

87483-2

FILED
JUN 13 2012
CLERK OF THE SUPREME COURT
STATE OF WASHINGTON

NO. 40809-1-II

COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

FILED
COURT OF APPEALS
DIVISION II
2012 JUN -8 AM 11:54
STATE OF WASHINGTON
BY DEWITT

RESA RAVEN,

Petitioner,

v.

WASHINGTON STATE DEPARTMENT OF SOCIAL
AND HEALTH SERVICES,

Respondent.

PETITION FOR REVIEW

Jeff B. Crollard, WSBA No. 15561
CROLLARD LAW OFFICE, PLLC
1904 Third Ave., Suite 1030
Seattle, WA 98101
Tel: (206) 623-3333
jbc@crollardlaw.com
Attorney for Petitioner

FILED
COURT OF APPEALS DIV I
STATE OF WASHINGTON
2012 JUN -6 PM 4:32

ORIGINAL

Table of Contents

I. IDENTITY OF PETITIONER 1

II. DECISION BELOW 1

III. ISSUES PRESENTED FOR REIVEW 1

IV. STATEMENT OF THE CASE 1

 A. Ida had a history of refusing or resisting needed care..... 2

 B. Ida did not want to be placed in a nursing home 3

 C. In late 2006 Ida’s condition worsened but she continued to resist nursing home placement up to the end of her guardianship 4

 D. Many steps were taken by Ms. Raven to help Ida ... 8

V. ARGUMENT WHY REVIEW SHOULD BE ACCEPTED..... 9

 A. The Court of Appeals’ decision undermines the legislature’s determination that guardians should honor an incapacitated person’s right of self determination 10

 B. The Court of Appeals misinterpreted the Vulnerable Adults Statute in authorizing a guardian to be held guilty of neglect in the absence of causation 15

 C. The court of Appeals’ decision will impede the quality of care for the most vulnerable by holding guardians to an impossible standard of care based on hindsight and in disregard for practical limitations on the availability of resources..... 19

VI. CONCLUSION 20

Table of Authorities

STATE CASES

<i>Bond v. Dep't of Soc. & Health Servs.</i> 111 Wn.App 566, 577, 45 P.3d 1087 (2002).....	16
<i>Conrad v. Alderwood Manor</i> 119 Wn.2d 551, 555, 825 P.2d 314(1992).....	16
<i>Cummings v. Guardianship Services of Seattle</i> 128 Wn.App 742, 750-52, 110 P.3d 796 (2005)	19
<i>In re Guardianship of Ingram</i> 102 Wn.2d 827, 689 P.2d 1363 (1984).....	9,11,12
<i>In re Schuoler</i> 106 Wn.2d 500, 504, 723 P.2d 1103 (1986).....	13
<i>State v. Elgen</i> 118 Wn.2d 551, 555, 825 P.2d 314 (1992).....	19
<i>Warner v. Regent Assisted Living</i> 132 Wn.App 126, 134, 130 P.3d 865 (2006).....	16

STATE STATUTES

RCW 7.70.065 10, 13
RCW 7.70.065(1)(c) 11, 12
RCW 11.92.043(5) 10, 11
RCW 11.92.043(5)(a) 13
RCW 11.92.190 7, 9, 11, 13, 18
RCW 34.05.461(4) 17
RCW 34.05.570(3)(e) 14
RCW 43.43.832(4) 19
RCW 43.43.834(2) 18
RCW 43.43.834(5) 18
RCW 71.05 4, 5
RCW 74.34.020 16
RCW 74.34.020(12) 15
RCW 74.34.020(12)(a) 1, 10, 16
RCW 74.34.095 2
RCW 74.39A.051(8) 18

RULES OF APPELLATE PROCEDURE

RAP 13.4(b)(1) 9
RAP 13.4(b)(3) 9
RAP 13.4(b)(4) 9, 10

STATE CODES

WAC 388-79-030 20

FEDERAL REGULATIONS

42 CFR § 488.335(e) 18

APPENDIX

Order Denying Motion for Reconsideration.....A-1
Published Opinion A-2 – A-27
Relevant Statutes A-28 – A-43

I. Identity of Petitioner

Resa Raven is the petitioner in this Court and was the respondent in the Court of Appeals.

II. Decision Below

The Court of Appeals' published opinion was filed on March 27, 2012. Appendix, A-2 to A-27. The court denied the motion for reconsideration on May 7, 2012, in an order at Appendix, A-1.

III. Issues Presented for Review

A. Can a guardian place and detain an incapacitated person in a residential treatment facility for care against her will?

B. Can a guardian be held responsible for ensuring that the care needs of an incapacitated person are met, regardless of legal and practical limitations on the guardian's ability to secure necessary care?

C. Can a guardian be guilty of "neglect" under RCW 74.34.020(12)(a) without any proof that the guardian's actions or inactions caused harm to the incapacitated person?

IV. Statement of the Case

This is a judicial review of an administrative action, involving allegations of neglect of a vulnerable adult by a guardian. The Department of Social & Health (DSHS) lost before the Administrative Law Judge, who held a five day hearing. The DSHS Review Judge partially reversed

the ALJ. The Pierce County Superior Court reversed the DSHS Decision and awarded Ms. Raven attorney's fees under the Equal Access to Justice Act. The Court of Appeals reversed the superior court, principally holding that Ms. Raven should have put her ward Ida¹ in a nursing home despite Ida's previous expressed wishes against it.

