DOCKET NUMBER 507-17-5489

IN THE MATTER OF	§	**BEFORE THE STATE OFFICE**
PERMANENT LICENSE	§	
NUMBER 832156,	§	**OF**
ISSUED TO	§	
SANGCHEOL CHOI	§	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: SANGCHEOL CHOI
c/o ELIZABETH HIGGINBOTHAM
HIGGINBOTHAM & ASSOCIATES, LLC
1100 NW LOOP 410, SUITE 700
SAN ANTONIO, TX 78213

SUZANNE FORMBY MARSHALL
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on October 25-26, 2018, the Texas Board of Nursing (Board) considered the following items: (1) the Proposal for Decision (PFD) regarding the above cited matter; (2) Staff's recommendation that the Board adopt the PFD; and (3) Respondent's recommendation to the Board regarding the PFD and order, if any.

The Board finds that after proper and timely notice was given, the above styled case was heard by an Administrative Law Judge (ALJ) who made and filed a PFD containing the ALJ's findings of facts and conclusions of law. The PFD was properly served on all parties and all parties were given an opportunity to file exceptions and replies as part of the record herein. Board Staff filed exceptions to the PFD on August 3, 2018.

The Board, after review and due consideration of the PFD; Staff's recommendations; and the recommendations made by the Respondent, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

Recommendation for Sanction

Although the Board is not required to give presumptively binding effect to an ALJ's recommendation regarding sanctions in the same manner as with other findings of fact or

conclusions of law[1], the Board agrees with the ALJ that the most appropriate sanction in this matter is a probated suspension of the Respondent's license for two years, with probationary stipulations, as set out herein[2].

The Board finds that the Respondent's conduct collectively warrants a second tier, sanction level II sanction, for his violations of §301.452(b)(10) and (b)(13). Within a level II sanction, the Board may impose a probated or enforced suspension.

The ALJ noted that the Respondent's moment of panic in this situation was quite serious, and the Board agrees. The Respondent's failure to immediately initiate lifesaving interventions placed the patient at serious risk of harm[3]. The ALJ also noted, however, that the Respondent seems to have learned from this event, in that he was able to perform appropriately in a similar situation in his new work setting[4]. Further, the Respondent has not demonstrated any known deficiencies in his new work setting[5].

After carefully reviewing and considering the aggravating and mitigating factors identified by the ALJ in this case, the Board has determined, pursuant to the Board's Disciplinary Matrix[6] and the Board's rules, including 22 Tex. Admin. Code §213.33, that the most appropriate sanction in this case is a probated suspension for two years.

The Board finds that the stipulations should include the completion of a nursing jurisprudence and ethics course, a critical thinking course, a professional accountability course, and a course in cardiopulmonary resuscitation[7]. Due to the Respondent's positive work history since the event in question, as noted by the ALJ, the Board finds that a lesser level of supervised practice is appropriate for the duration of the order. As such, the Board is requiring indirect supervision for the duration of the order instead of direct supervision for the first year of the order and indirect supervision for the second year of the order. Employer notifications and quarterly employer reports will still be required so that the Board can ensure Respondent is practicing in compliance with the terms of the order and so any patterns of deficient practice may be detected and remediated quickly. These requirements are authorized under 22 Tex. Admin. Code

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[1] Pursuant to Tex. Occ. Code. §301.459 (a-1), although the Administrative Law Judge may make a recommendation regarding an appropriate an action or sanction, the Board has the sole authority and discretion to determine the appropriate action or sanction.

[2] The Board would note that the ALJ has made a recommendation for sanction suggesting in part that the Board did not seek immediate suspension of Respondent's license (presumably under the authority of the Occupations Code §301.455). Staff excepted to this phrasing in the PFD without response to date. The Board is of the opinion that failure to initiate a temporary suspension of a license pursuant to §301.455 should not be considered a mitigation factor for purposes of determining a proper sanction. Notwithstanding, the Board agrees that a probated suspension is appropriate in this matter.

[3] See page 11 of the PFD.

[4] *Id.*

[5] *Id.*

[6] See 22 Tex. Admin. Code §213.33(b).

[7] See **Error! Main Document Only.**22 Tex. Admin. Code §213.33(f), which requires disciplinary orders to include participation in a program of education, including a course in nursing jurisprudence and ethics.

§213.33(e)(6)[8], are supported by the record, and are consistent with the Board's rules and policies.

