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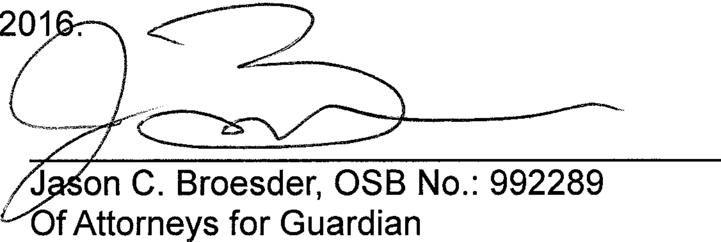
4 **IN THE CIRCUIT COURT OF THE STATE OF OREGON**

5 **FOR THE COUNTY OF JACKSON**

6 IN THE MATTER OF THE GUARDIANSHIP	CASE NO.: 13-017-G6
7 OF	
8 NORA RAUPERS HARRIS,	**CORRECTED MOTION FOR PROTECTIVE ORDER**
9 PROTECTED PERSON.	

10
11 COMES NOW, William L. Harris, Guardian, by and through his attorneys,
12 Arant & Broesder, does hereby pray for a Protective Order requiring that Fern
13 Gardens Senior Living be ordered to not assist the Protected Person in eating.
14 This Motion is supported by the Affidavit of William L. Harris, filed herewith and the
15 **Advance Health Care Directive attached hereto and incorporated herein** by
16 this reference.

17 **DATED** this 27th day of April, 2016.



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19 Jason C. Broesder, OSB No.: 992289
Of Attorneys for Guardian

20 ////

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Arant & Broesder, LLC
312 South Ivy Street
Medford, OR 97501
Tel: (541) 773-1222
Fax: (541) 779-5405

1 **SUBSCRIBED AND SWORN** to before me this 27th day of April, 2016.

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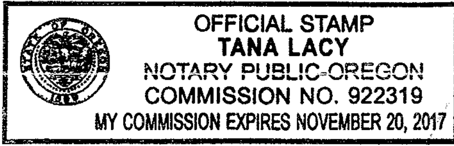
3 

4 Notary Public for Oregon

SUBMITTED BY:
5 Jason C. Broesder, OSB #992289
Arant & Broesder, LLC
6 jason@broesderlaw.com
Of Attorneys for Guardian
7 S:\Office\Protective Proceedings\Guardianship\Clients\Harris\Corrected Protective Order.Mtn.docx

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13-017-G6

ADVANCE HEALTH CARE DIRECTIVE

(California Probate Code Section 4701)

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.) Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.

(b) Select or discharge health care providers and institutions.

(c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.

(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

(e) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Exhibit "A" to this form lets you express an intention to donate your bodily organs and tissues following your death.

After completing this form, sign and date the form at the end and have your signature notarized. You may wish to give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to be sure he or she is willing to serve.

PART I: POWER OF ATTORNEY FOR HEALTH CARE

I revoke all prior advance health care directives and durable powers of attorney for health care signed by me. This document shall not be affected by my subsequent incapacity. I am not a patient in a skilled nursing facility, and I am not a conservatee.

1.1 NAME AND ADDRESS OF PRINCIPAL. My name and address are:

Nora R. Harris, 83 Arnold Drive, Novato, CA 94949

1.2 DESIGNATION OF AGENTS.

a. PRIMARY AGENT. I designate the following individual as my agent to make health care decisions for me:

William L. Harris, 83 Arnold Drive, Novato, CA 94949

b. FIRST ALTERNATE AGENT. If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Anne G. Harris, 1976 Cal Young Road #113, Eugene, OR 97401

c. SECOND ALTERNATE AGENT. If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Margery Harris, 124 Silver Shoals Drive, Shell Beach, CA 93449

1.3 AGENT'S AUTHORITY. Unless I otherwise specify in Exhibit "A", my agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive.

1.4 WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE. Unless I otherwise specify in Exhibit "A", my agent's authority to make health care decisions for me takes effect immediately.

1.5 AGENT'S OBLIGATION. My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of or Exhibit "A" to this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

1.6 AGENT'S POST -DEATH AUTHORITY. Unless I specify otherwise in Exhibit "A", my agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains.