A. Ida had a history of refusing or resisting needed care.

Ida, in her mid 80s at the time of these events in 2006, was a retired nurse with a very strong belief in independent living and alternative medicine, who had a deep distrust of the medical establishment, and a long history of noncompliance with her care. Administrative Record (AR) 105-06, Finding of Fact (FF) 20-25. Ida rarely took medications and sometimes went on hunger strikes if she thought people were trying to medicate her. AR 102, FF 12; AR 701. She frequently resisted health care that would have been in her best interests: for example, refusing treatment for glaucoma and cataracts, refusing to see a doctor when she had bloody stool indicative of internal bleeding, and refusing to let a visiting doctor examine her infected foot, telling a policeman called to the scene that she had the right to refuse medical treatment. AR 102, FF 12; AR 106-07, FF 26-27; AR 2188, 2165.

¹ Per confidentiality provisions in RCW 74.34.095, Ida is referred to by her first name.

The ALJ and DSHS Review Judge concluded there was “no persuasive evidence” that Ida was incompetent when she refused health care. AR 104, FF 19. The Review Judge further concluded “there was ample evidence” that Ida “did not wish to be subjected to procedures that caused her pain notwithstanding the long-term medical benefits such treatments could bring.” AR 152, Conclusion of Law (CL) 28.²

B. Ida did not want to be placed in a nursing home.

The Review Judge concluded that Ida had historically and consistently refused “to be permanently institutionalized or taken out of her home for medical treatment purposes.” AR 153, CL 28. On only one occasion, after fracturing her leg in 1996, did Ida agree to temporary rehabilitation in a nursing home, and even then it was unclear whether she agreed or it was forced upon her. AR 104, FF 18; AR 153, CL 28. In the mid 1990s, Ida and her husband absconded out of a window and fled Alaska in order to avoid placement in a nursing home. AR 1599. In 2001, despite being bedridden and incontinent at home, Ida was “unwilling to be placed in a group home or a nursing home.” AR 105, FF 21. Later she refused hospital care for bedsores and only agreed to treatment *if allowed*

² At home, this was the main reason Ida refused to be turned onto her side—it hurt. Ida was bedridden with contracted legs locked into an open splayed position. Repositioning was extremely difficult and painful. Verbatim Report of Proceedings (VRP) 221-22; AR 1240. When caregivers attempted to reposition Ida by placing pillows under her side, she would pull them out, even after the benefits were explained. AR 99, FF 6; AR 1323.

to return home. AR 106, FF 25; AR 2031. In 2002, Ida repeatedly told hospice that she wanted to die *at home.* AR 107, FF 27; AR 2043, 2045.

In March 2004, a limited guardianship was established based on Ida's self neglect. AR 108-09, FF 33, 36. When the guardianship began, Ida did not have a doctor, hospice care, or nurse oversight of her care. She had fired all previous doctors, was on Medicaid, and no doctor would accept her as a patient. AR 105, FF 21; AR 116-17, FF 50-51.

Ms. Raven was appointed guardian due to her experience in the mental health field: she is a licensed mental health counselor; she had served as a Designated Mental Health Professional (DMHP) for years and thus was familiar with the Involuntary Treatment Act, RCW 71.05; and she now has a Psy.D in psychology, intending to focus on clinical geriatric psychology. AR 111, FF 39; VRP 856-57; Clerk's Papers 28.

Ms. Raven met with Ida and her family, reviewed Ida's voluminous case records, and according to the ALJ and DSHS Review Judge, determined "in good faith" that Ida, "when competent, consistently refused to be placed in a nursing home or other long-term care facility." AR 108, FF 32; AR 112, FF 43. Ida made it clear that it was "her desire to spend the remainder of her life at home." AR 153, CL 28.

C. In late 2006 Ida's condition worsened, but she continued to resist nursing home placement, up to the end of her guardianship.

Ida had a history of pressure sores since 2001. AR 99, FF 6.³ The number of pressure sores varied during the guardianship from “multiple” to zero.⁴ At NO time from March 2004 through mid November 2006 were Ida’s pressure sores worse than stage II—superficial skin breakdown. *Id.*

In mid November 2006, Ida’s condition deteriorated when she was given a too firm mattress and developed two sores. AR 139, FF 103; AR 1287, 870. The worst of Ida’s new pressure sores, on her coccyx, was assessed on 11/25/2006 and 11/27/2006 to be stage II or III—not stage IV as the Court of Appeals said in *Raven* at 8. AR 1278; AR 140, FF 106. Ida’s mattress was then replaced, and her hospice records do not mention the stages of her pressure sores from 11/28/2006 through 12/26/2006. AR 1289, 1278-83.

In late November 2006, Ida was evaluated for involuntary commitment under RCW 71.05. The DMHP, who was familiar with Ida, determined that Ida did not meet the criteria for commitment, that Ida’s issues were mainly medical, and recommended: “continued in home care as long as possible, according to cl’s wishes.” AR 2137; AR 129, FF 77.

³ Pressure sores are categorized in four stages: stage I (skin redness), stage II (blister), stage III (skin breakthrough), or stage IV (breakthrough to muscle or bone). AR 1950.