IT IS THEREFORE ORDERED, subject to ratification by the Texas Board of Nursing, that Registered Nurse License Number 832156, previously issued to SANGCHEOL CHOI, to practice nursing in the State of Texas is/are hereby **SUSPENDED** and said suspension is **STAYED** and RESPONDENT is hereby placed on **PROBATION** for a minimum of two (2) years **AND** until RESPONDENT fulfills the additional requirements 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.

COMPLIANCE WITH LAW

While under the terms of this Order, RESPONDENT shall 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 Order.

UNDERSTANDING BOARD ORDERS

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[7] See **Error! Main Document Only.**22 Tex. Admin. Code 213.33(e)(6), which provides that a probated suspension may include reasonable probationary stipulations, such as the completion of remedial education courses, limitations of nursing activities, periodic Board review, and supervised practice for a period of at least two years.

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.

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. **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.

C. **The course "Professional Accountability,"** a 5.4 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension.

D. **Within sixty (60) days of effective date of this Order, a course in Basic Cardiopulmonary Life Support for Healthcare Providers** that shall be, at a minimum, four (4) hours and thirty (30) minutes in length. The course's content shall include: Adult, Infant, and Child 1- and 2-Rescuer CPR; Adult, Infant, and Child Foreign Body Airway Obstruction for both responsive and unresponsive victims; and Adult Automated External Defibrillation. Home study courses and video programs will not be approved.

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.*

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. **Indirect Supervision:** 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 of 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.

D. **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.

FURTHER COMPLAINTS

If, during the period of probation, an additional allegation, accusation, or petition is reported or filed against RESPONDENT'S license(s), the probationary period shall not expire and shall automatically be extended until the allegation, accusation, or petition has been acted upon by the Board.

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.

Entered this 25th day of October, 2018.

TEXAS BOARD OF NURSING

KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR FOR THE BOARD

Attachment: Proposal for Decision; Docket No. 507-17-5489 (July 18, 2018).

State Office of Administrative Hearings

Lesli G. Ginn
Chief Administrative Law Judge

July 18, 2018

Katherine A. Thomas, M.N., R.N.
Executive Director
Texas Board of Nursing
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701

VIA INTERAGENCY

RE: Docket No. 507-17-5489; TEXAS BOARD OF NURSING v. SANGCHEOL CHOI

Dear Ms. Thomas:

Please find enclosed a Proposal for Decision in this case. It contains my recommendation and underlying rationale.

Exceptions and replies may be filed by any party in accordance with 1 Tex. Admin. Code § 155.507(c), a SOAH rule which may be found at www.soah.texas.gov.

Suzanne Formby Marshall
Administrative Law Judge

SFM/et
Enclosures

xc: John Vanderford, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA INTERAGENCY**
Kathy A. Hoffman, Legal Assistant Supervisor, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 (with 1 CD; Certified Evidentiary Record) – **VIA INTERAGENCY**
Elizabeth Higginbotham, Attorney at Law, 1100 NW Loop 410, Suite 700, San Antonio, TX 78213 - **VIA REGULAR MAIL**

SOAH DOCKET NO. 507-17-5489

TEXAS BOARD OF NURSING, **Petitioner**	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
SANGCHEOL CHOI, RN LICENSE NO. 832156, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) seeks to take disciplinary action against the registered nurse (RN) license held by Sangcheol Choi (Respondent) because he allegedly failed to initiate emergency life-saving measures for an unresponsive patient (Patient). The Administrative Law Judge (ALJ) concludes that Staff met its burden to prove the allegation by a preponderance of the evidence, and recommends that the Board issue a probated suspension of two years to include indirect supervision and quarterly evaluations, as well as continuing nursing education in cardiopulmonary resuscitation (CPR), professional accountability, critical thinking, nursing jurisprudence, and ethics.

I. PROCEDURAL HISTORY, JURISDICTION, AND NOTICE

Neither party contested jurisdiction or notice; therefore, those issues are addressed only in the findings of fact and conclusions of law.

The hearing on the merits convened on May 21, 2018, before ALJ Suzanne Formby Marshall at the State Office of Administrative Hearings (SOAH) facilities in Austin, Texas. Assistant General Counsel John Vanderford represented Staff, and Respondent appeared through his attorney, Elizabeth Higginbotham, but he did not personally attend the hearing. The hearing concluded and the record closed that day.

