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NO. 40809-1-II

ORIGINAL

COURT OF APPEALS

DIVISION II

OF THE STATE OF WASHINGTON

RESA RAVEN,

Respondent,

vs.

WASHINGTON STATE DSHS,

Appellant.

ANSWER OF RESPONDENT TO BRIEF OF AMICUS CURIAE WASHINGTON ASSOCIATION OF PROFESSIONAL GUARDIANS

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I. INTRODUCTION

The Respondent Resa Raven agrees with the major points of Amicus Curiae Washington Association of Professional Guardians (WAPG), and appreciates their discussion of the legal constraints within which a guardian must work, and the harmful implications of the conclusions in the DSHS Review Decision that Ms. Raven "was ultimately responsible to ensure basic needs were met" and "*Attempts* at remedying Ida's untenable situation were not enough—effective *results*" were required. Conclusion of Law (CL) 55, 56; Administrative Record (AR) 167, 168. If that is the standard, with the resulting in the professional "death sentence" of a neglect finding, it will undoubtedly discourage competent professionals from becoming guardians, and will give guardians the incentive to follow only a "best interests" standard and take the easy way out in the hard cases by putting such clients in a nursing home. It will encourage others to abdicate their responsibilities if the Review Decision holding is affirmed that the guardian is "ultimately responsible." Instead, the standard should be that a guardian must exercise care and diligence when making decisions for an incapacitated person, must pursue reasonably available sources of care and services, and that a neglect finding should not be entered unless a breach causes harm. By that appropriate standard, Ms. Raven is not guilty of neglect.

II. LEGAL ARGUMENT

A. Ms. Raven Withdraws her Appeal of the Standard of Proof

Ms. Raven argued below and on appeal that the standard of proof for neglect should be by clear, cogent and convincing evidence. A final finding of neglect would have a devastating impact on the livelihood of Ms. Raven, who is now a licensed gero-psychologist. Respondent's Brief at 46-47. However, this matter is not before the Department of Health as a professional license disciplinary action. Given the Washington Supreme Court's recent decision in *Hardee v. DSHS*, No. 83728-7 (Wash. July 7, 2011), where a preponderance of evidence standard was affirmed in the revocation of a home care license, as opposed to a professional license, and the decision in *Kraft v. DSHS*, 145 Wn.App. 708, 187 P.3d 798 (2008), Ms. Raven withdraws her appeal of this issue.

B. Ms. Raven was Legally Constrained in her Authority

The amicus WAPG correctly notes that a vulnerable adult cannot be involuntarily detained in a nursing home or other residential treatment facility without complying with the civil commitment laws, and a guardian cannot put a person in such a facility when they reasonably believe, as Ms. Raven did, that it is against the person's wishes. WAPG Brief, at 5-13.

Many people involved in Ida's care did not understand the legal limits on a guardian's authority. The Adult Protective Services (APS) supervisor thought Ms. Raven could institutionalize Ida and that was the purpose of having a guardian appointed. AR 1600. Hospice thought Ms. Raven could force Ida into a nursing home. AR 1594. Judge Strophy thought the same until Ms. Raven brought RCW 11.92.190 to his attention. AR 1540-41. The Review Decision makes the same mistake, concluding that Ms. Raven should have placed Ida in a nursing home "and then dealt with whatever opposition she may have expressed at that time." CL 44, AR 162. The Review Decision ignores the duty of the guardian to choose what the person would do if competent. RCW 11.92.043(5), incorporating RCW 7.70.065(1)(c). Ida's opposition to placement in a facility was legendary, starting with her absconding out of a window and fleeing Alaska to avoid placement in a nursing home, AR 1599, to her multiple subsequent refusals to be placed in a nursing home or group home. AR 112, 105, 106, 108, 110, 112.