⁴ Ida had 10 sores in November 2004, two in October 2005, multiple in January 2006, and NO pressure sores in August 2006 and early November 2006. AR 100, 101, 128, FF 7, 8, 75; AR 864; VRP 169.

In mid December 2006, a severe winter storm and power outages hit the area, deflating Ida's mattress from 12/15/2006 to 12/17/2006, and she lay on a cold, hard floor or mat for over two days. AR 139-40, FF 104-05. By 12/20/2006, Ida had 10 open areas on her back and feet. AR 1282. Nurse entries for 12/23/2006 and 12/25/2006 indicate they were NOT infected, contrary to *Raven* at 8. See AR 1321, 1322, 1324.

Ms. Raven was trapped by the same severe storm and was without electricity or phone service from 12/14/2006 to 12/21/2006. AR 138, FF 101; AR 141, FF 107. Ms. Raven talked to the hospice social worker on 12/21/2006, who told her that Ida's needs had been met and the situation stabilized, but she felt Ida needed to be in a nursing home. VRP 134, 154; AR 169, CL 58; AR 141, FF 108-09. Hospice nurses testified that at this point, approximately 12/21/2006, that hospitalization was *not* appropriate or needed. AR 140, FF 106.

Ida's coccyx pressure sore worsened after the storm, but the nurses who treated her did not assess it as a possible stage IV sore until 12/27/2006. AR 1283, 1328; AR 140, FF 106. Ms. Raven was not informed of this development. Instead, the hospice social worker contacted DSHS and the DMHP agency to try to have Ida placed in a nursing home or involuntarily committed. AR 1319-20. The DMHP again declined to commit Ida. AR 2133-35. On 12/29/2006, Ms. Raven

was called by a DSHS supervisor and told of Ida's severe coccyx pressure sore. Ms. Raven consented to hospitalization, and Ida was admitted to the hospital on 12/30/2006. AR 131, FF 80; AR 1596-97.

In the hospital, Ida continued to oppose nursing home placement. The hospital's palliative care doctor noted that Ida "has . . . refused most care assistance, and has adamantly refused skilled nursing facility placement. . . When asked if there are any needs or medical care we can provide, she states "nothing, I wish you would just stop everything and leave me to die." AR 1434-35. A second doctor wrote that Ida was "refusing placement in SNF [skilled nursing facility]." AR 1443. Ida nonetheless was discharged from the hospital to a nursing home on 1/8/2007. Ida's home care providers had refused to resume home care, and Ms. Raven was told that discharge to a facility for "rehabilitative care" might not violate RCW 11.92.190. AR 131-32, FF 82-83; AR 1600.

Ida resisted the nursing home placement as much as possible. On the day of admission, the facility nurses characterized Ida as resistive to care, and documented screaming, clenched fists, striking out at others, and refusing food. AR 1455-56. Ms. Raven's guardianship partner visited and was told "Ida continues to fight the staff every time they change or turn her. Eating minimally." AR 1601. On 1/24/2007, the facility reported that Ida was non-compliant with care. AR 1454. On 1/30/2007, Ms.

Raven's partner visited during the provision of care and reported: "Took three staff to restrain Ida and keep her from biting and scratching. . . . She is eating poorly in spite of frequent encouragement." AR 1602. Ida died two months later. AR 1603.

D. Ms. Raven took many steps to help Ida.

Ms. Raven met often with Ida and her family for the first 18 months of the guardianship. After she secured Ida a doctor and hospice care, her visits decreased but she received frequent reports from Ida's case managers and the multiple professionals and caregivers working with Ida. AR 112, FF 44. Ms. Raven reported the difficulties in the case and her actions to the superior court in four timely reports. AR 1514-64; *see also* AR 1567-1604. Her actions include:

- In August 2005, after great effort, Ms. Raven got Ida on hospice, which included doctor care. AR 118-19, FF 56, 58.
- After Ida's doctor and hospice quit in May 2006, Ms. Raven found a nurse practitioner new to the area willing to treat Ida. AR 126, FF 69.
- In August 2006, after the nurse practitioner quit, Ms. Raven spent six hours with Ida at the hospital to obtain medications and try to find a new doctor. AR 126-27, FF 70; AR 1590.
- In October 2006, Ms. Raven found Ida a new doctor, went with her to the exam, and re-established hospice care; in November 2006 she met with Ida and the new hospice agency at Ida's apartment. AR 127-28, FF 71-74; AR 1592-94.

- When involuntary commitment of Ida was tried again in late November 2006, Ms. Raven tried to convince the DMHP to detain Ida for stabilization. AR 129, FF 77; AR 1594-95.
- In late November 2006, Ms. Raven pre-authorized hospitalization of Ida if hospice and her doctor thought it necessary. AR 1595.
- In January 2007, Ms. Raven explored admitting Ida to a geriatric psychiatric facility instead of a nursing home, but was told a guardian could not consent to such an admission. AR 1600.

V. Argument Why Review Should Be Accepted

In enacting RCW 11.92.190, the Legislature placed significant limits on the authority of a guardian to detain an unwilling ward in a residential care facility. The Court of Appeals decision below instead authorizes a guardian to involuntarily institutionalize a ward against her express wishes, if it is needed to receive care. Because of the specter of a neglect finding—a virtual professional death sentence—guardians will have a strong incentive to put unwilling wards in the apparent “safe harbor” of nursing homes, contrary to statutory and constitutional law, and in contravention of the substituted judgment rule adopted by this Court in *In re Guardianship of Ingram*, 102 Wn.2d 827, 689 P.2d 1363 (1984). Review is appropriate under RAP 13.4(b)(1), (3) and (4).