II. STAFF'S FORMAL CHARGE AND APPLICABLE LAW

Staff charges that on July 27, 2016, while employed as a staff nurse on the Progressive Care Unit (PCU) at North Central Baptist hospital in San Antonio, Texas (the facility), Respondent failed to initiate a "Code Blue" (code) and CPR after finding Patient unresponsive with no pulse.[1] The code and CPR had to be initiated by another nurse. Despite the intervention, Patient died.

Staff asserts that Respondent's conduct violated two provisions of the Nursing Practice Act,[2] as well as a number of subsections of two Board rules,[3] subjecting him to disciplinary action by the Board. With respect to the alleged statutory violations, the Board may discipline a nurse for, among other things, unprofessional conduct[4] or the failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that the Board finds exposes a patient or other person unnecessarily to risk of harm.[5]

With respect to Board Rule 217.12 addressing unprofessional conduct, Staff asserts that Respondent's conduct was unprofessional as defined by three subsections:

- **Board Rule 217.12(1)(A)**: Carelessly failing, repeatedly failing, or exhibiting an inability to perform nursing in conformity with the standards of minimum acceptable level of nursing practice set out in Board Rule 217.11;

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[1] Although the term "Code Blue" was not defined by the parties, its definition can be found in the Code Blue Response Policy and Procedure of the Baptist Health System, admitted into evidence as Staff exhibit 7. A Code Blue is an emergency code/alert indicating an actual or potential cardiopulmonary emergency has been identified. Staff Ex. 7 at 2.

[2] Tex. Occ. Code (Code) ch. 301.

[3] Board Rules 217.11 and 217.12. Board Rule 217.12 was revised effective February 25, 2018. This Proposal for Decision cites to the rule in effect in November 2016, when the alleged conduct occurred. For ease of reference, the Board's rules, found in title 22, part 11, chapters 211 to 228 of the Texas Administrative Code (TAC), shall be referred to as "Board Rule ____."

[4] Code § 301.452(b)(10) prohibits unprofessional conduct in the practice of nursing that is likely to deceive, defraud, or injure a patient or the public.

[5] Code § 301.452(b)(13).

- **Board Rule 217.12(1)(B)**: Carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings; and

- **Board Rule 217.12(4)**: Careless or repetitive conduct that may endanger a client's life, health, or safety. Actual injury to a client need not be established.

Board Rule 217.11 discusses minimum acceptable standards of nursing practice, four subsections of which Staff alleged were not met by Respondent:

- **Board Rule 217.11(1)(A)**: Nurses must know and conform to the Texas Nursing Practice Act, the Board's rules and regulations, and federal, state, or local laws, rules, or regulations affecting the nurse's current area of nursing practice;

- **Board Rule 217.11(1)(B)**: Nurses must implement measures to promote a safe environment for clients and others; and

- **Board Rule 217.11(1)(M)**: Nurses must institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications.

- **Board Rule 217.11(3)(A)**: Nurses must utilize a systematic approach to provide individualized, goal-directed, nursing care.[6]

Board Rule 213.33 sets out a disciplinary matrix (Matrix) that is intended to match the severity of the sanction imposed to the nature of the violation at issue, taking into account mitigating and aggravating factors.[7] The Matrix classifies offenses by tier and sanction level, and must be consulted by the ALJ and the Board in determining the appropriate sanction.

For purposes of the hearing on the merits, Staff must prove its allegations by a preponderance of the evidence.[8]

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[6] Staff's Formal Charges did not identify which subsections of Board Rule 217.11(3)(A) Respondent allegedly violated. However, the ALJ concludes that only subsection (iv) is relevant to the facts of this case: (iv) implementing nursing care.

[7] 22 TAC § 213.33; *see also* Code § 301.4531 (requiring the Board to adopt a schedule of sanctions).

[8] 1 TAC § 155.427.

III. DISCUSSION

Staff offered into evidence exhibits 1-11, which were admitted without objection. Additionally, Staff presented the testimony from two witnesses who were at the facility at the time of the incident, Chantal Hill and Lauren Contreras, both of whom are registered nurses, and a nursing practice consultant for the Board, Kristen Sinay, MSN, RN. Respondent introduced one exhibit that was admitted into evidence but did not call any witnesses.

