WISCONSIN DEPARTMENT OF REGULATION & LICENSING

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STATE OF WISCONSIN
BEFORE THE NURSING HOME ADMINISTRATOR EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
JOHNNA K. KUKLA, RESPONDENT.	:	LS0708091NHA

[Division of Enforcement Case # 03 NHA 012]

The parties to this action for the purposes of Wis. Stat. § 227.53 are:

Johnna K. Kukla
2 Amethyst Road
Palmyra, VA 22963

Division of Enforcement
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Wisconsin Nursing Home Administrator Examining Board
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Nursing Home Administrator Examining Board. The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Johnna K. Kukla, ("Respondent"), date of birth May 28, 1979, was licensed by the Wisconsin Nursing Home Administrator Examining Board as a nursing home administrator in the state of Wisconsin pursuant to license number 3244, which was first granted January 23, 2003.

2. Respondent has not renewed her license since it expired on June 30, 2006, but could renew it pursuant to Wis. Stat. § 440.08(3)(a) and Wis. Adm. Code § NHA 4.02(2) by payment of fees, completion of required continuing education and submission of an affidavit that she has not practiced while not registered.

3. Respondent's address of record with the Department of Regulation and Licensing is 2 Amethyst Road, Palmyra, VA 22963.

4. On all relevant dates, Respondent was the executive director at Highland Health Care in Green Bay, Wisconsin. As executive director, Respondent lead Highland Health Care's management staff and was responsible for ensuring compliance with state and federal regulations.

5. On various dates between December 26, 2002 and January 1, 2003, Respondent was on vacation.

6. On December 22, 2002, Resident DC, (DOB 12/18/24), a male with late-stage Alzheimer's disease, was

discharged from a CBRF due to aggressive behavior. Resident DC was admitted to Bellin Hospital on the same date. A report of Resident DC's history and physical at Bellin states:

> Over the past five years, there have been multiple episodes of aggressive behavior. [Resident DC] had been in Bellin Psychiatric Center at least one time. He has hit both his son and his wife. There are safety issues where he lives. He is fairly short-tempered and can do things aggressively both with confrontation and spontaneously. Apparently he has hurt and injured nursing personnel. He wanders and touches other people and confront[s] other people. Apparently he has tipped over a wheelchair. For this reason, he was discharged and sent to the hospital to resolve the social problems and [the CBRF] will not accept him back because of safety issues.

7. On December 23, 2002, Resident DC was placed at Highland Health Care. A preadmission assessment was done by a registered nurse employed by Highland Health Care. The admitting nurse did not have access to Resident DC's history and physical report until Resident DC arrived at the Highland facility. Immediately upon reviewing Resident DC's history, the admitting nurse recognized that the Highland facility was "not equipped to handle" Resident DC, but believed it was too late to decline admission.

8. Resident DC's aggressive behaviors were apparent immediately upon admission to Highland Health Care. Staff were unable to do assessments or check his vital signs because Resident DC was "very combative and abusive." The nursing note indicates he kicked one staff member four times and swung his fist at her.

9. On December 24, 2002, Resident DC continued to be combative and exhibited "excessive wandering in [sic] hall grabbing at other residents causing them to yell at him." Without provocation he raised his fist at another resident and also made four attempts at elopement. Staff noted that medication was only partly effective as Resident DC refused to take it.

10. On December 25, 2002, staff noted that Resident DC wandered into other residents' rooms, and attempted to crawl into bed with other residents. According to the nursing note, "requiring 1:1 constant supervision. Is combative [with] staff during redirect—swinging out [with] closed fists. Attempts x2 to give prn Haldol dose [with] no success."

11. Resident DC's combative behaviors continued through the day, with Resident DC tipping over dining room chairs and tables. At one point, Resident DC took off his clothing and wandered naked through the halls.

12. Resident DC's wife told staff that she was concerned for the safety of Resident DC's room-mate, indicating that she hoped Resident DC did not "go after him."

13. On December 29, 2002, Resident DC exhibited a number of concerning behaviors. He obtained a metal butter knife, which he wielded at staff in a menacing manner. Resident DC confronted a resident with whom he had had a previous conflict, and after staff redirected him, Resident DC returned and again confronted the same resident. Finally, Resident DC was put on a suicide precaution watch after he was found with a call-button cord wrapped around his neck.

14. On December 28, 2002, Resident DC was placed on precautionary 15-minute checks, which continued until January 6, 2003. During that time, his wandering behaviors continued, with Resident DC sometimes climbing into bed with other residents.

15. On January 8, 2003, Resident DC reportedly became involved in an altercation with another resident, during which he slapped her in the face and the side of her head.

16. Between January 1, 2003 and January 15, 2003, staff documented five shifts during which Resident DC was physically aggressive toward other people; twenty-five shifts during which he entered other residents' rooms; and one shift during which he was throwing items, including a chair.

17. On January 13, 2003, Respondent was notified that, on January 8, 2003, Resident DC entered the room of

a sixty-year-old female resident. Resident DC touched the female Resident's upper leg and grabbed her breast. The female resident screamed and a staff member removed Resident DC from her room. The female resident stated that earlier in the week, Resident DC had entered her room and exposed his genitals to her. Resident DC had previously entered her room on December 26, 2002, and on another date, he entered her room and urinated on the floor. The female resident summoned staff to her room on each of these earlier occasions.

18. On January 13, 2003, staff at Highland Health Care initiated an investigation of the January 8, 2003 incident. Staff began sitting with Resident DC on a one-on-one basis from 6:00 am until 2:00 p.m., with 15-minute checks reinstated after 2:00 p.m.