The Court of Appeals’ decision also imposes on guardians the duty to ensure that a ward’s needs are met regardless of legal and practical limitations, and if they cannot meet them, to then resign. Its decision will

dissuade competent and caring professionals from becoming guardians, and will deny persons like Ida, who are dependent upon Medicaid, access to guardians. The Court should review this issue of substantial public concern. RAP 13.4(b)(4).

The Court of Appeals authorizes a finding of “neglect” under RCW 74.34.020(12)(a) without proof of causation. This strained interpretation of first impression means that Ms. Raven can be barred *for life* from ever working unsupervised with vulnerable adults or children in our state, despite no proof that her conduct caused harm. The court’s interpretation of neglect is not supported by the statutory language and cannot have been intended by the Legislature. RAP 13.4(b)(4).

Finally, the Court of Appeals and the DSHS Review Decision below adopt key findings that are either directly contradicted by the record or not supported by substantial evidence in light of the whole record.

A. The Court of Appeals’ decision undermines the Legislature’s determination that guardians should honor an incapacitated person’s right of self-determination.

In consenting to medical care for an incapacitated person, guardians must comply with RCW 7.70.065, which preserves the incapacitated person’s right of self-determination when exercised by a surrogate. *See* RCW 11.92.043(5). Before consenting to care a guardian

“must first determine in good faith that that patient, if competent, would consent to the proposed health care,” and may only choose care in the person’s “best interests” if the patient’s wishes cannot be determined. RCW 7.70.065(1)(c).

The guardianship statute further constrains a guardian’s authority. RCW 11.92.190 prohibits a residential treatment facility from detaining a person against her will, and renders void any court order authorizing such detention, unless issued pursuant to the involuntary commitment laws. RCW 11.92.043(5) also prohibits a guardian from consenting to inpatient psychiatric care for a ward. In combination, RCW 11.92.190, 11.92.043(5), and 7.70.065(1)(c) prohibit the guardian from putting a person in a nursing home or other facility when the guardian knows that such placement is against the person’s wishes, as Ms. Raven knew of Ida.

In adopting this statutory scheme, the Legislature recognized that determining an incapacitated person’s wishes can be difficult. *In re Guardianship of Ingram*, 102 Wn.2d 827, gives the best guidance on this question. In *Ingram*, the guardian of a mentally ill elderly woman sought court authorization to remove her cancerous vocal cords. Ingram had diagnoses of delusion, paranoia, and dementia. She could not comprehend her medical condition, thinking her throat problems were caused by bad air. She was, however, described as alert, had fluent speech, and was

generally goal directed. She repeatedly said she wanted to keep her voice, and therefore did not want surgery, even to avoid death. *Id.* at 838.

This Court held that: “The goal is not to do what most people would do, or what the court believes is the wise thing to do, but rather what this particular individual would do if she were competent and understood all the circumstances, including her present and future competency.” *Ingram, id.* at 839. The Court held this “is a subjective test based on Ingram's attitudes, biases, and preferences, not what most people would do.” *Id.* at 844. The Court further held that “the ward's expressed wishes must be given substantial weight, even if made while the ward is incompetent” and “If the ward, despite her inability to understand her needs, is persistent and determined in her preferences, it should be given additional weight in the determination.” *Id.* at 840-42.

The Court of Appeals’ decision directly conflicts with *Ingram* and RCW 7.70.065(1)(c) because it holds Ms. Raven to an objective “best interests” standard without taking into account Ida’s long-standing subjective, personal wishes under the substituted judgment rule. In considering Ida’s repeated expressions, made while competent and not, of resistance to needed medical care, strong opposition to nursing home placement, and the desire to remain at home to the very end, Ms. Raven

sensitively followed the guidance of *Ingram*, the requirements in RCW 7.70.065, and the restriction on her authority in RCW 11.92.190.

The Court of Appeals held Ms. Raven should have balanced “Ida’s wishes against her medical needs” and should not have allowed “Ida’s historical opposition to residential care to override her critical medical needs.” *Raven* at 19. The court’s holding imposes the “best interests” standard over Ida’s known wishes, and ignores established case law and the statutory requirements. The Court of Appeals completely fails to analyze RCW 11.92.190, which requires that commitment processes be followed by guardians before imposing unwanted treatment. *Raven* at 15.⁵

In holding that Ms. Raven should have “aggressively pursued” facility placement, the Court of Appeals minimized Ida’s opposition to facility care, saying it was voiced in 2004 when Ida was delusional, and criticized Ms. Raven for allowing Ida’s “delusions to control the care she actually needed.” *Raven* at 19. However, as the ALJ and DSHS Review Judge expressly found, Ida had consistently and repeatedly, while competent and thereafter, voiced her strong opposition to being put in a nursing home, and said she wanted to live at home for the rest of her life.