A. Evidence

1. Background

Patient was admitted to the facility on July 20, 2016, after a referral from the nursing home in which he resided. His diagnosis upon admission to the facility included methicillin-resistant Staphylococcus aureus (MRSA), sepsis,[9] acute renal failure, multiple myeloma, pancytopenia,[10] and clostridium.[11] Although palliative care had been recommended by Patient's treating physician, Patient's family had not yet made a decision regarding hospice care. Patient did not have a medical power of attorney or do-not-resuscitate (DNR) order, and his family members had not reached agreement on the life-saving measures to be taken by the medical staff. As a result, Patient was considered to be a "full code" for purposes of CPR.[12] On July 27, 2016, Patient died after the facility's staff was unable to resuscitate him.[13]

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[9] Sepsis is a toxic condition resulting from the spread of bacteria or their toxins from a focus of infection. Merriam-Webster online Medical Dictionary, *https://www.merriam-webster.com/dictionary/sepsis.*

[10] Pancytopenia is an abnormal reduction in the number of erythrocytes, white blood cells, and blood platelets in the blood. Merriam-Webster online Medical Dictionary, *https://www.merriam-webster.com/medical/pancytopenia.*

[11] This is referred to as "C. diff." It is a bacteria that occurs widely in soil and water and sometimes in human and animal intestines and may produce a toxic-causing intestinal illness in people receiving antibiotic therapy. Merriam-Webster online Medical Dictionary, *https://www.merriam-webster.com/dictionary/C.%20diff.*

[12] Staff Ex. 7 at 2.

[13] Staff Ex. 5.

2. Testimony from Chantal Hill, RN

Ms. Hill has been a registered nurse for fifteen years. She worked for the facility for two years, during which time the incident at issue occurred. Ms. Hill worked on the PCU, which she described as a "step down" from the intensive care unit because it did not require one-to-one care. Patients were sent to the PCU from other floors of the facility. On the PCU, each nurse took care of four to five patients.

According to Ms. Hill, she and Respondent were working the night shift on the evening in question.[14] She said that although Respondent regularly worked on the medical/telemetry floor, he was "floated" to PCU for the evening shift. Ms. Hill and Respondent were assigned to different patients on the same side of the unit. As represented by Ms. Hill, Patient required more assistance than other patients.

Ms. Hill testified that she was sitting at the nurse's station, located across from Patient's room, when she saw Respondent go into the room and then quickly run out. Ms. Hill asked Respondent if she could help him, but he told her that he thought he needed to call a code. Ms. Hill said that Respondent looked like a "deer in the headlights," so she immediately went to Patient's room. At no time, she said, did Respondent ask for her help. It also did not look to Ms. Hill as if he were running for a crash cart.

After checking the patient and seeing that he was unresponsive, Ms. Hill started a sternal rub and checked the patient's pulse but was unable to detect one. She said the patient was not breathing. She pressed the code button, located on the wall above the patient's head, and started chest compressions in an attempt to get the patient's heart beating or, as she described it, to "bring him back to life."[15] Ms. Hill testified that CPR needed to be initiated as soon as possible in order to get oxygen circulating in Patient.

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[14] Although Respondent's shift began in the early evening on July 26, 2016, it carried over into the morning of July 27, 2016.

[15] Ms. Hill testified that the code button was placed in the same location in every patient room throughout the hospital.

The code team arrived at the room and assisted in putting leads and IV access on Patient. They relieved Ms. Hill of performing chest compressions, and a doctor arrived to give orders. Ms. Hill said that she was in the room for most of the code, but Respondent was not there when the code team arrived. She was unable to say how long Respondent was gone. When Respondent came into the room, he was unable to answer the doctor's questions about the patient's condition, making it necessary to bring a portable computer into the room in order to access Patient's medical information. Ms. Hill testified that the questions asked of Respondent were ones that he, as Patient's assigned nurse, should have been able to answer. Patient was considered a "full code," meaning that all measures were taken to try to save his life.

Ms. Hill described the process used by the nurses to exchange information about patients during shift change. As the nursing night shift arrives to take over care of the patients, they are given a report on their assigned patients by the day nurses for those patients so that the oncoming nurses are made aware of the patients' conditions. This process is referred to as "report." Respondent was advised of his patients' conditions during report. Additionally, when Respondent was "floated" to the PCU, he would have been given an orientation to the unit, either during report or shortly afterward. Darlene Timison was the charge nurse on duty who made the nurse/patient assignments for the evening. Ms. Hill agreed that when a charge nurse made nurse/patient assignments, she or he needed to be aware of the nurse's abilities in determining which patients to assign to that nurse. If Respondent thought he was not qualified to take care of a particular patient, Ms. Hill testified, he should have told the charge nurse so other arrangements could be made.