The Review Decision seeks to minimize these constraints by noting that Ms. Raven "eventually" placed Ida in a care facility in January 2007. CL 44, AR 162. It is clear that Ms. Raven did so only after APS told her that their attorney said Evergreen Nursing and Rehabilitation Center could be considered a *rehabilitation* facility, rather than a

residential treatment center governed by RCW 11.92.190. Finding of Fact (FF) 83, AR 131; AR 1600. Ida's pressure sores improved at Evergreen because of the availability of turning every 1 to 2 hours (including at night, which was never possible at Ida's home) and access to a highly advanced pressure relieving bed not available in the home setting. Verbatim Report of Proceedings (RP) 453:4-20. 455:14-18, 472:21 – 473:25. The care in a rehabilitation facility/nursing home may have been in Ida's "best interests" but Ms. Raven had to follow Ida's known wishes. Moreover, it is not entirely clear what Ida's "best interests" were. The Review Decision noted: "One could reasonably argue that the final change in residency had as much, or more, to do with Ida's eventual demise a short time after placement as her physiological medical conditions." CL 45, AR 162. It also may have contributed to the death of Ida's husband, who died two months after Ida was removed from the home. AR 1603.

After Ida's condition started to deteriorate in mid November 2006, Ms. Raven and the hospice agency unsuccessfully tried to have Ida civilly committed. FF 77, AR 129; AR 1594-96. A temporary period of involuntary treatment may have helped Ida, but Raven could not force it to happen.[1] Ms. Raven also asked Highline Geriatric Psychiatry and Auburn

[1] On 11/15/06, Ms. Raven's noted: "I let Lisa [the DMHP] know that detaining Ida so that she could be medically and psychiatrically stabilized and adequately assessed would be a great first step, and may allow Hospice to maintain Ida in her home." AR 1594. The

Geriatric Psychiatry to accept Ida for in-patient admission, but they refused. Auburn told Ms. Raven that they "cannot force treatment on anyone even when Guardian is involved, particularly since she is a hospice patient" and that "Guardians couldn't sign people into their facility." AR 1600. This is true. RCW 11.92.043(5) prohibits guardians from involuntarily committing a person for mental health treatment, observation, or evaluation if the person is unable or unwilling to give informed consent to such commitment, and instead requires the guardian to follow the involuntary commitment process. Ida was not competent to make medical decisions, so she could not give informed consent. The only legal way to force treatment on Ida, or force her into a care facility, was through civil commitment. Except for once in December 2001 (when Ida had an urinary tract infection) no mental health professional found Ida detainable. See FF 24, 29, 30, 34, 77; AR 106-109, 129; and AR 2109-09, 2117 for determinations made in August 2001, twice in late 2003, in February 2004, and in November 2006.

The 2008 Final Report of the Attorney General's Vulnerable Adult Initiative included a Guardianship Protection Subgroup section, where five of the six participants were Assistant Attorneys General. One problem

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mental health professional determined that Ida was not detainable because she was "neither violent nor delusional, as she had been described, but was rather an obstinate older medically fragile woman whose symptoms were primarily medical." AR 1595. Ms. Raven then pre-authorized emergency medical care whenever it was needed. AR 1595.

they identified was: "Limited legal ability of guardians to intervene when a higher level of care is necessary." WAPG Brief, Ex. A-42. The recommendation was to create a "separate involuntary detention process for vulnerable adults to facility settings when they are diagnosed with dementia." *Id.* at A-43. No such process existed in 2006 (or now) to assist Ida, who had dementia and mental illness. FF 5, AR 98. Ms. Raven had to work within the constraints of the law and the processes that existed, which included respecting Ida's opposition to facility placement.

C. Ms. Raven Pursued Reasonably Available Sources of Care

Ms. Raven agrees with WAPG that a guardian should exercise "due diligence in pursuing all reasonably available sources of care and services." WAPG Brief at 14. There is no basis for the Review Decision's conclusion that Ms. Raven "threw up her hands" in frustration and "let [Ida] deteriorate" or that Ms. Raven displayed a "lack of attention and remedial action." CL 51, 56, AR 166, 168. Ms. Raven's prior briefs set forth in detail the many, repeated, and varied steps she took to try to obtain better care for Ida, including a prolonged search for a doctor, obtaining an ARNP when the doctor quit, locating a new doctor after the ARNP quit; repeated attempts to establish nurse delegation to take medication administration out of the hands of Richard; multiple care meetings with care providers and case managers; reports to the

guardianship court of ongoing difficulties; and a referral to APS about interference by Richard and Pam with medication administration. *See* Respondent's Corrected Brief at 40-45 and Reply Brief at 14-21. To accuse Ms. Raven of "inaction" is rhetoric, not supported by the record.

