BEFORE THE BOARD OF COUNTY COMMISSIONERS
MULTNOMAH COUNTY, OREGON

In the Matter of the Denial of the Adult Care Home License) Application of Essie Askew)	ORDER NO. 96-166

The Board of County Commissioners has reviewed the record, Hearing Officer's Order and the Adult Care Home Program's Response regarding the appeal of Essie Askew from an Order of the Hearing Officer affirming the Adult Care Home Program's denial of her license application to operate an adult care home. The Hearing Officer found that Ms. Askew failed to maintain and make available medication charts complying with the provisions of MCAR 890-020-510, failed to maintain and make available progress notes complying with the requirements of MCAR 890-020-450, and failed to maintain care plans for her residents, as required by MCAR 890-020-720.

In addition, Ms. Askew neglected residents in violation of MCAR 890-015-660, by failing to seek medical advice when indicated, failing to obtain required medical assessments, and either administering medication inappropriately to a resident or failing to seek medical advice when a significant change in a resident's medical condition occurred. Ms. Askew also permitted unapproved care providers to give care in her home, who had not received required training.

Finally, the Hearing Officer found that the "record was replete" with evidence that Ms. Askew had dealt with County personnel in a dishonest and hostile manner, and failed to

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cooperate in investigations, in violation of MCAR 890-020-260.

The Board accepts the Hearing Officer's Order, attached hereto as Exhibit A. The Board finds that the Hearing Officer's Order is fully supported by the record and that there are no grounds for rejecting or modifying the Hearing Officer's Order.

IT IS HEREBY ORDERED that the Order of the Hearing Officer in the appeal of Essie Askew is accepted.

Review of this final Order may be taken solely and exclusively by Writ of Review in the manner set forth in ORS 34.020 to ORS 34.100.

Approved this 19th day of September, 1996.

BOARD OF COUNTY COMMISSIONERS
MULTNOMAH COUNTY, OREGON

By for Beverly Stein, Chair

REVIEWED:

PETER KASTING, SPECIAL COUNSEL
FOR MULTNOMAH COUNTY, OREGON

By
Peter Kasting

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HEARINGS OFFICER'S ORDER

APPEAL OF ESSIE RENE ASKEW

HEARING NO. 162173

DATE OF HEARING: Tuesday, July 16, 1996

APPEARANCES:

Ms. Mary Fassel, for Multnomah County
The Appellant, Essie Rene Askew did not appear.

HEARINGS OFFICER: Mr. William W. Shatzer

STATEMENT OF THE CASE:

This is an appeal from a determination of the Multnomah County Adult Care Home Program, denying the application of the appellant, Essie Askew, for a Multnomah County Adult Care Home License. The appellant was originally granted a provisional Adult Care Home License in November 1995 and that provisional license was renewed twice through April 14, 1996. On April 18, 1996, the Sanctions Specialist for the Multnomah County Adult Care Home Program determined that Ms. Askew had committed numerous and serious violations of the applicable Administrative Rules during the periods Ms. Askew had been operating under the provisional license and issued a Notification of Administrative Sanctions denying Ms. Askew's application for a permanent license. On May 3, 1996, Ms. Askew filed a written request for an appeal hearing pursuant to MCC 8.90.090 and MCAR 890-090-120. This proceeding followed.

PRELIMINARY RULING:

This matter was set for hearing at 9:00 A.M. on Tuesday, July 16, 1996. Written notification of the time, date and place of hearing was provided to all interested parties, including Ms. Askew on June 28, 1996.

Ms. Askew did not appear at the scheduled time for hearing. After waiting some time, the County requested and was permitted to proceed with the presentation of its prima facie case at approximately 9:15 A.M. The County concluded its presentation and the record was closed at approximately 11:15 A.M. Unbeknownst at that time to the hearings officer, a letter was received

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by the Hearings Office at approximately 11:05 A.M. from Ms. Askew requesting a postponement of the scheduled hearing. The letter was postmarked as being mailed on July 12, 1996.

Quite obviously, a request for postponement which is received nearly two hours after the hearing has commenced, more than two hours after the hearing was scheduled to commence, and after the County has presented the greater portion of its prima facie case comes far too late. Moreover, Ms. Askew had been duly informed of and been aware of the scheduled hearing time and date for at least two weeks prior to the scheduled hearing. Ms. Askew has provided no good reason why her request for postponement could not have been filed in a more timely manner. A letter mailed through the United States Postal Service only two business days before the scheduled hearing cannot be deemed to have been filed in a timely manner.

Ms. Askew's request for postponement is denied on the grounds that it was not timely filed and no good cause for her failure to file her request in a more timely manner has been shown.

FINDINGS OF FACT AND CONCLUSIONS OF LAW:

The County's evidence establishes that the appellant committed or suffered to be committed numerous and serious violations of the applicable Multnomah County Rules for the Licensure of Adult Care Homes during the approximately six-month period she operated her Adult Care Home under her provisional license.