⁵ *In re Schuoler*, 106 Wn.2d 500, 504, 723 P.2d 1103 (1986), obliquely cited in *Raven* at 15, actually supports Ms. Raven’s actions. *Schuoler* said that the guardianship statute [now at RCW 11.92.043(5)(a)] specifically denies guardians the power to consent to electroconvulsive therapy (ECT) absent a court order. *Id.* at 505. *Schuoler* reaffirmed the fundamental principle that competent adults have the right to determine what is done to their own bodies, and cited *Ingram* as reflecting this rule for guardians. *Id.* at 506.

The Court of Appeals juxtaposes an apparently benign picture of facility care—although anyone who reads the newspapers knows that care in nursing homes, adult family homes and other facilities can be harrowing—with an exaggerated depiction of Ida’s condition at home, lumping two years of events together as though they were contemporaneous, and then incorrectly describing Ida’s pressure sores in November and December 2006. *Raven* at 19-20.⁶ The court said Ms. Raven’s choice was between a “long failing home care plan” and “the only reasonable choice” of residential care. *Raven* at 20. This depiction is not accurate, as Ida did *not* have any skin breakdown worse than superficial for over two years.

We don’t always know what is best for another person. The Court of Appeals misconstrues key parts of the record, and ignores guardianship statutory and case law. This Court should accept review and uphold the respectful approach taken in *Ingram* and the guardianship statutes.

⁶ The court’s decision misstates the record in other ways. For example, page 20 starts with “By November 2005 . . .” and lists some assertions, including that “several treating nurses had recommended that Ida be placed in residential care.” Ida’s nurses actually did not recommend residential care until mid November **2006**, shortly before the end of the guardianship. AR 1594-95. The court repeats the error below in stating that Ida needed repositioning every two hours. *Raven* at 21. Ida’s DSHS case manager explained that the every two hour provision in her care plan was pre-printed boilerplate assigned to all bedbound patients. VRP 39-40. Ida *never* had caregivers in the evening or night, yet she often had few sores, and had NO pressure sores from August to November 2006. Factual findings are to be sustained only if supported by evidence that is *substantial in light of the whole record*. RCW 34.05.570(3)(e).

B. The Court of Appeals misinterpreted the Vulnerable Adults Statute in finding neglect in the absence of causation.

The Court of Appeals erroneously concluded that the statute does not require proof that Ms. Raven's conduct caused harm to Ida. *Raven* at 17. The Court of Appeals did not analyze the statutory language.

"Neglect" of a vulnerable adult is defined as:

"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; . . .

RCW 74.34.020(12)(a).⁷

The first part of the above definition requires a pattern of conduct or inaction "that fails to provide the goods and services that maintain physical or mental health." The logical meaning is that the conduct or inaction must *cause* the goods and services to not be provided, and that they must be needed to maintain the vulnerable adult's health, i.e., their absence must have a harmful effect on the person's health. Thus, neglect is a pattern of action or inaction that *causes* harm to the vulnerable adult.

The second part of the above definition says, alternatively, that the pattern of conduct or inaction must "fail to avoid or prevent physical or

⁷ DSHS found only a violation of this subsection (a). AR 168, CL 56.

mental harm or pain.” The logical meaning is that the action or inaction *causes* harm by failing to prevent it. Proximate cause again is required.⁸

The Court of Appeals cited three cases, none of which analyzed the RCW 74.34.020 definition of neglect. *Bond v. Dep’t of Soc. & Health Servs.*, 111 Wn.App. 566, 577, 45 P.3d 1087 (2002) was a licensing enforcement case that did not find or analyze the statutory definition. *Warner v. Regent Assisted Living*, 132 Wn.App. 126, 134, 130 P.3d 865 (2006) held that expert testimony was not needed to prove neglect. *Conrad v. Alderwood Manor*, 119 Wn.App. 275, 292, 78 P.3d 177 (2003) refused to set aside a special jury verdict that awarded damages for both neglect and negligence. Neither *Warner* nor *Conrad* analyzed the definition of neglect or said that proximate cause was not necessary.

The court accepted this DSHS formulation: Ms. Raven had a duty, Ida did not receive certain services, Ida suffered pain, so Ms. Raven was guilty of neglect. *Raven* at 16. Under this formulation, if a guardian fails to hire an *afternoon* caregiver and the ward is dropped in the *morning*, the guardian is guilty of neglect, despite the lack of connection. Under this standard, “inaction” regardless of its impact constitutes neglect. The court points to Ms. Raven’s failure to get independent caregivers for Ida, to visit

⁸ The Court of Appeals said Ms. Raven did not offer argument or authority for her position that proximate cause is required for neglect under RCW 74.34.020(12)(a). *Raven* at 17. This is incorrect. Ms. Raven’s argument and analysis are found below in Respondent’s Reply Brief, 1-5, and Respondent’s Answer to Amicus WAPG, 8-11.

her more often, to hire an attorney to go after Ida's husband Richard, or to ask Ida to reconsider nursing home placement, as evidence of Ms. Raven's neglect. *Raven* at 19-20, and fn. 7. None of these withstand scrutiny.

First, no home care agency in Thurston County could find any caregivers willing to work the short, one hour evening shift for Ida. *See* Resp. Corr. Opening Br. at 37-39, and Resp. Reply Br. at 9-14. It is unreasonable to think Ms. Raven could have done any better and impermissibly speculative. RCW 34.05.461(4).