After Ms. Raven was finally able to obtain a new doctor for Ida, she wrote to the doctor on 10/6/2006, stating: "I am desperately in search for services that will allow [Ida] to receive hospice care (or I suppose, some other form of in-home nursing services) so that she can continue to reside in her Lacey apartment. I think it unlikely that she will be with us much longer, and I am eager to make her as comfortable as possible in the time that she has remaining." AR 2064. These are not the words of an insensitive guardian; they are the words of a guardian trying to get Ida the care she needed.

Ida likely would have benefitted (at least physically) from 24 hour care, but DSHS never funded the 24 hour care she needed. Instead, DSHS funded Ida for 280 hours/month, which translated into about 5 hours/day coverage, because Ida often needed two people to turn her. FF 84, 85, AR 132. While on paper 280 hours is more than the 190 hours/month the home care agency routinely was able to fill, the additional 90 hours were almost worthless in practical terms because "it would have been necessary to find people willing to go to Ida's home and work for

only one half or one hour slots," and it was "difficult to find providers willing to work on weekends or after 5:00 pm." FF 85, AR 132. None of the three home care agencies were able to fill the short, undesirable evening slot. AR 846, 851-52, AR 875-79; RP 300:15-17. (See also fn. 6 in Respondent's Reply Brief, describing the difficulties posed by the short, scattered shifts and lack of 24 hour funding.) It would not have been any different if Ms. Raven had tried to find "individual providers" to fill that slot. Filling a ½ to 1 hour evening slot for a complicated and combative patient was not a "reasonably available care or service" for Ms. Raven. This is a problem inherent in home care for difficult, low-income Medicaid patients, who are not funded for 24 hour home care by DSHS. While they could live in a facility, they have the right to choose care at home. Ms. Raven had to work within the constraints of the law. She did all that she reasonably could, given the forces and conditions arrayed against her, to get Ida the care that she needed. The Review Decision itself said "**one could not script a more trying case.**" CL 39, AR 158.

D. A Finding of Neglect under RCW 74.34.020(12)(a) Requires Causation and Harm

WAPG disagrees with Ms. Raven's position that a finding of neglect under RCW 74.34.020(12) requires proof of actual harm to the vulnerable adult. WAPG references child dependency cases and the

definition of "negligent treatment or maltreatment" in RCW 26.44.020(14), where the courts have held that the state can act without waiting for the child to suffer actual harm. WAPG Brief at 1, and fn. 2.

Two distinctions are important. First, there are two definitions of "neglect" in RCW 74.34.020(12), with subparagraphs (a) and (b).[2] DSHS alleged neglect under both (a) and (b): neglect over a period of time, and neglect from two specific incidents. AR 1-2; CL 6, AR 144; FF 111, AR 142. The ALJ did not uphold any of the three allegations of neglect. AR 2. The Review Judge affirmed the dismissal of the neglect allegations regarding the two incidents, CL 57-59, AR 169-70, but found Ms. Raven's guilty of neglect for "a pattern of conduct or inaction that failed to provide the services to maintain Ida's physical health and failed to prevent physical harm to her." CL 56, AR 168. That is the definition of neglect under RCW 74.34.020(12)(**a**).

Neglect under subparagraph (a) requires harm and causation. *See* Respondent's Reply Brief at 2-4 and fn. 3. By contrast, neglect under subparagraph **(b)** does *not* refer to actual harm, and in this regard it is

[2] RCW 74.34.020(12): "Neglect" means (a) a pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; ***or*** (b) an act or omission that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety." (emphasis added)

nearly identical to the definition of "negligent treatment or maltreatment" in RCW 26.44.020(14).[3] Subparagraph (b), however, is not the definition of neglect found in this case, and therefore is inapplicable.

The second important distinction is between the laws governing a protection order under RCW 74.34 versus a *finding* of actual neglect. RCW 74.34.110(2) allows a petition for a protection order against *threatened* abuse or neglect. RCW 74.34.120(5)(b) authorizes the court to issue an ex parte temporary protection order if it appears from the pleadings that irreparable injury "*would* result" if the order were delayed until a hearing. RCW 74.34.130(1) authorizes the court to issue an order "as it deems necessary for the protection of a vulnerable adult" that restrains the respondent "*from committing* acts of . . . neglect." In each of these provisions, the focus is on *preventing* abuse or neglect. A protection order can be issued without a finding that neglect has occurred.