1. Record Keeping Violations.

The record discloses that Ms. Askew's keeping of required records for her Adult Care Home were, quite frankly, sloppy and slipshod almost beyond belief.

A. Medication records, as required by MCAR 890-020-510, were not kept or maintained in a proper or usable manner. The medication chart for one resident shows that one resident "refused" his medications on December 18, 1995 when, in fact, that resident was in the hospital and not in Ms. Askew's home at all on that date. The medication chart for the same resident shows no medication at all for the dates of December 19 and 20 and for most of the day on December 21 when, in fact, the resident had been returned to Ms. Askew's home from the hospital and medicines should have had been administered. This resident's chart shows that all prescribed medications were administered on December 9, 1996 , while handwritten notes in this resident's file indicate that the resident "refused' medication on that date.

Some of the other medication charts, such as Exhibits 8 and 11 have more medications entered in the charts than there are lines provided for initialing for the administration of the medications, making it impossible to determine exactly which, if any, medications were actually administered or which, if any, were "refused" by the resident.

Other charts failed to correctly list medications prescribed by the resident's physicians. Exhibit 8, for instance, indicates Carafate (a stomach medication) is to be administered 3 times a day and Dilantin (an anti-seizure medication) is to be administered 4 times per day while the evidence shows that, in fact, the physician's prescription required exactly the reverse with Carafate being administered 4 times per day and Dilantin 3 times per day. Either the medication charts do not

accurately reflect the medication actually administered or Ms. Askew was administering medication not in compliance with physicians' instructions.

Finally, as is evidenced by Exhibits 1 and 7, some or all of the medications entered on the charts fail to include the dosage administered. That dosage information is, of course, required to be included on medication charts by MCAR 890-020-510 (d).

The failure to maintain and make available medication charts complying with the provisions of MCAR 890-020-510 was a violation of that Rule.

B. Similar problems are apparent with the progress notes required to be maintained under MCAR 890-020-450 (c) and (d). As demonstrated by Exhibits 4 and 5, for one resident at least two separate sets of progress notes existed for the period between December 11, 1995, and January 3, 1996 - one set of which indicated the resident engaging in normal and unremarkable activities in and around the Adult Care Home on December 18 and 19 and one of which indicates the resident suffered a seizure in the very early morning hours of December 18 which required that 911 be notified and the resident transported to Emmanuel Hospital where he remained until the afternoon of the 19th. The conclusion is, of course, inescapable that one of these sets of progress notes is grossly inaccurate.

Similarly, a check of Ms. Askew's records by Multnomah County investigative personnel in late February of 1996 disclosed that **no** progress notes could be provided for either of Ms. Askew's two residents for the period between January 17 and February 27, 1996. Later, in March of 1996, Ms. Askew produced progress notes for that period but they had been prepared in a completely different manner than the remainder of her progress reports, incorporating weekly progress notes summaries rather than daily entries as used in the balance of Ms. Askew's progress reports. The conclusion is inescapable that Ms. Askew either failed to maintain or lost the required progress notes and later attempted to cover this failure by creating or recreating progress notes after the fact.

This failure to maintain and make available progress notes complying with the requirements of MCAR 890.020-450 was a violation of that Rule.

C. Ms. Askew failed to maintain care plans for either of her residents. Such plans are required under MCAR 890-020-720 and her failure to do so was a violation of that rule.

2. Neglect of Residents.

A. A resident was prescribed Dilantin, an anti-seizure medication. Apparently, according to Ms. Askew's medication charts, the resident "refused" this medication on six consecutive days from December 13, 1995 , through December 18, 1996, apparently because it was causing him stomach distress. Perhaps not surprisingly, the resident suffered a seizure and required hospitalization in the early morning hours of December 18th. It seems apparent that this resident's seizure and hospitalization was directly related to the resident's failure to receive the prescribed medication during the preceding six-day period.

There is no indication in the records that Ms. Askew, at any time, sought the advice of professional medical personal or referred the resident to a physician. Had a physician been consulted, it is quite likely that a change in prescription to a different anti-seizure medication or the prescription of anti-

nausea medications would have allowed this resident to ingest an appropriate anti-seizure medication while lessening or eliminating the resident's distress. Ms. Askew was, or should have been, aware that the resident's failure to take prescribed medication could have serious adverse effects upon this resident's health. The failure to seek professional medical advice and assistance almost certainly directly contributed to the resident's seizure and subsequent hospitalization. Ms. Askew's failure to seek professional medical advice or to refer the resident to a physician caused or threatened to cause physical harm to the resident and was neglect under the provisions of MCAR 890-015-660.

B. When this resident was released from the hospital on December 19, 1995, he was scheduled to visit his physician for a follow-up exam on January 8, 1996. The resident failed to appear for this scheduled appointment and, in fact, was not re-examined by a physician until March of 1996. Under MCAR 890-020-500, the operator of an Adult Care Home is required to provide prompt assessment of a resident's medical needs. Ms. Askew's failure to ensure such a prompt assessment was neglect under the provisions of MCAR 890-015-660.

