining 1 mg; and
- At 0039 removed Hydromorphone 2 mg and at 0000 documented the administration of Hydromorphone 1 mg on the MAR, but failed to waste or otherwise account for the remaining 1 mg.

i. On July 17, 2011, for scheduled shift of 1900 (7:00PM) to 0700 (7:00 AM) for Patient # 9 (BY) who had orders for Ativan (Lorazepam) 1 mg IV every 6 hours as needed for anxiety and Morphine 3 mg IVPS every 4 hours as needed for severe pain (or mild/mod pain and NPO), Respondent:
- At 2109 removed Morphine 5 mg and at 2105 documented the administration of Morphine 3 mg on the MAR, but failed to waste or otherwise account for the remaining 2 mg; and
- At 2109 removed Lorazepam 2 mg and at 2130 documented the administration of Lorazepam 1 mg on the MAR, but failed to waste or otherwise account for the remaining 1 mg.

j. On June 27, 2011, for scheduled shift of 1900 (7:00PM) to 0700 (7:00 AM) for Patient # 10 (RS) who had orders for Ativan (Lorazepam) 1 mg PO or IV every 4 hours as needed for anxiety, Respondent:
- At 2202 removed Lorazepam 2 mg and at 2100 (prior to the removal) documented the administration of Lorazepam 1 mg IV on the MAR and at 2203 documented a waste of Lorazepam 1 mg;

LOUISIANA STATE BOARD OF NURSING
BATON ROUGE, LOUISIANA

IN THE MATTER OF:

| | | |
|---|---|---|
| JAYME REEVES FARRIS | * | FINAL ORDER |
| 265 RACHAL | * | |
| BRIDGE CITY, TX 77611 | * | |

RESPONDENT

- At 2319 removed Lorazepam 2 mg (approximately three hours earlier than ordered) and at 0100 documented the administration of Lorazepam 1 mg IV on the MAR, but failed to waste or otherwise account for the remaining 1 mg; and
- At 0612 removed Lorazepam 2 mg and at 0500 (prior to the removal) documented the administration of Lorazepam 1 mg IV on the MAR, but failed to waste or otherwise account for the remaining 1 mg.

9. Between September 21, 2011, and October 27, 2011, Respondent failed to provide written information to the board staff, as requested, regarding the allegation of demonstrating narcotic discrepancies in June 2011 and July 2011, while employed at West Calcasieu Cameron Hospital in Sulphur, Louisiana:
   - On September 21, 2011, letter mailed, certified return receipt requested, to address of record from the Louisiana State Board of Nursing and on October 11, 2011, Respondent signed for receipt of the letter; and
   - On October 27, 2011, letter mailed certified return receipt requested, to address of record from the Louisiana State Board of Nursing and on October 31, 2011, Respondent signed for receipt of the letter.

10. On February 14, 2012, an administrative hearing was held. The Board reviewed documents, evidence and heard testimony.

## CONCLUSIONS OF LAW

1. That pursuant to La. R.S. 37:911, et seq., the Louisiana State Board of Nursing has jurisdiction over this matter.

2. That Respondent was properly notified of the charges and date of hearing.

3. That based on the foregoing Findings of Fact, Respondent did violate La. R.S. 37:921 as follows:
   - Respondent failed to practice nursing in accordance with the legal standards of nursing practice; L.A.C. 46:XLVII.3405 (a);
   - Respondent has demonstrated improper use of drugs, medical supplies or equipment, patient's records, or other items; L.A.C. 46:XLVII.3405 (h); and
   - Respondent demonstrated inappropriate, incomplete or improper documentation; L.A.C. 46:XLVII.3405 (q); and

4. That the evidence presented constitutes sufficient cause pursuant to La. R.S. 37:921 to suspend Respondent's license to practice as a Registered Nurse in Louisiana.