But a *finding* of actual neglect is different. It requires proof of the elements of the statutory definition, and if appealed to the courts, upheld after judicial review. WAC 388-71-01255 and 388-71-01275. This distinction makes sense because the consequences are quite different. The

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[3] RCW 26.44.020(14) in pertinent part reads: "Negligent treatment or maltreatment" means an act or a failure to act, or the cumulative effects of a pattern of conduct, behavior, or inaction, that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to a child's health, welfare, or safety."

issuance of a protection order can require the person to not neglect a named vulnerable adult, RCW 74.34.130; a final *finding* of neglect prohibits that person from ever being employed in the care of, or having unsupervised access to, vulnerable adults. RCW 74.39A.050(8).

In sum, to uphold a finding of neglect under RCW 74.34.020(12)(a), DSHS must prove harm to Ida caused by Ms. Raven. *See* Respondent's Reply Brief at 2-4 and fn. 3. DSHS has not done so.[4]

E. DSHS Blames Ms. Raven For Outcomes Beyond Hers or Anyone's Control

WAPG correctly notes that DSHS had independent duties toward Ida to investigate and take appropriate actions regarding the referral made

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[4] An analogy can be drawn from the case law on using a profession's standards of practice to determine negligence. The Review Decision expressly looked to the Standards of Practice for Certified Professional Guardians (CPGs) as relevant to determining Ms. Raven's duties and responsibilities. CL 47-50, 52, AR 163-64, 166. The Standards of Practice adopted by the CPG Board under General Rule 23 do not alter existing law: "[GR 23] shall not expand, narrow, or otherwise affect existing law, including but not limited to, Title 11." GR 23(i). The Review Judge cited alleged breaches of the CPG Standards of Practice as evidence of "inaction" and therefore neglect by Ms. Raven. Courts have held that professional standards of practice CANNOT be used as evidence of malpractice or negligence. Instead, there must be proof of a (1) duty, (2) breach, (3) harm, and (4) proximate cause. *See e.g., Hizey v. Carpenter*, 110 Wn.2d 251, 830 P.2d 646 (1992) (RPCs for attorneys are for disciplinary actions and cannot be referenced in malpractice actions); *Woodhouse v. ReMax Northwest Realtors*, 75 Wn.App. 312, 878 P.2d 464 (1994) (realtors code is used for disciplinary actions, not proof of malpractice). Ironically, the only qualified expert in this case, Mr. Tom O'Brien, who had served on the CPG Board since its inception, testified that Ms. Raven did not breach her duty of care as Ida's guardian. FF 46, AR 115. He said monthly visits by Ms. Raven would have been better, as recommended in his seminar materials, "but I also don't think that it would have changed a thing." RP 645:24-25. In other words, there was no causal link to harm. Use of the CPG Standards of Practice to prove neglect was inappropriate. DSHS does not have any expertise in guardianship law, so its interpretation of the law is reviewed de novo. Respondent's Corrected Brief at 22.

to APS by Ms. Raven that household members were refusing to administer Ida's prescribed medications. WAPG Brief at 17-19. APS actually received *two* referrals and in neither case found neglect. On 3/21/06, Ms. Raven was told by APS that their investigation of the caregiver Pam "as referred by Hospice is still open, although it has been resolved by our team meeting addressing the issues." AR 1586. The referenced meeting is probably the care conference of 1/10/06, see AR 1585-86, where it was reported that Ida was now getting her medications. On 5/24/06 and 5/31/06, Ms. Raven called APS about the case status and was told it was closed but could be re-opened. AR 1588. In early June Ms. Raven made a referral to APS regarding Richard and Pam's interference with Ida's medications. AR 858, 1588. APS visited Ida's home, interviewed Richard, and the investigator later reported that "she can't really do anything with this case. She hasn't found substantiation." AR 858-59. DSHS thus had the opportunity to substantiate inadequate pain management, failed to do so, and initiated no protective action for Ida. A year later it blamed Ms. Raven for not taking "action" against Pam or Richard. AR 1; Appellant's Brief at 10, 32.[5]

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[5] The WAPG Brief at fn. 17 correctly notes: "The fact that DSHS could no more ensure that Ida received necessary services than the guardian even though it had far more resources at its disposal also illustrates the fallacy and unfairness of the Review Decision's conclusions of law that hold the guardian responsible for not guaranteeing Ida's care needs were met."