3. Testimony from Lauren Contreras, RN

Ms. Contreras has been a registered nurse for approximately twenty-six years. She currently works as a nurse surveyor for the Texas Health and Human Services Commission. At the time of the incident involving Respondent, she was the interim director of the telemetry unit at the facility. Respondent worked under her supervision on that unit. She testified that

Respondent had worked on the unit for about six months, and that it was common for nurses from that unit to be "floated" to the PCU or other facility floor as the need arose. She testified that Respondent had worked on the PCU before, and he should have known to contact the charge nurse or house officer if he was uncomfortable assuming care for any patient.

Ms. Contreras testified that Respondent had a three-month orientation period to the telemetry unit, which had to be extended due to the "language barrier." Respondent was telemetry-certified, and he had certifications in CPR and acute coronary life support. As a result, she said, Respondent was competent to initiate and perform CPR. At the time Respondent was floated to the PCU, Ms. Contreras did not have any concerns about Respondent's competency.

Ms. Contreras corroborated Ms. Hill's testimony with respect to the location of code buttons in the facility's patient rooms, and the procedures for calling a code. She discussed the process for initiating CPR on an unresponsive patient. First, the nurse would check to see if the patient was breathing and if there was pulse. If not, the nurse would initiate a code or CPR until someone came to help, at which time, the nurse could leave to obtain a crash cart. She disputed the suggestion that Respondent ran out of the room in order to get the crash cart, noting that every second counts, and a nurse would not spend the time to get the cart when CPR needed to be initiated. She said that the first person responding to a code would get the crash cart and take it to the patient's room. Ms. Contreras agreed that the problem was a sequencing problem because Respondent should have first tried CPR to get the patient's heart going.

Ms. Contreras spoke to Respondent in the morning before he left his shift. He told her that he panicked and did not know what to do. He described himself as having "blacked out." After the incident, Respondent was suspended pending an investigation. He was later terminated for failure to timely initiate CPR.

4. Testimony from Kristen Sinay, MSN, RN

Ms. Sinay also testified that in the case of an unresponsive patient, a nurse should assess a patient and determine whether he has a pulse and is breathing. If not, the nurse should call for help in order to get other people in the room and begin CPR by performing chest compressions. She said the nurse could use a code button, physically call out for help, or call on the phone. She said that it was not appropriate to get a crash cart before beginning CPR because the patient had an immediate need for oxygen to the brain and in the bloodstream, and time was of the essence in this situation.

Ms. Sinay reviewed the documents offered into evidence in the case. Additionally, she considered the mitigating factors of Respondent's recent performance evaluation and letter of support written by Leticia Rangel, MSN, RN, from the Metropolitan Methodist Hospital in San Antonio, Texas (Respondent's current employer) and Respondent's current practice. Ms. Sinay also acknowledged that Respondent had no prior disciplinary action and that his license had not been suspended on an emergency basis by the Board.

With respect to the alleged violation of Code § 301.452(b)(10) (unprofessional conduct), Ms. Sinay testified that Respondent's conduct should be considered as a second tier offense, Level II sanction level, due to the patient's vulnerability. Ms. Sinay recommended a penalty of a two-year suspension, to be stayed with a two-year probation. Additionally, she said that courses in CPR, professional accountability, critical thinking, nursing jurisprudence, and ethics should be required of Respondent. Respondent should also be required to notify his employers about the sanction and have a practice monitor for the two years of the probated suspension, with one year of direct and one year of indirect supervision. Further, quarterly performance evaluations should be required of the practice monitor.

With respect to the allegation that Respondent violated Code § 301.452(b)(13) (failure to adequately care for a patient or conform to minimum standards of nursing practice), Ms. Sinay testified she assessed the violation as a third tier offense because initiating CPR in an emergency

is such a fundamental skill, although she acknowledged that Respondent's conduct also could be considered a second tier offense. She said that a sanction Level 1 was appropriate and recommended a stayed suspension with a two-year probation because it would allow Respondent the opportunity to remediate.