Second, there was no evidence that if Ms. Raven had visited Ida more often it would have made any difference. The only guardianship expert, Tom O'Brien, testified that more frequent visits by Ms. Raven would have been better, "but I also don't think that it would have changed a thing." VRP 645.⁹

Third, there was no evidence that hiring an attorney to put pressure on Richard would have accomplished anything. DSHS presented "no argument that there would have been a legal basis" to file a motion against Richard. AR 125, FF 68. Even if a contempt order were issued against Richard, he was poor so could not have paid a court fine, and if Richard were jailed, Ida would have had no one to administer medications. *See* Resp. Reply Br. at 7-9. Finally, to think that Ms. Raven could have to

⁹ The court's fn. 6 references the first half of Mr. O'Brien's sentence but omits the rest.

changed Ida's mind about nursing home placement has no basis in the record, and countenances guardians bullying their difficult clients.

The Court of Appeals cited obstacles to Ida's care as proof that Ida should have been institutionalized and/or Ms. Raven resigned. *Raven* at 20. The court did not explain how a different guardian could have resolved Ida's resistance to care, the unwillingness of doctors to serve Ida, the DMHP's refusal to commit Ida, or the severe winter storm. Nor does the court reconcile its conclusions with RCW 11.92.190. The court imposed a finding of "neglect" despite the many factors beyond Ms. Raven's control, and no proof that her conduct caused harm to Ida.¹⁰

A finding of neglect is a virtual professional death sentence. It prohibits a person from being employed by, and having unsupervised access to, the clientele of any licensed facility or agency in this state that provides care to vulnerable adults or children. RCW 74.39A.051(8). Any business caring for vulnerable adults or children must require a background check of prospective employees that includes whether the person has a finding of neglect. RCW 43.43.834(2) and (5). DSHS also must consider a neglect finding when hiring people or contracting for

¹⁰ Ms. Raven argued that guidance could have been drawn from 42 CFR §488.335(e), which says: "*Factors beyond the individual's control.* A State must not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual." *See* Resp. Reply Br. at 1-2.

services in the home setting. RCW 43.43.832(4). The finding bars Ms. Raven from virtually all employment, with no proof that she caused harm. Courts avoid interpreting statutes in a way that leads to absurd or strained consequences. *State v. Elgen*, 118 Wn.2d 551, 555, 825 P.2d 314 (1992).

C. The Court of Appeals’ decision will impede care for the most vulnerable by holding guardians to an impossible standard based on hindsight and in disregard of practical limitations on the availability of resources.

The Court of Appeals initially states on p. 1 that Ms. Raven’s duty was to make “every reasonable effort to provide the care Ida needed”—a standard she agrees with—but then proceeds to impose impossible standards. The court criticizes Ms. Raven for not procuring independent caregivers, but to do so would require Ms. Raven to become a licensed home care agency, per *Cummings v. Guardianship Services of Seattle*, 128 Wn.App. 742, 750-52, 110 P.3d 796 (2005), *rev. denied* 157 Wn.2d 1006 (2006). The court criticizes Ms. Raven for not hiring an attorney regarding Richard’s non-cooperation with Ida’s medication regimen, but when DSHS investigated Richard for the same problem, they concluded they could do nothing. AR 858. The court criticizes Ms. Raven for not re-approaching Ida about facility placement, yet Ms. Raven had previously spent hours discussing the issue with Ida, her opposition to nursing home placement was legendary, and Ida continued to voice this opposition. The

court criticizes Ms. Raven for not attending to Ida's "critical medical needs," yet Ida did not have a stage IV sore until 12/27/2006, it was not previously infected or requiring hospitalization, and Ms. Raven consented to hospitalization the same day she was informed that it was stage IV.

Ms. Raven, like other guardians of DSHS clients, was authorized fees of up to \$175 per month. AR 111, FF 38; WAC 388-79-030. Given the unrealistic interpretation of a guardian's duties in *Raven*, with the specter of a neglect finding over their heads, it is likely few guardians will find the low pay worth the risk to their professional livelihood.

VI. Conclusion

The Court of Appeals' decision is contrary to public policy and law and should be reversed. The court's decision will lead to greater institutionalization of disabled clients, reduce access to guardians for low income people, scare competent professionals from becoming guardians, and unfairly punishes Ms. Raven for trying to respect Ida's wishes.

Respectfully submitted this 6th day of June, 2012.

CROLLARD LAW OFFICE, PLLC


Jeff B. Crollard, WSBA No. 15561
Attorney for Petitioner Resa Raven
1904 Third Ave., Suite 1030
Seattle, WA 98101
206-623-3333

CERTIFICATE OF SERVICE:

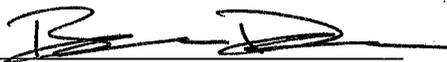
I certify that on the 6 day of June, 2012, a true and accurate copy of the Petition for Review in this matter, and the attached Appendix, was served by First Class Mail and electronic mail to the following persons:

Catherine Hoover, AAG
Office of the Attorney General
7141 Cleanwater Drive SW
PO Box 40124
Olympia, WA 98504-0124
CatherineH1@atg.wa.gov
Attorneys for Respondent DSHS

Karen Marie Thompson
Carol Vaughn
Thompson & Howle
601 Union Street, Suite 3232
Seattle, WA 98101
karent@ud.thompsonhowle.com
carolv@thompsonhowle.com
Attorneys for Amicus Curiae Washington Association of Professional Guardians

Susan Kas
Disability Rights Washington
315 Fifth Avenue S., Suite 850
Seattle, WA 98104
susank@dr-wa.org
Attorneys for Amicus Curiae Disability Rights Washington

Dated this 6 day of June, 2012.