DSHS and other professionals had other duties to Ida that they could not or did not fulfill. RCW 74.39A.090(2) directs DSHS to contract with Area Agencies on Aging (AAAs) for Medicaid clients living at home. The AAA case manager is responsible for "Monitoring the consumer's plan of care to verify that it adequately meets the needs of the consumer," and for developing a care plan that "ensures coordination of health and long-term care services that meet the consumer's needs." RCW 74.39A.095(1) and (2). Ida's AAA care plan said it was the case manager's duty to "Verify that services are provided in accordance with the plan of care and to modify the plan as needed." AR 722, 756.

Home care agencies must develop and implement a written plan of care and "provide the services as outlined on the client's plan of care," WAC 246-335-090(1), 388-71-0515(2). The record is replete with the inability of any home care agency to find aides for the short evening shift. Home care agencies must also "accommodate the client's individual preferences and differences in providing care." WAC 388-71-0515(3). The record is replete with Ida refusing to be repositioned by her aides. This was a problem also faced by Ida's hospice nurse[6] and doctors.[7]

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[6] 12/24/06—hospice nurse: "Instructed caregivers that pt should be positioned off coccyx; They responded that she won't stay. Assisted caregivers to position pt on rt side with pillows. Patient immediately pulled out pillows & rolled onto her back although reason for positioning explained." AR 1323.

Home *health* care agencies are required to develop and implement care plans, and assure compliance. WAC 246-335-080(1), 246-335-095(4)(e). The care plan by Providence on 11/4/2006 said it would provide a home health aide for personal care and bathing on an as needed (PRN) basis, to supplement the aides provided by the home care agency. AR 1265. Initially Providence did not provide an aide, AR 2098, then on 11/20/2006 it starting providing a home health aide 3 times a week, and stayed at that level thru 12/28/2006. AR 2098-2097. Providence did **not** increase its home health aide to 7 times a week in December 2006, which could have provided the additional shift of care Ida was said to need.

DSHS itself had responsibilities under RCW 74.39A.090(4) to provide "oversight and monitoring of area agency on aging performance," including "assessing the degree and quality of the case management performed by the AAA staff for elderly and disabled persons in the community." There was no evidence of any DSHS monitoring.

Ida's AAA case manager could not verify and ensure services were delivered, nor could the home care and home health agencies fully implement Ida's care plan and ensure compliance, nor apparently did DSHS monitor the AAA's performance. Ms. Raven assumes the

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[7] 9/8/05 Discharge Summary: "She did have mild decubiti ulcers on her buttocks. Wound care consult was obtained. However, the patient essentially refused most of her care. . . Care was severely limited during this hospitalization due to the patient's refusal to allow blood tests, x-rays, etc." AR 2131.

professionals involved in Ida's care, including Ms. Raven, were trying in good faith to do the best they could with an extremely difficult situation. Perhaps a temporary period of involuntary treatment would have helped Ida, but Ms. Raven could not force it. Nor could Ms. Raven force Richard to always give Ida her medications, or Ida to comply with repositioning, or Ida's first doctor and the ARNP to not quit. Nor could Ms. Raven create 24 hour Medicaid funding for home care. Ms. Raven acted with due diligence and care, and tried to obtain the reasonably available sources of care and services. She should not be punished for not taking the easy way out and just putting Ida in a nursing home.

III. CONCLUSION

Ms. Raven agrees with WAPG that the DSHS Review Decision, if affirmed, will encourage other parties to abdicate their responsibilities, discourage competent professionals from becoming guardians, and wrongly punish Ms. Raven. She requests that the Review Decision be reversed, and attorney's fees and cost be awarded.

RESPECTFULLY SUBMITTED this 25 day of August, 2011.

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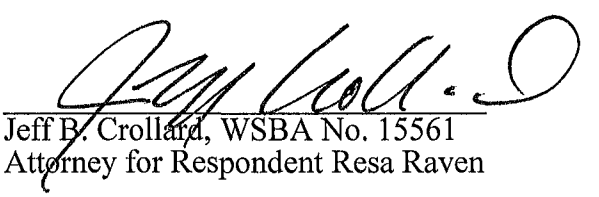

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Dated this 25 day of August, 2011.

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