## ORDER

In an open meeting of the Louisiana State Board of Nursing, on **February 14, 2011**, the following Order was rendered:

LOUISIANA STATE BOARD OF NURSING
BATON ROUGE, LOUISIANA

IN THE MATTER OF:
JAYME REEVES FARRIS * FINAL ORDER
265 RACHAL *
BRIDGE CITY, TX 77611 *
RESPONDENT

It is **ORDERED, ADJUDGED, AND DECREED** that the license summary suspension issued by board staff on December 7, 2011, is hereby ratified, the Board finding that the public health and safety required emergency action.

FURTHER, Respondent's license shall remain suspended and Respondent shall have the opportunity to request license reinstatement after completion of the following stipulations, after approval by board staff and after completion of the license reinstatement process:

1. Refrain from working in any capacity as a Registered Nurse. Failure to do so shall cause further disciplinary action and/or criminal charges.
2. Immediately (within 72 hours) inform the Board in writing of any change in address.
3. Submit to comprehensive **outpatient** psychiatric, psychological, and substance abuse evaluation, at Respondent's expense, at a Board-recognized evaluation and treatment center; Shall authorize and cause a written report of the said evaluation to be submitted to the Board; Shall include the entire evaluation report including diagnosis, course of treatment, prescribed or recommended treatment, prognosis, and professional opinion as to Respondent's capability of practicing nursing with reasonable skill and safety to patients.
4. Shall submit all pages of this Order to each evaluator prior to the start of evaluations.
5. Immediately submit to all recommendations thereafter of the therapist, physician, or treatment team, and cause to have submitted evidence of continued compliance with all recommendations by the respective professionals. This stipulation shall continue until the Respondent is fully discharged by the respective professionals and until approved by the Board staff.
6. If the evaluations give any treatment recommendations or findings to warrant concern for patient safety, shall meet with Board or Board staff. Must demonstrate, to the satisfaction of the Board, that Respondent poses no danger to the practice of nursing or to the public and that Respondent can safely and competently perform the duties of a Registered Nurse. If the Board subsequently approved licensure, license shall be issued as suspended with stay of suspension and probation to ensure that patients and the public are protected.
7. If found to be chemically dependent, immediately sign an agreement with the Recovering Nurse Program, and cause to have submitted evidence of compliance with all program requirements for a minimum of 3 years.
8. Submit written evidence of completion of 30 hours of LSBN staff approved continuing education to include the areas of Legal Aspects of Nursing Care, Legal Accountability and Ethical Issues.
9. Submit payment of $ 750.00 to the Board as a fine.
10. Submit payment of $ 600.00 to the Board as cost of this hearing.
11. Failure to comply with the above orders shall result in further disciplinary action.

**Reporting: This will be reported to the Healthcare Integrity and Protection Data Bank (HIPDB) as F2, Unable to Practice Safely by Reason of Alcohol or Other Substance Abuse.**

**HIPDB Narrative: Summary suspension on December 7, 20111, of Respondent's license was approved and license suspension was continued with opportunity to request license reinstatement after RN demonstrated a pattern of controlled medication discrepancies.**

LOUISIANA STATE BOARD OF NURSING
BATON ROUGE, LOUISIANA

| IN THE MATTER OF: | | |
|---|---|---|
| JAYME REEVES FARRIS | * | FINAL ORDER |
| 265 RACHAL | * | |
| BRIDGE CITY, TX 77611 | * | |
| RESPONDENT | | |

A copy of this Final Order shall be served upon the Respondent by certified mail, return receipt requested.

Entered this 17th day of February, 2012.