Additionally, Ms. Sinay noted that a nurse was responsible for accepting assignments that he or she is safe to perform, and she said Respondent violated Board Rule 217.11(1)(T).[16]

B. Analysis

Staff asserts that Respondent should have immediately pushed the code button in the patient's room and initiated CPR when he saw that Patient was unresponsive. In support, Staff notes that Respondent is certified in CPR and he had the training to appropriately respond. Moreover, Staff contends that Respondent's rapid departure from Patient's room, combined with his remark to Ms. Hill that he thought he would have to call a code, was contrary to acceptable standards of nursing practice. Although the patient's prognosis was poor, Staff maintains that this is irrelevant, given that the patient did not have a DNR and had not yet been placed on hospice care.

Respondent asserts that he followed the Code Blue protocol of the facility, and that Staff disagrees with the order or sequence in which he attempted to respond to the need for emergency care. Moreover, in response to Staff's position that he should have refused being assigned to Patient if Respondent did not feel qualified to provide care to him or asked for a reassignment, Respondent contends that he had already been assigned to the patient at the time report was made to him by the day nurse. As a practical matter, his counsel suggested, he was not able to refuse the assignment or request another one.

The evidence in this case demonstrates that Respondent failed to properly initiate CPR and activate a code for an unresponsive patient. Respondent's actions indicate that he panicked

[16] This subsection of Board Rule 217.11 was not alleged in the Formal Charges; therefore, the ALJ does not address whether Respondent violated this rule and, if so, the appropriate sanction for the violation.

during the situation, ran from the room, and returned to the patient only after another nurse, Ms. Hill, took over for him. Suggestions that he was following a different sequence of responses to the situation or was not qualified to care for the patient are unpersuasive. The hospital's code policy and procedure require the staff member who is present or first to arrive to a cardiopulmonary emergency to "begin Basic Life Support (BLS) and call for help."[17] It is only after BLS (or CPR) is started that the emergency is reported through activation of the code sequence through the hospital's paging system or using the code button or cord.[18] There is no evidence that Respondent immediately began CPR or that he called the hospital's paging system or pushed the code button. Respondent had completed basic and acute coronary life support training. Although he worked regularly on another floor of the facility, he had been "floated" to the PCU previously and oriented to that unit. There was no evidence that Respondent was unaware of the facility's code procedures or that he did not know that a Code Blue button was located in every patient's room at the head of the bed, making it easy for a nurse to activate as he or she began CPR. The preponderance of the evidence establishes violations of Texas Occupations Code (Code) §§ 301.452(b)(10) and (13).

Although Ms. Sinay did not specifically address the particular rule violations pleaded by Staff, the ALJ finds that Board rules were also violated by Respondent's failure to initiate CPR immediately to Patient. Related to the violation of Code § 301.452(b)(10) (unprofessional conduct), Respondent's conduct violated Board Rules 217.12(1)(A) (carelessly failing to perform nursing in conformity with the standards of minimum acceptable level of nursing practice), 217.12(1)(B) (carelessly failing to conform to generally accepted nursing standards in applicable practice settings), and 217.12(4) (careless conduct that may endanger a client's life, health or safety). In connection with the violation of Code § 301.452(b)(13) (failing to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that exposes a patient unnecessarily to risk of harm), Respondent's conduct violated Board Rules 217.11(1)(A), (failing to conform to the applicable laws, rules, and regulations affecting the

[17] Staff Ex. 5 at 3.

[18] Staff Ex. 7 at 3.

nurse's current area of nursing practice), and 217.11(1)(M) (failing to institute appropriate nursing interventions required to stabilize a client's condition).[19]

With respect to the argument that Respondent was not able to refuse his assignment to Patient or ask for a reassignment to another patient, there is also no evidence that he attempted to do either before he began his shift. Consequently, the ALJ does not find this argument to be persuasive. Further, although Respondent did not make this argument, the fact that Patient was likely to die from his very serious medical condition does not mitigate the necessity to provide life-saving intervention in the absence of a DNR or a family's decision to cease such intervention through a medical power of attorney. Respondent's moment of panic in the situation was quite serious and supports the need for disciplinary action. However, the ALJ notes that Respondent appears to have learned from this incident, as he was able to respond appropriately to another patient who required critical intervention at the Metropolitan Methodist Hospital. The ALJ does not recommend direct supervision, as suggested by Ms. Sinay, for the two-year probated suspension but recommends indirect supervision due to the fact that the Board did not immediately suspend Respondent's license after the incident in question, Respondent has been practicing without any known deficiencies during the interim period, and Respondent recently performed appropriately in a similar situation.