Ben Drachler
Paralegal

FILED
COURT OF APPEALS
DIVISION II
2012 JUN -8 AM 11:54
STATE OF WASHINGTON
BY _____
DEPUTY

FILED
COURT OF APPEALS
DIVISION II

12 MAR 27 AM 8:32
COURT OF APPEALS
WASHINGTON

DEPUTY

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

RESA RAVEN,

Respondent,

v.

DEPARTMENT OF SOCIAL & HEALTH
SERVICES,

Appellant.

No. 40809-1-II

PUBLISHED OPINION

ARMSTRONG, J. — The Department of Social and Health Services (DSHS) found that Resa Raven,¹ a court-appointed limited guardian, neglected her ward, Ida, by failing to provide the medical services Ida needed to maintain her health and prevent harm and pain to her. Raven appealed and the administrative law judge found no neglect. The DSHS Board of Appeals (Board)² reversed the administrative law judge, concluding that Raven neglected Ida by inattention and by failing to ensure that Ida's medical needs were met under the Abuse of Vulnerable Adults Act, chapter 74.34 RCW. The superior court reversed and awarded Raven attorney fees. DSHS now appeals.

We affirm the Board, thereby reversing the superior court. Although Raven's duty did not include guaranteeing effective care and treatment, it did include making every reasonable effort to provide the care Ida needed. And the findings support the Board's conclusion that Raven failed to meet her duty. We also reject Raven's argument that DSHS had to prove neglect by clear, cogent, and convincing evidence, rather than by a preponderance of the evidence.

¹ We refer to Resa Raven, formerly known as Eileen Lemke-Maconi, as Raven.

² The Board adopted the decision of its review judge.

A-2

No. 40809-1-II

Finally, because DSHS's action was substantially justified, we reverse the trial court's award of attorney fees to Raven.

FACTS

Ida³ was born on April 15, 1921, and died on April 24, 2007. In 1996, Ida fell and fractured her fibula, leaving her bedridden. Her leg muscles atrophied and she was no longer able to ambulate or sit up.

Ida became physically fragile, requiring assistance with most activities of daily living. She suffered from periodic urinary tract infections, ongoing rheumatoid arthritis, congestive heart failure, and allergies. She had muscle contractures that locked her legs in a splayed position. As of 2001, she was incontinent of bladder and bowel. She also experienced deteriorating pressure ulcers⁴ associated with poor nutrition, lack of turning, and incontinence. These conditions caused Ida severe and chronic pain. In addition to her physical ailments, Ida had symptoms of dementia and hallucinations.

Catholic Community Services (Catholic Services) provided in-home care to Ida. DSHS's Area Agency on Aging (Aging Agency) provided case management, and Ida's husband and daughter provided additional care. Ida was often hostile, uncooperative, and physically abusive

³ Under the confidentiality provisions of RCW 74.34.095, we refer to Ida by her first name only.

⁴ A "pressure ulcer" is a localized injury to the skin and underlying tissue, also known as a "pressure sore" or "bed sore," usually over a bony prominence, caused when a person's body is pressed against a surface for long periods. Administrative Record (AR) at 1950. The National Pressure Ulcer Advisory Committee categorizes pressure ulcers into four stages. Stage I is an area of redness that does not quickly fade. Stage II is a superficial area of breakdown, like a blister. Stage III is an area of damage that extends below the skin to the subcutaneous tissue. Stage IV is a wound extending to the muscle and bone.

No. 40809-1-II

to her care providers. Her aggressive behavior was exacerbated when her husband failed to consistently administer her pain medication.

Ida resisted medical treatment between 1996 and 2001, although the reasons were not clear. A consultant noted on December 8, 2001, that she had a history of hallucinations and was disoriented. He also commented that home care was difficult because of her "personality" and because she was "very unclean when she came to the hospital" and was covered in stool and urine. Administrative Record (AR), Ex. 95 at 2113. Still, after an investigation in which it found some paranoia, Adult Protective Services (Protective Services) did not substantiate allegations of self-neglect.

In 2001, Ida refused surgery for her glaucoma and cataracts. In 2003, she refused to see a doctor when her dark stool suggested internal bleeding, stating that she did not care and that she wanted to die. Later that year, her daughter called the police so a doctor could inspect Ida's infected foot. Ida's primary care physician discharged her as a patient when she refused to come to his office.

~~In January 2004, Protective Services found self-neglect in a second investigation. DSHS~~
petitioned for guardianship based on its concerns that Ida was refusing medical care and neglecting herself, and because her husband and daughter were unable to make competent decisions for her. Ida told Protective Services that she was refusing treatment and care because "she believed that her husband and caregiver had run away to California and left imposters behind." AR, Ex. 71 at 2055.