LOUISIANA STATE BOARD OF NURSING

Barbara L. Morvant

Barbara L. Morvant, MN, RN
Executive Director

# Louisiana State Board of Nursing

17373 Perkins Road
Baton Rouge, LA 70810
Telephone: (225) 755-7500 Fax: (225) 755-7582
www.lsbn.state.la.us

Certified Mail/Return Receipt Requested

December 7, 2011

JAYME REEVES FARRIS
265 RACHAL
BRIDGE CITY, TX 77611

Re: RN # 130247

Dear Ms. Reeves:

It has come to the attention of the Louisiana State Board of Nursing that you, referred to here as "Respondent", have been involved with incidents which could affect patient safety, specifically:

Between June 5, 2011, and July 28, 2011, while employed as a Registered Nurse at West Calcasieu Cameron Parish Hospital in Sulphur, Louisiana, Respondent demonstrated narcotic discrepancies by removing narcotic medications (Ativan, Dilaudid, Morphine) then failing to document waste or otherwise account for the remaining medication not administered; by removing medication earlier than ordered; and by documenting administration of medication prior to removal of the medication. Specifically,

1. On June 5, 2011, for shift of 1900 (7:00PM) to 0700 (7:00 AM) for Patient # 1 (TS) who had orders for Ativan (Lorazepam) 1 mg IV every 6 hours as needed for anxiety, Respondent:
    - At 2208 removed Lorazepam 2 mg; at 2200 documented administration of Lorazepam 1 mg on the MAR, but failed to waste or otherwise account for the remaining 1 mg.

2. On June 7, 2011, for shift of 1900 (7:00PM) to 0700 (7:00 AM) for Patient # 2 (MC) who had orders for Ativan (Lorazepam) 1 mg IV every 6 hours as needed for anxiety, Respondent:
    - At 2056 removed Lorazepam 2 mg; at 2200 documented administration of Lorazepam 1 mg on the MAR; but failed to waste or otherwise account for the remaining 1 mg.

3. On June 19, 2011, for scheduled shift of 1900 (7:00PM) to 0700 (7:00 AM) for Patient # 3 (MM) who had orders for Morphine 2 mg IV every 4 hours as needed for pain, Respondent:
    - At 0048 removed Morphine 10 mg and at 0145 and at 0545 documented administration of Morphine 2 mg on the MAR, but failed to waste or otherwise account for the remaining 6 mg.

4. On June 19, 2011, for scheduled shift of 1900 (7:00PM) to 0700 (7:00 AM) for Patient # 4 (EY) who had orders for Ativan (Lorazepam) 0.5 mg to 1 mg IVP every 2 hours as needed for signs and symptoms of anxiety, Respondent:
   - At 2320 removed Lorazepam 2 mg and at 2200 (80 minutes prior to removal) documented the administration of Lorazepam 1 mg on the MAR, but failed to waste or otherwise account for the remaining 1 mg; and
   - At 0039 removed Lorazepam 2 mg and at 0045 documented the administration of Lorazepam 1 mg on the MAR, but failed to waste or otherwise account for the remaining 1 mg.

5. On June 19, 2011, for scheduled shift of 1900 (7:00PM) to 0700 (7:00 AM) for Patient # 5 (MS) who had orders for Morphine 2 mg IV every 4 hours as needed for pain, Respondent:
   - At 0518 removed Morphine 10 mg and at 0545 documented the administration of Morphine 2 mg on the MAR, but failed to waste or otherwise account for the remaining 8 mg.

6. On June 27, 2011, for scheduled shift of 1900 (7:00PM) to 0700 (7:00 AM) for Patient # 6 (TC) who had orders for Ativan (Lorazepam) 1 mg IV every 6 hours as needed for agitation, Respondent:
   - At 0035 removed Lorazepam 2 mg and at 0040 documented the administration of Lorazepam 1 mg on the MAR, but failed to waste or otherwise account for the remaining 1 mg.

7. On July 12, 2011, for scheduled shift of 1900 (7:00PM) to 0700 (7:00 AM) for Patient # 7 (KA) who had orders for Dilaudid (Hydromorphone 0.5 mg IV every 4 hours as needed for pain, Respondent:
   - At 0122 removed Hydromorphone 2 mg and at 0130 documented the administration of Morphine 0.5 mg on the MAR, but failed to waste or otherwise account for the remaining 1.5 mg.