IV. RECOMMENDATION

Based on the evidence presented and after considering the arguments of counsel, the ALJ recommends that Respondent's license be suspended for two years, with the suspension to be probated for that period. During the probated suspension, Respondent should be required to have indirect supervision and quarterly evaluations. In addition, the ALJ recommends that Respondent be required to take continuing nursing education courses in CPR, professional

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[19] Respondent's practice failed to conform to the applicable laws, rules, and regulations because he did not operate within the standard of nursing care and did not follow the facility's procedure for code incidents and did not initiate CPR when it was necessary to do so. Although Staff also alleged violations of Board Rules 217.11(1)(B) and 217.11(3)(A), the evidence did not clearly establish these violations.

accountability, critical thinking, nursing jurisprudence, and ethics. In support of this recommendation, the ALJ makes the following findings of fact and conclusions of law.

V. FINDINGS OF FACT

1. Sangcheol Choi (Respondent) was licensed by the Texas Board of Nursing (Board) as a registered nurse through Permanent Registered Nurse License No. 832156 on February 14, 2013.

2. On July 26-27, 2016, Respondent was employed as a nurse at North Central Baptist Hospital (the facility) on the medical/telemetry unit.

3. On July 26, 2016, Respondent reported for his evening shift and was assigned to the Progressive Care Unit (PCU) to provide care to a number of patients on that unit.

4. One of the patients (Patient) had been sent to the facility from a nursing home for medical treatment. Patient was placed on the PCU.

5. Patient did not have a medical power of attorney or a "do not resuscitate" order.

6. Although Patient had been evaluated for hospice care, his family members had not approved transferring the Patient into hospice.

7. A "Code Blue" button is located in the same location in every patient room throughout the facility. It is located on the wall at the head of each patient's bed.

8. During his shift, Respondent checked on Patient and found him unresponsive.

9. Instead of immediately performing cardiopulmonary resuscitation (CPR) and activating the "Code Blue" button in Patient's room, Respondent panicked and ran from the room.

10. Chantal Hill, a nurse working nearby, observed Respondent run from the patient's room and asked if she could help.

11. By way of response, Respondent said he thought he needed to call a code.

12. Ms. Hill immediately went to Patient's room, checked his pulse, and determined that he was not breathing. She pushed the "Code Blue" button and began CPR by performing chest compressions.

13. A "Code Blue" response team went to Patient's room and continued CPR.

14. At some point after the response team arrived, Respondent returned to Patient's room. However, he was unable to provide information to the doctor about Patient's condition, and Patient's electronic medical records had to be brought into the room to provide the requested information to the doctor.

15. Patient was unable to be resuscitated and died.

16. Prior to leaving the facility, Respondent talked to his supervisor, Lauren Contreras, who worked as a nurse on the telemetry unit.

17. Respondent told Ms. Contreras that he did not know what to do when he saw that Patient was unresponsive, and he panicked.

18. After he was placed on suspension pending investigation, Respondent's employment with the facility was terminated.

19. Respondent's nursing license was not temporarily suspended by the Board after the incident.

20. Respondent subsequently became employed by Metropolitan Methodist Hospital in San Antonio, Texas, on November 14, 2016, where he continues to work.

21. Respondent's supervisor reports that he is doing well in his job, including responding appropriately to a patient who required critical intervention.

22. Respondent has no prior disciplinary history.

23. On January 26, 2018, Staff sent Respondent a Second Amended Notice of Hearing. The notice contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and either a short, plain statement of the factual matters asserted or an attachment that incorporated by reference the factual matters asserted in the complaint or petition filed with the state agency.

24. The hearing convened at the State Office of Administrative Hearings on May 21, 2018, before ALJ Suzanne Formby Marshall. Assistant General Counsel John Vanderford represented Staff. Attorney Elizabeth Higginbotham appeared represented Respondent, who did not personally attend the hearing. The hearing concluded and the record closed that day.

VI. CONCLUSIONS OF LAW

1. The Board has jurisdiction over the licensing and discipline of nurses. Tex. Occ. Code (Code) ch. 301.

2. SOAH has jurisdiction over contested cases referred by the Board, including the authority to issue a proposal for decision with findings of fact and conclusions of law. Code § 301.459; Tex. Gov't Code ch. 2003.

3. Respondent received adequate and proper notice of the hearing on the merits. Code § 301.454; Tex. Gov't Code §§ 2001.051-.052.

