BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of Registered Nurse License Number 734309 issued to BENJAMIN KIM	§ § §	AGREED ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board considered the matter of BENJAMIN KIM, Registered Nurse License Number 734309, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Section 301.452(b)(10)&(13), Texas Occupations Code. Respondent waived informal proceedings, notice and hearing, and agreed to the entry of this Order offered on December 2, 2011, 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 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 a Baccalaureate Degree in Nursing from Johns Hopkins University, Baltimore, Maryland, on May 25, 2006. Respondent was licensed to practice professional nursing in the State of Texas on October 3, 2006.

5. Respondent's nursing employment history includes:

6/2006 - 9/2010	Staff Nurse	Seton Family of Hospitals Austin, Texas
10/2010-Present	Unknown	

6. At the time of the initial incident, Respondent was employed as a staff nurse with Seton Family of Hospitals, Austin, Texas, and had been in this position for three (3) years and three (3) months.

7. On or about September 15, 2009, while employed as a Staff Nurse with Seton Family of Hospitals, Austin, Texas, Respondent failed to document completely in the medical record of Patient MR#507553, in that the urine output was not noted between 23:00pm and 02:00am, the procedural area was left blank and there were no narrative notes. Respondent's conduct resulted in an incomplete medical record that subsequent care givers would rely on to provide further patient care.

8. In response to the incident in Finding of Fact Number Seven (7), Respondent states he did fail to document the urine output during the indicated time period, but no harm resulted from this documentation error and that the patient's urine output was carefully monitored.

9. On or about September 15, 2009, while employed as a Staff Nurse with Seton Family of Hospitals, Austin, Texas, Respondent failed to notify the physician when Patient MR#507553, experienced sustained low blood pressure and other abnormal vital signs. Respondent's conduct deprived the physician of essential information to initiate timely medical intervention which may have been required to stabilize the patient.

10. In response to the incident in Finding of Fact Number Nine (9), Respondent states that he was very busy that day treating a very time-intensive patient and there was a lack of adequate nursing coverage that he addressed with his clinical managers during the initial review of this incident.

11. On or about May 24, 2010, while employed as a Staff Nurse with Seton Family of Hospitals, Austin, Texas, Respondent failed to document the correct Intravenous(IV) Catheter Insertion date for Patient MR#5279555. Subsequently, the IV catheter remained in place three (3) days longer than policy allows. Respondent's conduct resulted in an incomplete medical record which subsequent care givers would rely on to provide further patient care and could have placed the patient at risk of developing an infection at the IV site.

12. In response to the incident in Finding of Fact Number Eleven (11), Respondent states there was a transcription error regarding the catheter insertion date, but multiple subsequent care givers should have cross referenced the documentation of the initial IV insertion date and corrected it accordingly.

13. On or about September 13, 2010, while employed as a Staff Nurse with Seton Family of Hospitals, Austin, Texas, and assigned to Patient MR#5334170, Respondent failed to assess the bladder status of Patient MR#5334170, when the patient failed to void during the 12 hour shift. Subsequently, the patient's bladder was scanned by the next shift and 900'cc of urine was drained. Respondent's conduct deprived the patient of timely assessment and detection of retained urine and a full bladder which could have led to further complications of bladder infection and distention.

14. In response to the incident in Finding of Fact Number Thirteen (13), Respondent states the patient's 12 hour overnight urine output was correctly documented and the patient was capable of requesting restroom use at any time.

15. On or about September 13, 2010, while employed as a Staff Nurse with Seton Family of Hospitals, Austin, Texas, Respondent failed to report the lack of urine output, lack of oral intake of fluids, and the elevated heart rate for Patient MR#5334170, to the physician. Respondents conduct deprived the patient of timely medical assessment and medical intervention which might have been required to stabilize the patient.

16. In response to the incident in Finding of Fact Number Fifteen (15), Respondent states the patient was being held for psychiatric issues and waiting for a placement to an appropriate psych facility. Respondent adds that the IV fluids and Foley catheter had been discontinued prior to this date and the patient was restrained with bedside sitter present at all times. Respondent states the patient repeatedly refused food and drink and had been tachycardic for virtually the entire hospital stay, and both these issues had been well-documented and the physician was well aware. Respondent also states the patient was fully capable of requesting drinks and restroom use at any time. Respondent states the physicians were aware of all issues and no condition change had occurred.

17. On or about September 13, 2010, while employed as a Staff Nurse with Seton Family of Hospitals, Austin, Texas, Respondent failed to administer Thorazine to Patient MR#5334170, who was confused and restrained, as ordered by the physician. Instead, Respondent documented the medication was refused by the patient, however, but failed to notify the physician of the patient's refusal of the medication. Respondent's conduct may have resulted in the patient experiencing a non-therapeutic level of medication and non-efficacious treatment, and deprived the physician of essential information which may have been necessary to stabilize the patient.

18. In response to the incident in Finding of Fact Number Seventeen (17), Respondent states the patient refused the medication and the refusal was noted on the MAR by the Respondent.

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 Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.11(1)(B),(1)(C),(1)(D)&(1)(M) and 22 TEX. ADMIN. CODE §217.12(1)(B)&(4).

4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 734309, heretofore issued to BENJAMIN KIM, 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 a LIMITED LICENSE 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 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) While under the terms of this Order, RESPONDENT SHALL NOT provide direct patient care. For the purposes of this Order, direct patient care involves a personal relationship between the Nurse and the client, and includes, but is not limited to: teaching, counseling, assessing the client's needs and strengths, and providing skilled nursing care.

(2) SHOULD RESPONDENT desire to return to a clinical practice setting, which would require her to provide direct patient care, RESPONDENT SHALL petition the Board for such approval.

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RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violations 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 21 day of December, 2011.

BENJAMIN KIM, Respondent

Sworn to and subscribed before me this 21st day of December, 2011.

SEAL

PINKIE D. HENDERSON
Notary Public, State of Texas
My Commission Expires
SEPTEMBER 9, 2015

Notary Public in and for the State of TEXAS

Approved as to form and substance.

Dan Lype, Attorney for Respondent

Signed this 21 day of December, 2011.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 21st day of December, 2011, by BENJAMIN KIM, License Number 734309, and said Order is final.

Effective this 19th day of January, 2012.

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

BOARD OF NURSING STATE OF TEXAS

I certify this to be a true copy of the records on file with the Texas Board of Nursing.
Date: _____
Signed: _____