8. On July 16, 2011 and July 17, 2011, on the shift from 1900 (7:00PM) to 0700 (7:00 AM) for Patient # 8 (EM) who had orders for Dilaudid (Hydromorphone 1 mg IV every 4 hours as needed for pain, Respondent:

   July 16, 2011,
   - At 2349 removed Hydromorphone 2 mg and at 0000 documented the administration of Hydromorphone 1 mg on the MAR, but failed to waste or otherwise account for the remaining 1 mg; and
   - At 0446 removed Hydromorphone 2 mg and at 0500 documented the administration of Hydromorphone 1 mg on the MAR, but failed to waste or otherwise account for the remaining 1 mg.

   July 17, 2011,
   - At 2028 removed Hydromorphone 2 mg and at 2030 documented the administration of Hydromorphone 1 mg on the MAR, but failed to waste or otherwise account for the remaining 1 mg; and
   - At 0039 removed Hydromorphone 2 mg and at 0000 documented the administration of Hydromorphone 1 mg on the MAR, but failed to waste or otherwise account for the remaining 1 mg.

9. On July 17, 2011, for scheduled shift of 1900 (7:00PM) to 0700 (7:00 AM) for Patient # 9 (BY) who had orders for Ativan (Lorazepam) 1 mg IV every 6 hours as needed for anxiety and Morphine 3 mg IVPS every 4 hours as needed for severe pain (or mild/mod pain and NPO), Respondent:
    - At 2109 removed Morphine 5 mg and at 2105 documented the administration of Morphine 3 mg on the MAR, but failed to waste or otherwise account for the remaining 2 mg; and
    - At 2109 removed Lorazepam 2 mg and at 2130 documented the administration of Lorazepam 1 mg on the MAR, but failed to waste or otherwise account for the remaining 1 mg.

10. On June 27, 2011, for scheduled shift of 1900 (7:00PM) to 0700 (7:00 AM) for Patient # 10 (RS) who had orders for Ativan (Lorazepam) 1 mg PO or IV every 4 hours as needed for anxiety, Respondent:
    - At 2202 removed Lorazepam 2 mg and at 2100 (prior to the removal) documented the administration of Lorazepam 1 mg IV on the MAR and at 2203 documented a waste of Lorazepam 1 mg;
    - At 2319 removed Lorazepam 2 mg (approximately three hours earlier than ordered) and at 0100 documented the administration of Lorazepam 1 mg IV on the MAR, but failed to waste or otherwise account for the remaining 1 mg; and
    - At 0612 removed Lorazepam 2 mg and at 0500 (prior to the removal) documented the administration of Lorazepam 1 mg IV on the MAR, but failed to waste or otherwise account for the remaining 1 mg.

11. Between September 21, 2011, and October 27, 2011, Respondent failed to provide written information to the board staff, as requested, regarding the allegation of demonstrating narcotic discrepancies in June 2011 and July 2011, while employed at West Calcasieu Cameron Hospital in Sulphur, Louisiana:
    - On September 21, 2011, letter mailed, certified return receipt requested, to address of record from the Louisiana State Board of Nursing and on October 11, 2011, Respondent signed for receipt of the letter; and
    - On October 27, 2011, letter mailed certified return receipt requested, to address of record from the Louisiana State Board of Nursing and on October 31, 2011, Respondent signed for receipt of the letter.

Grounds for disciplinary proceedings against a Registered Nurse are specified in La. R.S. 37:921 and authorizes the Board to probate, limit, restrict or revoke any license issued to Respondent on any of the following grounds:

- Respondent is unfit or incompetent by reason of negligence, habit, or other cause; La. R.S. 37:921(3);
- Respondent failed to practice nursing in accordance with the legal standards of nursing practice; L.A.C. 46:XLVII.3405 (a);
- Respondent has demonstrated improper use of drugs, medical supplies or equipment, patient's records, or other items; L.A.C. 46:XLVII.3405 (h);
- Respondent demonstrated inappropriate, incomplete or improper documentation; L.A.C. 46:XLVII.3405 (q); and
- Respondent failed to cooperate with the board by :not furnishing in writing a full and complete explanation covering a matter requested by the board.