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

BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of Registered Nurse License Number 762299 issued to JAE SUNG CHO	§ § §	AGREED ORDER FOR KSTAR PILOT PROGRAM

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of JAE SUNG CHO, Registered Nurse License Number 762299, 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 Order approved by Katherine A. Thomas, MN, RN, FAAN, Executive Director, on January 22, 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 Order.

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

4. Respondent received a Baccalaureate Degree in Nursing from Texas Houston Community College, Houston, Texas, on September 26, 2008. Respondent was licensed to practice professional nursing in the State of Texas on November 4, 2008.

5. Respondent's nursing employment history includes:

01/2009- Present	RN	Triumph LTAC Hospital Sugarland, Texas

Respondent's nursing employment history continued:

07/2009- 03/2017	RN	North Cypress Medical Center Houston, Texas
08/2017- Present	RN	Memorial Hermann Hospital Cypress Cypress, Texas

7. At the time of the initial incident, Respondent was employed as a Registered Nurse with North Cypress Medical Center, Houston, Texas, and had been in that position for six (6) years and five (5) months.

8. On or about December 12, 2015 while employed in the Emergency Department at North Cypress Medical Center, Cypress, Texas, Respondent inappropriately turned off the cardiac monitor for Patient Number V1340349, a patient whose heart rate was abnormally low and ranging from the 30's-40's. Respondent's conduct was likely to harm the patient from possible demise due to undetected changes in heart rate and/or cardiac arrest.

9. On or about January 14, 2016 while employed in the Emergency Department at North Cypress Medical Center, Cypress, Texas, Respondent failed to clarify an order from the physician to administer an excessive dose of 50mg of Pheregan intravenous push (IVP) to Patient Number V1354476. As a result, Respondent administered the Phenergan 50mg IVP to the patient instead of Fentanyl 50mcg IVP, as ordered. The normal dose of Pherergan for adults is 25mg. Respondent's conduct was likely to injure the patient from adverse effects of medication administered in error, including irregular heart rate, cardiac arrest, and/or respiration depression.

10. On or about January 31, 2016, while employed as a Staff Nurse in the Emergency Department with North Cypress Medical Center, Cypress, Texas, Respondent inappropriately discharged Patient Number V1362069 without having the physician re-evaluate the patient's abnormal elevated temperature of 102.9F. Instead Respondent placed the information on the communication board where the physician did not see it until two (2) hours after patient was discharged. Subsequently, the patient was called back and admitted to the facility. Respondent's conduct was likely to injure the patient from untreated disease processes.

11. On March 10, 2016, through March 12, 2017, while employed as a Staff Nurse in the Medical-Surgical Unit with North Cypress Medical Center, Cypress, Texas, Respondent failed to timely administer medications and, instead, inappropriately and repeatedly left oral and injectable medications, including insulin, inside the room of Patient Number V1354476 and later returned to administer them. Respondent's conduct may have harmed the patient because of non-efficacious results in regulating the patient's diabetic condition, therefore causing the patient's blood sugar level to fluctuate, becoming too high or too low, and placed others at risk by leaving a high risk medication unsupervised.

12. In response to the incidents in Findings of Fact Numbers Eight (8) through Eleven (11), Respondent admits to turning off the cardiac monitor on Patient Number V1340349 because his focus was on isolating patient stressors and providing comfort and, since the patient stated he/she was unable to rest with the cardiac monitor alarms sounding, he turned them off. Respondent further states that, regarding Finding of Fact Number Nine (9), he misunderstood a verbal order given by the physician to administer Fentanyl 50 mcg and administered Phenergan 50mg IVP (intravenous push). Respondent states he repeated back the verbal order of Phenergan 50mg prior to going into the medication room. With response to Finding of Fact Number Ten (10), Respondent states the patient was discharged from ER after he confirmed discharge orders had been noted on communication board (where MD to RN, RN to RN, and RN to tech communication takes place). When he noted the elevated temperature, Respondent states he placed the information on the communication board for the physician to review. When there had been no response from the physician after a period of time, he went ahead and discharged the patient. However, Respondent states he realizes that he should not just rely on the computer communication board. Finally, in response to the incident in Finding of Fact Number Eleven (11), Respondent admits leaving medication for the patient unattended on top of a closet where the TV was located and acknowledges that medication should never be left in patient room unattended.

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 violation(s) of 22 TEX. ADMIN. CODE §217.11(1)(A),(1)(B),(1)(C),(1)(M)&(1)(N) and 22 TEX. ADMIN. CODE §217.12(1)(A),(1)(B)&(4).

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 762299, heretofore issued to JAE SUNG CHO.

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 **WARNING 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 Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §§211.1 *et seq*., and this Order.

III. KNOWLEDGE, SKILLS, TRAINING, ASSESSMENT AND RESEARCH (KSTAR) PILOT PROGRAM

IT IS AGREED and ORDERED that RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the Knowledge, Skills, Training, Assessment and Research (KSTAR) Pilot Program and RESPONDENT SHALL:

(A) Within forty-five (45) days of entry of this Order, apply to and enroll in the KSTAR Pilot Program, including payment of any fees and costs, unless otherwise agreed in writing;

(B) Submit to an individualized assessment designed to evaluate RESPONDENT'S nursing practice competency and to support a targeted remediation plan;

(C) Follow all requirements within the remediation plan, if any;

(D) Successfully complete a Board-approved course in Texas nursing jurisprudence and ethics as part of the KSTAR Pilot Program; and

(E) Provide written documentation of successful completion of the KSTAR Pilot Program to the attention of Monitoring at the Board's office.

IV. FURTHER COMPETENCY ISSUES AND VIOLATIONS

IT IS FURTHER AGREED, SHOULD RESPONDENT'S individualized KSTAR Pilot Program assessment identify further competency issues and violations of the Nursing Practice Act, including inability to practice nursing safely, further disciplinary action, up to and including revocation of Respondent's license(s) to practice nursing in the State of Texas, may be taken based on such results in the assessments.

V. RESTORATION OF UNENCUMBERED LICENSE(S)

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, 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

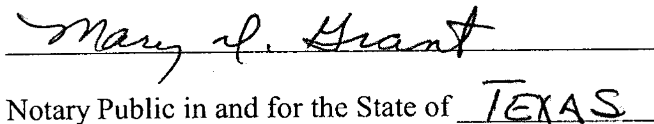
I understand that I have the right to legal counsel prior to signing this Agreed Order. I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violation(s) alleged herein. By my signature on this Order, I agree to the entry of this Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that when this Order becomes final and the terms of this Order become effective, 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 possible revocation of my license(s) to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 24 day of Feb., 2018.

JAE SUNG CHO, Respondent

Sworn to and subscribed before me this 24 day of Feb, 2018.

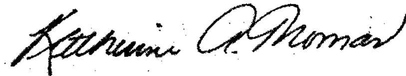
SEAL



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 24th day of February, 2018, by JAE SUNG CHO, Registered Nurse License Number 762299, and said Order is final.

Effective this 19th day of April, 2018.



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