PART 2: INSTRUCTIONS FOR HEALTH CARE

2.1 END-OF-LIFE DECISIONS. I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

[initials] **a. I Choose NOT To Prolong Life.** If I initial this line, I do **not** want my life to be prolonged and I do **not** want life-sustaining treatment to be provided or continued if **any** of the following conditions apply:

(1) I am in a coma or persistent vegetative state which two qualified physicians who are familiar with my condition, have diagnosed as irreversible (that is, there is no reasonable possibility that I will regain consciousness).

(2) I am terminally ill and the use of life sustaining procedures would only serve to artificially delay the moment of my death.

(3) I have an incurable and irreversible condition that will result in my death within a relatively short time.

(4) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness.

(5) The likely risks and burdens of treatment outweigh the expected benefits.
In such circumstances, I authorize my agent to sign a request to forego resuscitation measures, including a "do not resuscitate" ("DNR") form.

____ **b. I Choose To Prolong Life:** If I initial this line, I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

2.2 RELIEF FROM PAIN: Except as I state here, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

[initials] **a. NO RESTRICTIONS.** If I initial this line, no restrictions.

____ **b. RESTRICTIONS.** If I initial this line, the following restrictions: ________________

____

____

(Add additional sheets if needed.)

2.3 OTHER WISHES: I may attach special wishes and directions at Exhibit "A" attached to this instrument.

PART 3: DONATION OF ORGANS AT DEATH

___ **a. NO DONATIONS.** If I initial this line, I do NOT want any organs, tissues or parts donated following my death; **OR**

_MW_ **b. MAXIMUM DONATION AUTHORITY.** If I initial this line, I authorize my agent to give any needed organs, tissues, or parts following my death; **OR**

___ **c. LIMITED DONATION AUTHORITY.** If I initial this line, I give the following organs, tissues, or parts only following my death: ______________________________
____
____

___ **d. SPECIFIC PURPOSES.** If I initial this line and I have authorized any donations, my gift is for the following purposes only (I will line through any of the following purposes that I do not want):

(1) Transplant (2) Therapy (3) Research (4) Education

PART 4: HIPAA RELEASE AUTHORITY

My agent has the authority to exercise the same rights as I would be able to exercise and shall be treated as I would be regarding the use and disclosure of my individually identifiable health information and medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320d and 45 CFR 160-164. I authorize any of the following entities that have provided treatment or services to me or that has paid for or is seeking payment from me for such services to give, disclose and release to my agent without restriction all of my individually identifiable health information and medical records:

i. Physicians, dentists, medical or healthcare personnel;
ii. Health plans, hospitals, clinics, laboratories, pharmacies, or other health care providers;
iii. Any insurance company or other health care clearinghouses.

The authority given my agent shall supersede any prior agreement that I have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only upon my explicit revocation in writing.

PART 5: EFFECT OF COPY

A copy of this form has the same effect as the original.

SIGNATURE

9/3/09 (date)

Nora R. Harris (sign your name)

STATE OF CALIFORNIA)
) ss.
COUNTY OF SAN FRANCISCO)

On September 3, 2009, before me, John J. Alkazin, a Notary Public for California, personally appeared Nora R. Harris, who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that she executed the same in her authorized capacity, and that by her signature on the instrument the person or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

(seal)

Notary Public for California

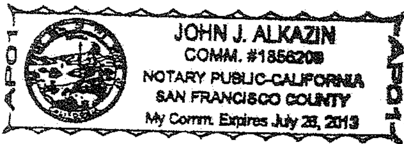

Exhibit "A" to Advance Health Care Directive

I make the following special directions and statement of desires.

- **This Advance Directive becomes effective only upon my incapacity.** This instrument becomes effective only if
-

*my primary physician signs a written statement that I am unable to make my own health care decisions.
*a board-certified psycho-neurologist or a board-certified psychiatrist, who is unrelated by blood or marriage to me, signs a written statement that he or she has examined me and that I lack the capacity to contract under the criteria set forth in California Probate Code Section 810 et. seq.

- **Restrictions on my agent's post-death authority.**
-

*My agent may authorize an autopsy (California Health & Safety Code Section 7113).
*My agent may direct disposition of my remains.
*My agent is authorized and directed to handle the disposition of my remains in accordance with the directions contained in my Last Will and Testament or as otherwise communicated to my agent.

