BEFORE THE INDIANA STATE
BOARD OF NURSING
CAUSE NUMBER: 2004 NB 0192

STATE OF INDIANA,)
)
Petitioner,)
)
v.)
)
JANIAN KUNICKI STYGAR, L.P.N.,)
LICENSE NUMBER: 27043062,)
)
Respondent.)

COMPLAINT

The State of Indiana, by counsel, Deputy Attorney General, Shelley M. Johnson, on behalf of the Office of the Attorney General ("Petitioner"), and pursuant to Indiana Code § 25-1-7-7, Ind. Code §25-1-5-3, Ind. Code §25-23-1-7 et seq., the Administrative Orders and Procedures Act, Ind. Code § 4-21.5-3 et seq. and Ind. Code § 25-1-9-1 et seq., files its Complaint against the Practical Nurse license of Janina Kunicki Stygar, L.P.N. ("Respondent"), and in support alleges and states:

COUNT I

1. The Respondent's address on file with the Board is 8031 Harrison Avenue, Munster, Indiana 46321 and she is a duly licensed Practical Nurse in the State of Indiana having been issued license number 27043062.

2. Respondent worked as a licensed practical nurse at Hammond-Whiting Care Center 1000 114th Street, Whiting, Indiana, from January 23, 2002 until her termination on September 8, 2003 and at all times relevant to this Complaint.

3. On or about July 18, 2002, Respondent received a Counseling Form or a "written verbal warning," from Hammond-Whiting Care Center for placing a resident in restraints due to combativeness. The Respondent failed to notify the resident's physician prior to placing the resident in restraints and failed to attempt to console the resident before attempting to use restraints.

4. On or about November 13, 2002, Respondent received a Counseling Form, or a "written verbal warning" from Hammond-Whiting Care Center for non-compliance with charting during her work schedule. Respondent verbally stated that her charting was completed at the end of her shift. However, no charting was completed for Medicare and summaries were incomplete for seventy-two (72) hour charting. In addition, treatments were not completed, yet the Respondent signed that she had completed treatments for patients during her shift.

5. On or about May 25, 2003, Respondent received an Employee Warning Notice from Hammond-Whiting Care Center for "Unsatisfactory Work Quality." A resident was caught between the side-rails and the Respondent waited for some time before seeking assistance. Because the resident was combative, the Respondent subsequently refused to assess the resident for injuries and to measure the resident's wounds. The Respondent failed to notify the resident's physician of the incident.

6. On or about June 12, 2003, Respondent received a Teachable Moment memorandum or a "written verbal warning," because she left medications on the top of a linen barrel in the hallway of the facility. The medications were easily accessible to any resident who could have walked in the hallway, thus endangering the residents' safety.

7. On or about July 15, 2003, Respondent received a Teachable Moment memorandum

or a "written verbal warning," from Hammond-Whiting Care Center. A medication documentation error was discovered during a pharmacy review. Respondent was counseled that if a triple check had been performed on the medications when pills were missing, the documentation error could have been avoided.

8. On or about September 3, 2003, a resident, M.C., ninety-one (91) years of age with end stage Alzheimers was wandering around the facility. M.C. was grabbing at staff and knocking things around the top of the medicine cart.

9. Respondent grabbed M.C. by the arm, dragged M.C. to her room, shoved her into her room and closed the door. Respondent stated to M.C. "Now you stay there."

10. Respondent continued walking down the hall to finish her medication pass. M.C. began screaming and the Respondent did not investigate as to why M.C. was screaming and did not check on resident M.C. after she shoved her in the room.

11. Two C.N.A.s found the resident M.C. had fallen on the floor between her bed and her dresser. The nurse from the opposite floor conducted a head to toe assessment and found no injury on resident M.C.

12. On or about September 8, 2003, after an investigation, Respondent was terminated from Hammond Whiting Care Center for abuse of a resident.

13. On or about September 10, 2004, on Respondent answered "No" to the question "Have you been terminated, reprimanded, disciplined or demoted in the scope of your practice as a nurse or another health care professional?" on renewal application for her Indiana nursing license. Respondent failed to disclose her termination from the Hammond-Whiting Care Center to the Indiana State Board of Nursing.

14. The conduct described above constitutes a violation of Indiana Code § 25-1-9-4(a)(1)(A) in that the practitioner has engaged in or knowingly cooperated in fraud or material deception in order to obtain a license to practice; Indiana Code § 25-1-9-4(a)(3) in that the practitioner has knowingly violated a state statute or rule or federal statute or regulation regulating the profession in question, to wit: 848 IAC 2-3-3(1) Using unsafe judgment, technical skills or inappropriate behaviors in providing nursing care; 848 IAC 2-3-3(3) Disregarding a patient/client's right to dignity, right to privacy, or right to confidentiality; 848 IAC 2-3-3(4) Abusing a patient/client verbally, physically, emotionally or sexually; 848 IAC 2-3-3(7) Abandoning or knowingly neglecting patient/clients requiring nursing care.

WHEREFORE, Petitioner demands an order against the Respondent that:

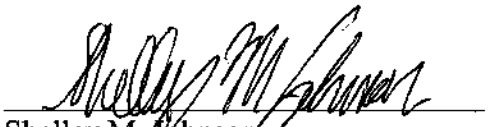
1. Imposes the appropriate disciplinary sanction;

2. Directs Respondent to immediately pay all costs incurred in the prosecution of this case; and;

3. Provides any further relief as the Board deems just and proper.

Respectfully submitted,

Steve Carter,
Attorney General of Indiana

By: 

Shelley M. Johnson
Deputy Attorney General
Attorney No.: 22412-49

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CERTIFICATE OF SERVICE

I certify that a copy of the "Complaint" has been duly served upon the Respondent listed below, by United States mail, first-class, postage prepaid, on this 30th day of September, 2004.

Janina Kunicki Stygar, L.P.N.
8031 Harrison Ave.
Munster, IN 46321

Shelley M. Johnson
Deputy Attorney General

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