VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE: JENNIFER FU CHANG, R.N.
License No.: 0001-245457

ORDER

Pursuant to §§ 2.2-4020, 54.1-110 and 54.1-2400(11) of the Code of Virginia (1950), as amended ("Code"), a formal administrative hearing was held before a panel of the Board of Nursing ("Board") on January 28, 2015, in Henrico County, Virginia, to inquire into evidence that Jennifer Chang, R.N., may have violated certain laws and regulations governing nursing practice in Virginia. The case was presented by Wendy Deaner, Adjudication Specialist, Administrative Proceedings Division. James Rutkowski, Assistant Attorney General, was present as legal counsel for the Board. Ms. Chang was not present and was not represented by legal counsel. The proceedings were recorded by a certified court reporter.

Upon consideration of the evidence presented, the Board adopted the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. Jennifer Fu Chang, R.N. was issued License No. 0001-245457 to practice professional nursing in the Commonwealth of Virginia on July 2, 2013. Ms. Chang's primary state of residence is Virginia.

2. Based upon the representations of Wendy Deaner, Adjudication Specialist and Commonwealth's Exhibit #1, the Notice of Formal Hearing and Statement of Particulars, Allegation Summary Worksheet and Affidavit of Mailing, the presiding officer ruled that adequate notice was provided to the respondent and the hearing proceeded in her absence.

3. During the course of her employment with Inova Fairfax Hospital, Falls Church, Virginia:

a. On March 16, 2014, when a patient complained of chest pain, Ms. Chang called for a "rapid response." Ms. Chang then left the patient's room and was not present when the rapid response team

arrived to inform them why they had been called. When Ms. Chang's preceptor asked Ms. Chang why she had called for a rapid response she responded "I guess I didn't realize that I wasn't in a simulation lab."

b. Between March 16, 2014 and March 30, 2014, Ms. Chang discontinued a patient's magnesium drip against physician orders and spoke to the patient about contractions and pregnancy but the patient was not pregnant. Ms. Chang indicated to her preceptor that she thought the magnesium drip was causing confusion. Her preceptor described her response as "babbling."

c. Between March 16, 2014 and March 30, 2014, Ms. Chang overheard a charge nurse report that a patient needed Levaquin. Ms. Chang went to the medication room and obtained the Levaquin and attempted to administer it to the patient. Ms. Chang was unable to calculate the medication dosages for the patient with a percutaneous endoscopic gastrostomy (PEG). A fellow nurse stopped Ms. Chang before the medication was administered.

d. Between March 31, 2014 and April 11, 2014, Ms. Chang failed to properly waste a narcotic medication. The patient denied needing the medication and Ms. Chang left the tablet lying on the medicine room counter. When asked about the medication Ms. Chang indicated she thought she had properly disposed of the medication, and her supervisor described her as "vague and unresponsive." She was repeatedly asked to properly return the medication but she failed to complete the task.

4. After being placed on leave on April 16, 2014 and following her termination from Inova Fairfax Hospital, which occurred on May 15, 2014, Ms. Chang reported to the emergency department on May 17, 2014, wearing scrubs and presented her hospital identification badge. Ms. Chang told the triage nurse that she had been sent to help out on the unit and she told the charge nurse that she had come to the emergency department to shadow. While in the emergency department:

a. Ms. Chang incorrectly prepared a patient for an EKG. A staff nurse stopped Ms. Chang and re-applied the leads and performed the EKG.

b. Without physician orders, Ms. Chang removed all monitors from a patient, including the

crash cart monitor and pacer pads, and turned off the monitor. The patient was subsequently transported to a different unit with a different monitor and a defibrillator. When asked by a fellow nurse what she was doing Ms. Chang responded "I thought he was leaving. I thought it was okay."

5. Ms. Chang's employment with Inova Fairfax Hospital was suspended on April 16, 2014, and was terminated on May 15, 2014.

6. Following her placement on leave and her subsequent termination, Ms. Chang repeatedly returned to the hospital and misrepresented her employment status with the hospital to numerous hospital departments. She told a PACU charge nurse that she had been hired in the PACU, which was untrue, and she continued to call her supervisor asking when she could work.

CONCLUSIONS OF LAW

The Board concludes that:

1. Findings of Fact Nos. 3(a) and (b) constitute a violation of § 54.1-3007(2), (5) and (8) of the Code and 18 VAC 90-20-300(A)(2)(f) of the Regulations Governing the Practice of Nursing ("Regulations").

2. Findings of Fact Nos. 3(c) and (d) constitute a violation of §54.1-3007(5) of the Code.

3. Finding of Fact No. 4 constitutes a violation of §54.1-3007(2), (5) and (8) of the Code and 18 VAC 90-20-300(A)(2)(a) and (f) of the Regulations.

ORDER

WHEREFORE, the Virginia Board of Nursing, effective upon entry of this Order, hereby ORDERS as follows:

1. License No. 0001-245457, issued to Jennifer Fu Chang, R.N., to practice professional nursing in the Commonwealth of Virginia is hereby INDEFINITELY SUSPENDED.

2. The license of Ms. Chang will be recorded as SUSPENDED and no longer current. Should Ms. Chang seek reinstatement of her license consistent with this Order, she shall be responsible for any fees that may be required for the reinstatement of her license prior to issuance of her license to resume practice.

3. At such time as Ms. Chang shall petition the Board for reinstatement of her license, an administrative proceeding will be convened to determine whether she is able to return to the safe and competent practice of nursing.

4. This Order shall be applicable to Ms. Chang's multistate licensure privileges, if any, to practice professional nursing.

Pursuant to §§ 2.2-4023 and 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as public record and shall be made available for public inspection or copying on request.

FOR THE BOARD

Elaine Mitchell-Lindsay

for Jay P. Douglas, MSM, RN, CSAC, FRE
Executive Director
Virginia Board of Nursing

Feb. 6, 2015
ENTERED

NOTICE OF RIGHT TO APPEAL

As provided by Rule 2A:2 of the Supreme Court of Virginia, you have 30 days from the date you are served with this Order in which to appeal this decision by filing a Notice of Appeal with Jay P. Douglas, MSM, RN, CSAC, FRE, Executive Director, Board of Nursing, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233. The service date shall be defined as the date you actually received this decision or the date it was mailed to you, whichever occurred first. In the event this decision is served upon you by mail, three days are added to that period.

Certified True Copy
By Graham
Virginia Board Of Nursing