- **Medical Care.** In addition to general authorities, my agent is specifically authorized to:

*Request, review and receive any information, verbal or written, regarding my physical or mental health, including (but not limited to) medical and hospital records; sign on my behalf any releases or other documents that may be required to obtain this information; and consent to disclosure of this information.
*Sign on my behalf documents purporting to be "Refusal to Permit Treatment", "Leaving Hospital Against Medical Advice", "Do Not Resuscitate (DNR)" and "No Code" or similar instructions, and to sign any waiver or release from liability reasonably required by a hospital or physician.
*Consent to X-ray examinations and anesthesia.

- **Extent of Agent's Authority.** My agent shall have the broadest discretion possible during any period that I am incapable of giving informed consent about my medical care, which shall include consenting to, withdrawing consent to, any treatment, service, or procedure to diagnose, maintain or treat any physical or mental condition of mine. Unless I line through any power listed below, this authority shall include:

*Artificial respiration (commencement or termination) .
*Artificial nutrition and hydration (nourishment provided by feeding tube) (commencement or termination).
*Cardiopulmonary resuscitation (CPR).
*Antibiotics.
*Organ transplantations.

*Blood transfusions.
*Other treatments.

- **What my agent may NOT do.** I acknowledge that California law provides that my agent may **not** do any of the following without a court order:
-

*Commitment or placement in a mental health treatment facility against my objection.
*Consent to convulsive treatment as defined in Welfare and Institutions Code Section 5325.
*Consent to psychosurgery as defined in Welfare and Institutions Code Section 5324).
*Consent to sterilization.
*Consent to abortion.

- **Determining where I may live.**
-

* I wish to live in my home for as long as reasonably possible without endangering my physical or mental health and safety, or my financial security. My agent is authorized to hire whatever household employees or personal care givers as may be necessary to permit me to live in my home.
* If my agent determines that it is inappropriate or dangerous for me to live in my home, then I desire the least restrictive and most home-like environment deemed appropriate by my agent, to include (but not be limited to) residential facilities, hospitals, hospices, nursing homes, convalescent facilities, and private board and care facilities. I wish to live as close as possible to my residence, so that I may still visit friends and neighbors to the extent that my agent determines that I will benefit from those relationships. I ask that my agent allow me as much autonomy and privacy as possible, including placement in an assisted living care facility or board and care facility. I desire that my agent encourage me in my social relationships and social interaction even if I seem no longer able to recognize my family and friends or to fully participate in social activities.
* I wish to return home as soon as possible after any hospitalization or convalescent care.

- **Visitation rights.** My agent shall have the first right of visitation while I am a patient in a hospital, health care facility, or other institution, including (but not limited to) any intensive care or coronary care unit of a medical facility. My agent shall have the right to restrict other visitors if my agent determines that is necessary for my health.

- **Employment and discharge of others.** My agent shall have the power to employ and discharge physicians, dentists, nurses, therapists, household employees and other persons as my agent determines necessary or proper for my physical, mental and emotional well being. My agent shall arrange for my transportation and meals; shall handle my mail; and shall arrange for my recreation and entertainment. My agent shall have the right to arrange for reasonable compensation for these persons, and to charge these expenses to my trust or other assets.

- **Psychiatric care.** If two independent psychiatrists licensed to practice in the State of California examine me and determine that I am in immediate need of hospitalization or institutionalization because of mental disorders, alcoholism or substance abuse, then my

agent shall have the authority to arrange for my voluntary admission to an appropriate hospital or institution for treatment of the diagnosed problem or disorder; to arrange for and consent to private psychiatric and psychological treatment for me; and to refuse consent for any such hospitalization or treatment; and to revoke consent for any such hospitalization or treatment that my agent or I may have given at a prior time.

- **Life prolonging procedures**. My agent is authorized to request that aggressive medical therapy be instituted or discontinued, including (but not limited to) cardiopulmonary resuscitation, cardiac pacemaker, renal dialysis, parental feeding, the use of respirators and ventilators, blood transfusions, nasogastric tube use, intravenous feeding, and endotracheal tube use.