19. On January 15, 2003, Resident DC was relocated to the Alzheimer's Care Unit, with 15-minute checks continued. On the same date, staff began supervising Resident DC on a one-on-one staff to resident basis. Fifteen minute checks were discontinued on January 20, 2003.

20. On February 27, 2003, Resident DC was discharged to another facility.

21. Respondent's conduct in managing Highland Health Care unreasonably placed residents at risk of harm and substantially departed from the standard of care ordinarily exercised by a nursing home administrator in the following ways:

a. Respondent failed to require that Resident DC's condition was adequately investigated prior to his admission to Highland Health Care;
b. Respondent failed, until January 15, 2003, to insure that Resident DC had adequate staff supervision to avoid physically aggressive behaviors.

CONCLUSIONS OF LAW

1. The Wisconsin Nursing Home Administrator Examining Board has jurisdiction over this matter pursuant to Wis. Stat. § 456.10 and has authority to enter into this stipulated resolution of this matter pursuant to Wis. Stat. § 227.44(5).

2. Respondent, by engaging in the conduct set out above, has committed unprofessional conduct as defined by Wis. Adm. Code § NHA 5.02(2), which subjects Respondent to discipline pursuant to Wis. Stat. § 456.10(1)(b).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED:

1. Respondent, Johnna K. Kukla, is REPRIMANDED for the conduct set out above.

2. Respondent's shall not be permitted to renew her license until she has provided proof sufficient to the Board o its designee that Respondent has:

a. Completed six (6) hours of continuing education on the subject of abuse, neglect and sexual harassment o vulnerable populations, which course or course(s) shall first be approved by the Board, or its designee. These credit shall be in addition to the continuing education required for renewal of licensure for the following biennium, pursuant t Wis. Adm. Code § NHA 3.02, and shall not be applied toward meeting that requirement.
b. Paid to the Department of Regulation and Licensing costs of this proceeding in the amount of $782.50, whic the Board could have ordered pursuant to Wis. Stat. § 440.22(2).

3. All payments, requests and evidence of completion of the education required by this Order shall be mailed, fax or delivered to:

Department Monitor
Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Ave.
P.O. Box 8935
Madison, WI 53708-8935
Fax (608) 266-2264
Telephone (608) 267-3817

4. This Order is effective on the date of its signing.

Wisconsin Nursing Home Administrator Examining Board

By: David Egan 8/9/07
A Member of the Board Date

STATE OF WISCONSIN
BEFORE THE NURSING HOME ADMINISTRATOR EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	STIPULATION
JOHNNA K. KUKLA, RESPONDENT.	:	LS _____ NHA

[Division of Enforcement Case # 03 NHA 012]

It is hereby stipulated and agreed, by and between Johnna K. Kukla, Respondent; and Sandra L. Nowack, attorney for the Complainant, Department of Regulation and Licensing, Division of Enforcement, as follows:

1. This Stipulation is entered into as a result of a pending investigation of Respondent's licensure by the Division o Enforcement (file 03 NHA 012). Respondent consents to the resolution of this investigation by stipulation and without the issuance of a formal complaint.

2. Respondent understands that by signing this Stipulation, she voluntarily and knowingly waives her rights, including the right to a hearing on the allegations against her, at which time the state has the burden of proving those allegations by a preponderance of the evidence; the right to confront and cross-examine the witnesses against her; the right to call witnesses on her behalf and to compel their attendance by subpoena; the right to testify herself; the right to file objections to any proposed decision and to present briefs or oral arguments to the officials who are to render the final decision; the right to petition fo rehearing; and all other applicable rights afforded to her under the United States Constitution, the Wisconsin Constitution, the Wisconsin Statutes, the Wisconsin Administrative Code, and any other provisions of state or federal law.

3. Respondent has been provided an opportunity to obtain advice of legal counsel prior to signing this Stipulation.

4. Respondent agrees to the adoption of the attached Final Decision and Order by the Board. The parties to the Stipulation consent to the entry of the attached Final Decision and Order without further notice, pleading, appearance o consent of the parties. Respondent waives all rights to any appeal of the Board's Order, if adopted in the form as attached.

5. If the terms of this Stipulation are not acceptable to the Board, the parties shall not be bound by the contents of this Stipulation, and the matter shall be returned to the Division of Enforcement for further proceedings. In the event that this Stipulation is not accepted by the Board, the parties agree not to contend that the Board has been prejudiced or biased in any manner by the consideration of this attempted resolution.

6. The parties to this Stipulation agree that the attorney or other agent for the Division of Enforcement and any member of the Board ever assigned as a case advisor in this investigation may appear before the Board in open or closed session, without the presence of the Respondent or her attorney, for purposes of speaking in support of this agreement and answering questions that any member of the Board may have in connection with the Board's deliberations on the Stipulation. Additionally, any such case advisor may vote on whether the Board should accept this Stipulation and issue the attached Final Decision and Order.

7. Respondent is informed that should the Board adopt this Stipulation, the Board's Final Decision and Order is a public record and will be published in accordance with standard Department procedure.

8. Respondent is further informed that should the Board adopt this Stipulation, the Board's Final Decision and Order would constitute an agency finding within the meaning of Wis. Stats. §§ 48.685 and 50.065. Should Respondent wish to work in a Wisconsin DHFS-licensed facility, she will need to pass a Rehabilitation Review through DHFS prior to commencement of such employment.

9. The Division of Enforcement joins Respondent in recommending that the Board adopt this Stipulation and issue the attached Final Decision and Order.

_____ _____

Johnna K. Kukla
Respondent
2 Amethyst Road
Palmyra, VA 22963

Date

_____ _____

Sandra L. Nowack
Attorney for Complainant
Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935

Date

[03 NHA 012: Costs $782.50]

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