

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of
Registered Nurse License Number 742553
issued to ASHLEE NICOLE JACOBS

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AGREED ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of ASHLEE NICOLE JACOBS, Registered Nurse License Number 742553, 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)(10)&(13), 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 September 12, 2018.

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 Texarkana Community College, Texarkana, Texas, on May 11, 2007. Respondent was licensed to practice professional nursing in the State of Texas on June 19, 2007.
5. Respondent's nursing employment history includes:

6/2007 – 02/2008

Staff Nurse

Christus St. Michael's
Texarkana, Texas

Respondent's nursing employment history continued:

03/2008 – 10/2008	Unknown	
11/2008 – 07/2015	Registered Nurse	Christus St. Elizabeth Beaumont, Texas
08/2015 – 03/2018	Registered Nurse	Baptist Hospital of Southeast Beaumont, Texas
04/2018 - Present	Unknown	

6. At the time of the initial incident, Respondent was employed as a Registered Nurse with Baptist Hospital of Southeast Texas, Beaumont, Texas, and had been in that position for two (2) years and seven (7) months
7. On or about February 27, 2018, while employed as a Registered Nurse with Baptist Hospital of Southeast Texas, Beaumont, Texas, Respondent falsely documented at 10PM that another nurse completed the focused assessment and triage of Patient 4018896 earlier that morning, when Respondent was assigned to triage the patient. Respondent's conduct resulted in an inaccurate, incomplete medical record, and was likely to injure the patient in the that subsequent care givers would rely on her documentation in order to provide further patient care.
8. On or about February 27, 2018, while employed as a Registered Nurse with Baptist Hospital of Southeast Texas, Beaumont, Texas, Respondent failed to properly assess, intervene and failed to notify her supervisors when Patient 4018896 presented to the Emergency Department (ED) with low blood pressure, tachycardia, dizziness and seeing spots, symptoms of insufficient blood flow. Instead, she placed the patient in a minor care room. Respondent failed to document the patient's history of severe, late-stage alcoholism, his state of being unkempt, and his jaundice (yellow skin), a symptom of liver problems that occur as a complication of late-stage alcoholism. Shortly after coming to the ED, the patient began to repeatedly vomit blood, a hallmark symptom of varices in alcoholic patients, which has a high risk for death especially without treatment; it continued throughout the afternoon, the patient was subsequently diagnosed with gastrointestinal hemorrhage, and transferred to the Intensive Care Unit (ICU). Respondent's conduct resulted in an inaccurate, incomplete medical record, and may have contributed to the delay of the start of medical treatment required to prevent complications, and likely contributed to patient injury and suffering from gastrointestinal hemorrhage with risk for death.

9. On or about November 08, 2015, while employed as a Registered Nurse with Baptist Hospital of Southeast Texas, Beaumont, Texas, and providing care for Patient 3191577 in the Emergency Department (ED), Respondent: failed to document the patient's open wound on this right hand and index finger, the neurovascular assessment distal to the injury caused by a crushing injury, failed to document wound care the temperature of the patient between 7:42PM, when she assumed care of the patient, through 10:34PM, when the patient left the Emergency Department (ED) for surgery, and the remaining vital signs during this time period, except at 9:41PM. Respondent's conduct resulted in an inaccurate, incomplete medical record, and was likely to injure the patient in the that subsequent care givers would rely on her documentation in order to provide further patient care, and Respondent's conduct was likely to injure the patient from possible complications of a laceration and crush injury to the hand, including risk of infection, and possible loss of limb.
10. On or about December 25, 2015, while employed as a Registered Nurse with Baptist Hospital of Southeast Texas, Beaumont, Texas, Respondent failed to document the vital signs of Patient 3214827, an elderly patient with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) exacerbation, and pneumonia, from 5:44PM, when she assumed care of the patient, through 10:11PM, when patient was transferred from the Emergency Department (ED), to the Intensive Care Unit (ICU). Respondent's conduct resulted in an inaccurate, incomplete medical record, and was likely to injure the patient in that subsequent care givers would rely on her documentation in order to provide further patient care, and Respondent's conduct was likely to injure the patient from possible complications of lung disease and pneumonia, including acute respiratory distress, cardiac arrest, and possible death.
11. On or about February 26, 2016, while employed as a Registered Nurse with Baptist Hospital of Southeast Texas, Beaumont, Texas, Respondent failed to document that she provided care, including an initial assessment, for Patient 3247059, who presented to the Emergency Department with complaints of vomiting blood. Instead, Respondent reported to the oncoming nurse that she had not seen the patient. Subsequently, the initial nursing assessment for Patient 3247059 was not documented until after the night shift nurse assumed care of the patient. Respondent's conduct resulted in an inaccurate, incomplete medical record, and was likely to injure the patient in the that subsequent care givers would rely on her documentation in order to provide further patient care, and Respondent's conduct was likely to injure the patient from delayed onset of medical care for treatment of a medical condition.