C. This resident was prescribed Diazepam, a Valium-type drug, to be administered on an "as needed" basis, no more frequently than once a day. The resident was, according to Ms. Askew's medical charts, administered Diazepam twice on March 12, 1996. This was a violation of MCAR 890-020-510(b).

Additionally, the medical charts show that this resident was administered Diazepam every single day, without exception, during the period January 18 through February 28, 1996, yet there is nothing in the medical records or progress notes to demonstrate any medical need for the administration of this drug that frequently. Nor is there any indication that professional medical advice was sought for any change in the resident's medical condition which might require or justify administering Diazepam this frequently.

While the state of Ms. Askew's records makes it difficult to determine exactly what, clearly something inappropriate was occurring during this period with the administration of Diazepam to this resident. Either the medication was being administered inappropriately or Ms. Askew failed to seek and obtain professional medical advice concerning any changes in the resident's condition which would make administering Diazepam with such frequency appropriate. Either case would constitute neglect under MCAR 890-015-660.

3. Unapproved Caregivers.

A. MCAR 890-020-230 forbids persons convicted of enumerated crimes from acting as a caregiver or being in the Adult Care Home on a regular basis. Ms. Askew employed or utilized her daughter, Patricia Askew, as a caregiver in the Adult Care Home, despite Patricia Askew's previous conviction of assault, an enumerated crime under MCAR 890-020-230. Ms Askew continued to utilize Patricia Askew as a caregiver and allowed her to be present in the Adult Care Home on a regular basis even after being informed by the Multnomah County Adult Care Home Program that this was not permitted. This was a violation of MCAR 890-020-230.

B. MCAR 890-020-230(e) requires persons employed as caregivers to furnish a criminal record release authorization form to the Adult Care Home Program prior to or at the time of employment. Ms. Askew employed her daughter Jennifer Askew Solas as a caregiver in her Adult Care Home,

despite the fact that Ms. Solas had never furnished the required criminal record release authorization and was never approved as a caregiver. This was a violation of MCAR 890-020-230(e).

C. MCAR 890-020-320 requires certain training for all managers and caregivers in Adult Care Homes. Ms. Askew employed or utilized and continued to utilize Jennifer Askew Solas and Luis Solomon as caregivers in her Adult Care Home even though neither had completed the required training. This was a violation of MCAR 890-020-320.

4 Dishonesty and Lack of Cooperation.

MCAR 890-020-260 requires Adult Care Home operators to cooperate fully with Multnomah County Adult Care Home Program personnel and other regulatory personnel. This required cooperation necessarily implies that Adult Care Home operators deal with Multnomah County personnel honestly. The record in this case is replete with evidence that Ms. Askew has not meet this required standard of honesty.

When the criminal records check on Patricia Askew disclosed her assault conviction, Ms. Askew maintained to County personnel that the "Patricia Askew" on the conviction record was a different person than her daughter. She continued to do so even after Patricia Askew had submitted a letter admitting that she was, indeed, the person identified in the conviction record. There is evidence that Ms. Askew was attempting to actively conceal Patricia Askew's continued presence at the Adult Care Home after she had been informed that Patricia Askew's continue presence in the home was not permitted. There is substantial evidence to support the County's conclusion that Ms. Askew, or someone in her employ, prepared a fraudulent after-the-fact fire drill record in an attempt to conceal the fact that a required fire drill had not been performed as required. The presence of the two conflicting sets of progress notes on one resident contains a strong implication that one or the other was prepared in a conscious attempt to mislead County investigative personnel or to conceal prior record keeping deficiencies. Similarly, the sudden appearance of the missing progress notes for the period January 17 through February 27 prepared in a completely different format than the progress notes before and after that date supports a reasonable inference that those progress notes were prepared after the fact in an attempt to conceal Ms. Askew's failure to create and maintain these records initially.

B. Ms. Askew's actions during the March 20, 1996 staff visit to her Adult Care Home evidences a similar lack of cooperation with Multnomah County personnel. The evidence establishes that Ms. Askew was extremely hostile and belligerent with County personnel; yelling, engaging in derogatory and belittling remarks and throwing dishes. She instructed Luis Solomon not to answer questions about medications administered to the residents. The situation was sufficiently hostile that County personnel felt compelled to terminate the visit prematurely and before all desired records and information had been obtained or reviewed.

Creating a hostile and threatening environment sufficient to impede the legitimate investigative functions of County personnel falls far short of the level of cooperation required by MCAR 890-020-260 and is a violation thereof. Similarly, Ms. Askew's attempts to "cover up" and mislead County personnel are the antithesis of the cooperation required by MCAR 890-020-260 and is a violation there of.

ORDER AND DETERMINATION:

The Notice of Sanctions dated April 18, 1996, denying the appellant Essie R. Askew's application for a Multnomah County Adult Care Home License is SUSTAINED.

This order and determination has been mailed to the parties on July 19, 1996, and shall become final on August 8, 1996, unless written exceptions are file with the Board of County Commissioners prior to such date.

Dated:Thursday, July 18, 1996

Code Hearings Officer

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