

**VIRGINIA:**

**BEFORE THE BOARD OF NURSING**

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

**NOTICE OF HEARING**

Pursuant to §§ 2.2-4020, 2.2-4024(F), and 54.1-2400(11) of the Code of Virginia (1950), as amended ("Code"), Jennifer Fu Chang, who holds License No. 0001-245457 which is set to expire on May 31, 2016, is hereby given notice that a formal administrative hearing will be held in the presence of a panel of the Board of Nursing. The hearing will be held on January 28, 2015, at 1:00 p.m., at the offices of the Department of Health Professions, Board of Nursing, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia 23233, at which time Ms. Chang will be afforded the opportunity to be heard in person or by counsel.

At the hearing, Ms. Chang has the following rights, among others: the right to representation by counsel; the right to have witnesses subpoenaed and to present witnesses on her behalf; the right to present documentary evidence; and the right to cross-examine adverse witnesses. If Ms. Chang desires any witnesses to appear on her behalf, she must notify the Director of Administrative Proceedings, Department of Health Professions, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in accordance with the Instructions for Requesting Subpoenas.

The purpose of the hearing is to inquire into evidence that Ms. Chang may have violated certain laws and regulations governing nursing practice in Virginia, as more fully set forth in the Statement of Particulars below.

### STATEMENT OF PARTICULARS

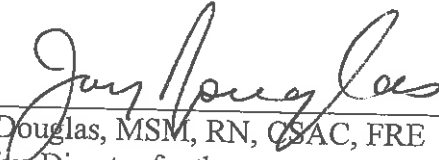
The Board alleges that:

1. Jennifer Fu Chang, R.N., may have violated §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”) in that, during the course of her employment with Inova Fairfax Hospital, Falls Church, Virginia:
  - a. On or about 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.
  - b. Between on or about March 16, 2014 and March 30, 2014, Ms. Chang discontinued a patient’s magnesium drip against physician orders.
2. Ms. Chang may have violated §54.1-3007(5) of the Code in that:
  - a. Between on or about March 16, 2014 and March 30, 2014, when Ms. Chang overheard a charge nurse reporting that a patient needed Levaquin, she 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).
  - b. Between on or about March 16, 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.
3. Ms. Chang may have violated §54.1-3007(2), (5) and (8) of the Code and 18 VAC 90-20-300(A)(2)(a) and (f) of the Regulations in that, following her termination from Inova Fairfax Hospital, which occurred on or about April 28, 2014, on or about May 17, 2014, Ms. Chang reported to the emergency room wearing scrubs and had her identification badge in her pocket. 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.
- 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.

FOR THE BOARD



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

ENTERED: \_\_\_\_\_

December 19<sup>TH</sup>, 2014