12. On or about January 13, 2018, through January 14, 2018, while employed as a Registered Nurse with Baptist Hospital of Southeast Texas, Beaumont, Texas, Respondent failed to document the triage assessment of Patient 3798907, who presented to the Emergency Department (ED) for burns and smoke inhalation, until the morning after the patient was transferred to another facility for treatment of his burns and respiratory problems caused by smoke inhalation. Additionally, Respondent failed to document upper lobe lung sounds for the patient. Consequently, the medical record that accompanied Patient 3798907 to the receiving facility was incomplete. Respondent's conduct resulted in an inaccurate, incomplete medical record, and was likely to injure the patient in the that subsequent care givers would rely on her documentation in order to provide further patient care.
13. In response to the incident in Finding of Fact Number Seven (7), Respondent admits she documented, around 10pm the day of the incident, that her coworker did the triage for the patient in this incident; she admits that this was wrong and takes responsibility. In response to the incident in Finding of Fact Number Eight (8), Respondent denies that she triaged the patient, she reports she did not log out of the computer when she left the nursing station in triage at the time of the incident, so that the documentation of the triage is electronically in her name. In response to the incident in Finding of Fact Number Nine (9), Respondent reports that she documented on the patient's right index finger at 8:15PM, and that the vital signs were documented at 7:41PM and 9:41PM, before the patient left for surgery at 10:37PM. In response to the incident in Finding of Fact Number Ten (10), Respondent reports that the initial vital signs were done at 5:44PM, that vital signs were not due again unless there was a change in condition, and that she gave report at 6:47PM to the oncoming nurse. In response to the incident in Finding of Fact Number Eleven (11), Respondent reports she did not take care of this patient. She states the patient was triaged at 8:53PM by another nurse, long after Respondent was gone. In response to the incident in Finding of Fact Number Twelve (12), Respondent reports that the patient left at shift change, and she completed her documentation and faxed it to the receiving facility before she left work.

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 to prove violations of 22 TEX. ADMIN. CODE §217.11(1)(A),(1)(B),(1)(C),(1)(D),(1)(M),(1)(P)&(3)(A) and 22 TEX. ADMIN. CODE 217.12(1)(A),(1)(B),(1)(C),(4),(6)(A)&(6)(H).
4. The evidence received is sufficient cause pursuant to Section 301.452(b)(10)&(13), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 742553, heretofore issued to ASHLEE NICOLE JACOBS.

5. 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 **REPRIMAND WITH STIPULATIONS** in accordance with the terms of this Order.

- A. This Order SHALL apply to any and all future licenses issued to RESPONDENT to practice nursing in the State of Texas.
- B. This Order SHALL be applicable to RESPONDENT'S nurse licensure compact privileges, if any, to practice nursing in the State of Texas.
- C. As a result of this Order, RESPONDENT'S license(s) will be designated "single state" and RESPONDENT may not work outside the State of Texas in another nurse licensure compact party state.

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. UNDERSTANDING BOARD ORDERS

Within thirty (30) days of entry of this Order, RESPONDENT must successfully complete the Board's online course, "Understanding Board Orders", which can be accessed on the Board's website from the "Discipline & Complaints" drop-down menu or directly at: <http://www.bon.texas.gov/UnderstandingBoardOrders/index.asp>. Upon successful

completion, RESPONDENT must submit the course verification at the conclusion of the course, which automatically transmits the verification to the Board.

IV. **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. **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.
- B. **A Board-approved course in physical assessment** with a didactic portion of not less than six (6) hours and a clinical component of not less than twenty-four (24) hours. Both the didactic and clinical components must be provided by the same Registered Nurse. The course's content shall include physical assessment of all body systems. The clinical component SHALL include physical assessment of live patients in a clinical setting; Performing assessments on mock patients or mannequins WILL NOT be accepted. 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. Successful completion of this course requires RESPONDENT to successfully complete both the didactic and clinical portions of the course.
- C. **A Board-approved course in nursing documentation** that shall be a minimum of six (6) hours in length. The course's content shall include: 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. Home study courses and video programs will not be approved.

- D. **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/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.*

V. EMPLOYMENT REQUIREMENTS

In order to complete the terms of this Order, RESPONDENT must work as a nurse in the State of Texas, providing direct patient care in a clinical healthcare setting, for a minimum of sixty-four (64) hours per month for eight (8) quarterly periods [two (2) years] of employment. This requirement will not be satisfied until eight (8) quarterly periods of employment as a nurse 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 period and will not count towards completion of this requirement.

- A. **Notifying Present and Future Employers:** 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.
- B. **Notification of Employment Forms:** RESPONDENT SHALL CAUSE each present employer in nursing to submit the Board's "Notification of Employment" form to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Board's "Notification of Employment form" to the Board's office within five (5) days of employment as a nurse.

- C. **Direct Supervision:** For the first year [four (4) quarters] of employment as a Nurse under this order, RESPONDENT SHALL be directly 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. Direct supervision requires another nurse, as applicable, to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on 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.
- D. **Indirect Supervision:** For the remainder of the stipulation/probation period, 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.
- E. **Nursing Performance Evaluations:** 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 individual who supervises the RESPONDENT and these reports shall be submitted by the supervising individual to the office of the Board at the end of each three (3) month quarterly period for eight (8) quarters [two (2) years] of employment as a nurse.

VI. RESTORATION OF UNENCUMBERED LICENSE(S)

Upon full compliance with the terms of this Agreed Order, all encumbrances will be removed from RESPONDENT'S license(s) to practice nursing in the State of Texas and, subject to meeting all existing eligibility requirements in Texas Occupations Code

Chapter 304, Article III, RESPONDENT may be eligible for nurse licensure compact privileges if any.

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RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this 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 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 26 day of February, 2019.

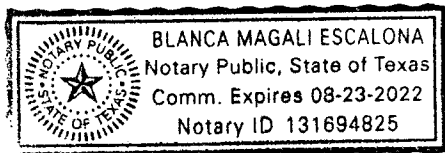
Ashlee Nicole Jacobs
ASHLEE NICOLE JACOBS, Respondent

Sworn to and subscribed before me this 26 day of February, 2019.

SEAL

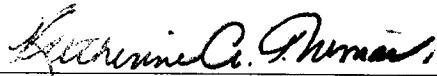
Blanca Magali Escalona

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 26th day of February, 2019, by ASHLEE NICOLE JACOBS, Registered Nurse License Number 742553, and said Agreed Order is final.

Effective this 25th day of April, 2019.

A handwritten signature in cursive script, reading "Katherine A. Thomas".

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