

5. Respondent's nursing employment history includes:

09/1973 - 10/1974	Staff Nurse	Roosevelt Hospital New York, New York
10/1974 - 07/1975	Staff Nurse	Mt. Sinai Hospital New York, New York
07/1975 - 01/1976	Volunteer Nurse	Hadassah Hospital Jerusalem, Israel
02/1976 - 04/1976	Unknown	
05/1976 - 06/1982	Intensive Care Unit (ICU)	Lenox Hill Hospital New York, New York
06/1982 - 05/1987	Staff Nurse	Hermann Hospital Houston, Texas
05/1987 - 10/1988	Agency Nurse	Agency Unknown New York, New York
10/1988 - 08/2003	Observation Unit	Hermann Hospital Houston, Texas
08/2003 - 04/2006	Staff Nurse	TIRR Hospital Houston, Texas
05/2006 - 10/2006	Unknown	
11/2006 - 04/2007	Home Health Nurse	3M Healthcare Services Houston, Texas
04/2007 - 05/2008	Admission Nurse	Westwood Rehabilitation and Healthcare Houston, Texas
05/19/2008 - 09/05/2008	Staff Nurse	St. Luke's Hospital Houston, Texas
10/13/2008 - 11/18/2009	Staff Nurse	Quentin Mease Community Hospital Houston, Texas
12/2009 - Present		Not Employed in Nursing

6. At the time of the initial incident in Finding of Fact Number Seven (7), Respondent was employed as a Staff Nurse with St. Luke's Hospital, Houston, Texas, and had been in this position for one (1) month.
7. On or about June 13, 2008, while employed with St. Luke's Episcopal Hospital, Houston, Texas, Respondent incorrectly administered Humulin regular insulin to Patient Medical Record Number 02733700 instead of Aspart, as ordered by the physician. Respondent's conduct was likely to injure the patient in that administration of the incorrect insulin could have resulted in adverse reactions, including hypoglycemia.
8. On or about August 12, 2008, while employed with St. Luke's Episcopal Hospital, Houston, Texas, Respondent incorrectly started an infusion of Normal Saline with 20 mEq potassium chloride to Patient Medical Record Number 02001285 instead of 1/2 Normal Saline with 20 mEq potassium chloride, as ordered by the physician Respondent's conduct was likely to injure the patient in that failure to administer medications as ordered by the physician could have resulted in nonefficacious treatment.
9. On or about August 31, 2008, while employed with St. Luke's Episcopal Hospital, Houston, Texas, Respondent failed to contact the physician to clarify whether to discontinue the administration of a Sandostation drip of 100 microgram IV/Normal Saline 100 cc NS to Patient Medical Record Number 02184378 once the initial bag of the medication was completed. One bag of the medication was administered until the next day. Respondent's conduct could have injured the patient in that the physician's order was not clarified as to whether this patient required additional doses of the medication.
10. At the time of the incident in Finding of Fact Number Eleven (11), Respondent was employed as a Staff Nurse at Quentin Mease Community Hospital, Houston, Texas and had been in this position for approximately one (1) year and one (1) month.
11. On or about November 15, 2009, while employed with Quentin Mease Community Hospital, Houston, Texas, Respondent pre-charted that she had made rounds and checked on Patient Medical Record Number 047453551 up until 0600 by initialing the "Safety and "Activity" sections of the patient's flowsheet. The patient coded at 0109 and transferred to Ben Taub Emergency Room with Cardiopulmonary Resuscitation in progress. Respondent's conduct would have been likely to injure the patient in that pre-documentation of patient observation, had the patient not been transferred, could have provided inaccurate information to subsequent care givers.
12. In response to Findings of Fact Numbers Seven (7) through Eleven (11), Respondent states that she made her first two medication errors while being under supervision of a preceptor. Respondent had requested to be transferred to a quieter floor but her manager refused. Respondent states that the order for Standostatin had not been clarified and the physician had been called when she came on shift. By the time Respondent got around to the charts, it was 0100 and the physicians came in at 0500, so Respondent put a note on top of the chart. Respondent states that she pre-charted because the patient had a sitter in the room and Respondent left the flowsheet in the room. When the patient coded, Respondent drew a line through her initials, initialed the lines, and charted in the narrative.

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), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.11(1)(A),(1)(B),(1)(C)&(1)(P). .
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 464565, heretofore issued to JUDY WONG, 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

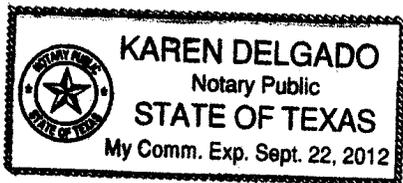
I understand that I have the right to legal counsel prior to signing this Agreed Order. I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and 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 13 day of JANUARY, 20 11.

Judy Wong
JUDY WONG, Respondent

Sworn to and subscribed before me this 13 day of January, 2011.

SEAL



Karen Delgado
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 13th day of January, 2011, by JUDY WONG, License Number 464565, and said Order is final.

Effective this 8th day of March, 2011.



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