4. Staff had the burden of proof by a preponderance of the evidence. 1 Tex. Admin. Code (TAC) § 155.427.

5. Respondent is subject to sanction because he committed unprofessional conduct by carelessly failing to perform nursing in conformity with the standards of minimum acceptable level of nursing practice and carelessly endangering a patient's life by failing to immediately begin CPR or call a "Code Blue" when he found his patient to be unresponsive. Code § 301.452(b)(10); 22 TAC § 217.12(1)(A), (B), (4).

6. Respondent is also subject to sanction because his conduct failed to meet minimum practice standards by not conforming to the relevant laws, rules, and regulations affecting his current area of nursing practice and by failing to institute appropriate interventions that might be required to stabilize a client's condition. Code § 301.452(b)(13); 22 TAC § 217.11(1)(A), (M).

7. The Board may impose a disciplinary sanction, which can range from remedial education to revocation of a nurse's license. Code § 301.453; 22 TAC § 213.33(e).

8. To determine the appropriate disciplinary sanction to be imposed in this case, the Board must consider the factors set forth in 22 Texas Administrative Code § 213.33 and the Board's Disciplinary Matrix. 22 TAC § 213.33.

SIGNED July 18, 2018.

SUZANNE FORMBY MARSHALL
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

Texas Board of Nursing

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Katherine A. Thomas, MN, RN, FAAN
Executive Director

August 3, 2018

The Honorable Suzanne Formby Marshall, Administrative Law Judge
State Office of Administrative Hearings
P.O. Box 13025
Austin, Texas 78711-3025

Re: In the Matter of Permanent Certificate No. RN 832156
Issued to **SANGCHEOL CHOI**
SOAH Docket No. **507-17-5489**

Dear Judge Marshall:

Enclosed is ***Staff's Exceptions to the Proposal for Decision.***

If you have questions regarding this matter, please feel free to contact me at (512) 305-6879.

Thank you for your time and assistance with this case.

Very truly yours,

John Vanderford
Assistant General Counsel

Electronically Signed as Authorized by
Tex. Bus. & Comm. Code §322.007

JV:cll
Enclosure

cc: Elizabeth L. Higginbotham, RN, Attorney, Higginbotham & Associates, LLC, 1100 NW Loop 410, Suite 700, San Antonio, TX 78213; Via Facsimile: (866) 250-4443

SOAH DOCKET NO. **507-17-5489**

IN THE MATTER OF	§	BEFORE THE STATE OFFICE
PERMANENT CERTIFICATE	§	
NUMBER RN 832156	§	OF
ISSUED TO	§	
SANGCHEOL CHOI	§	ADMINISTRATIVE HEARINGS

STAFF'S EXCEPTIONS TO PROPOSAL FOR DECISION

COMES NOW, Staff of the Texas Board of Nursing (hereinafter "Staff" or "Board"), and respectfully files its exceptions to the Proposal for Decision ("PFD") issued in this matter on July 18, 2018, as follows:

On Page 11 of the PFD, the Administrative Law Judge (ALJ) states that the ALJ does not recommend direct supervision for the two year probated period of the suspension but rather recommends indirect supervision "due to the fact that the Board did not immediately suspend Respondent's license after the incident in question ...." The ALJ goes on to state the subsequent work history of the Respondent that was considered in the decision of whether to recommend direct or indirect supervision as justification for the recommendation. Staff recognizes that the subsequent work history exists because Staff did not temporarily suspend the license of the nurse and recognizes that this may be the reason that the quoted clause is included in the analysis. The language of the PFD can be read, however, to interpret the licensee's unsuspended licensure to be mitigating. Therefore, Staff excepts to the extent that the language of the PFD indicates the Board's decision to not suspend a nurse's license through the Board's temporary suspension process is mitigating.

Respectfully submitted,

TEXAS BOARD OF NURSING

John Vanderford, Assistant General Counsel
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Austin, Texas 78701
P: (512) 305-6879; F: (512) 305-8101

CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing ***Staff's Exceptions to PFD*** was sent via Electronic Filing and Certified Mail on this, the 3rd day of August, 2018, to:

State Office of
Administrative Hearings

Via Electronic Filing

Elizabeth L. Higginbotham, RN, Attorney
Higginbotham & Associates, LLC
1100 NW Loop 410, Suite 700
San Antonio, TX 78213

Via Facsimile: (866) 250-4443

John Vanderford, Assistant General Counsel