The superior court appointed a guardian ad litem (GAL), Jan Carrington, who arranged a mental health professional to evaluate Ida. The mental health professional documented that Ida

No. 40809-1-II

was delusional and believed that her husband of 18 years was not her husband, that the emergency room doctor was not a doctor, and that the hospital was not St. Peter's. Carrington concluded that Ida needed a professional guardian with a mental health background who could reasonably assess Ida's needs and make competent health care decisions.

Based on the GAL's recommendation, the superior court appointed Raven as Ida's limited guardian on March 12, 2004. Raven is a licensed mental health counselor and a professional guardian. Ida was Raven's first ward as a guardian. The trial court gave Raven authority to (1) consent to or refuse medical treatment and (2) decide who would provide care and assistance. The court also granted Raven "[t]he power and duties of the guardian . . . as required by RCW 11.92." AR, Ex. 25 at 1510.

After her appointment, Raven reviewed Ida's records, including the GAL's report, the Providence St. Peter Hospital records, and the court order appointing her. She discussed Ida's psychological problems with the GAL and met with the Aging Agency and Catholic Services personnel involved in Ida's care, along with Ida's daughter and husband. Raven concluded that ~~Ida was variable in her responses to medical treatment but had consistently resisted nursing home~~ placement. Raven visited Ida with some frequency during this investigative phase of their relationship but her home visits subsequently decreased, especially when Ida was under hospice care. Raven testified that she maintained a log of some, but not all, of her actions taken on Ida's behalf.

In November 2004, the Aging Agency comprehensively assessed Ida's condition and treatment plan. At the time, Ida had 10 pressure ulcers and the Aging Agency recommended bi-hourly repositioning to prevent further skin deterioration. The caregivers remained reluctant to

No. 40809-1-II

turn her more than once or twice a day, however, because of Ida's intense pain. The assessment noted the continuing problems of rheumatoid arthritis, congestive heart failure, allergies, and angina.

In August 2005, a registered nurse from the Aging Agency examined Ida and concluded that she should be taken to the emergency room because of open sores on her leg, a possible urinary tract infection, and contractures of the leg. Raven stayed with Ida in the emergency room and she participated in planning Ida's discharge. Ida was discharged under hospice care because her life expectancy was considered to be less than six months. Raven selected Assured Home and Hospice as the hospice provider. Through hospice, Ida obtained a new primary care physician.

On October 19, 2005, an Aging Agency nurse assessed Ida's health and found only two pressure ulcers. On October 25, 2005, a hospice nurse spent "significant time" explaining to Ida's primary caregiver from Catholic Services the need to frequently turn Ida and control her pain. In her report, the nurse noted that the Catholic Services caregiver resisted these instructions because she believed that repositioning once a day was sufficient for skin care. The nurse concluded that Ida needed additional staff to reposition and medicate her if she was to remain at home.

On November 17, Raven conferred with the Aging Agency case manager, hospice nurse, and social worker to discuss concerns about Catholic Services' cooperation and Ida's husband's resistance to giving Ida pain medicine. Raven decided that they should wait until after the holidays to discuss changes to the situation to avoid additional stress.

A-6

No. 40809-1-II

Ida's skin condition was deteriorating in December 2005. In January 2006, the hospice nurses documented several painful stage II pressure ulcers. Raven and all the health care providers attended a care conference on January 10, 2006. Raven's notes acknowledge that Ida's pressure ulcers were worsening. The team agreed to seek additional support so that Ida could receive more hours of care and it could train the Catholic Services caregivers on techniques for turning Ida.

In February 2006, Ida's Aging Agency case manager asked Raven to fill the additional hours with independent care providers. Raven responded that she did not want to because she wanted providers who the agency supervised. The case manager then pointed out that the current plan was not working because they did not have enough workers. Raven replied that "we'd have to do the best we could with what we have." Administrative Record (AR), Verbatim Report of Proceedings (VRP) at 58. Raven explained that she was still determining whether Catholic Services could meet Ida's health care needs, but she acknowledged the possibility that Ida might need independent providers at some point.

~~Hospice discharged Ida as a client on May 16, 2006, citing difficulties with Ida's~~
husband. Ida had become more agitated because he had not been medicating her as needed. Ida's hospice doctor quit the same day despite Raven's request that he keep Ida as a patient.

On May 30, 2006, Raven petitioned Thurston County Superior Court for direction on how to proceed with Ida's care. At the hearing, the superior court initially stated it believed that Ida needed institutional care and that the statute and appointment order authorized Raven to place Ida in an institution. Raven explained her concern that the statute prohibited her from placing Ida in a residential treatment facility against her will. The superior court then suggested

No. 40809-1-II

that Raven hire, perhaps with financial assistance, an experienced attorney. Raven never followed the court's suggestion to contact an attorney.

On June 16, 2006, Raven met with the case managers and supervisors from the Aging Agency and Catholic Services. Raven was asked to find a new physician. She asked Catholic Services to implement staffing changes, and Catholic Services agreed to provide nurses to train the caregivers who could then legally give Ida her prescribed medicines.

Raven found an advanced registered nurse practitioner who was able to write Ida prescriptions. But one month later, the nurse took a new job and could not keep Ida as a client. When Ida's medications ran out in August, Raven transported her to the emergency room. Raven was given a list of doctors who accepted Medicaid patients, but she could not find one who was taking new patients.

On August 31, 2006, Raven made an appointment for Ida at the Sea Mar Clinic. Raven filled out new patient paperwork and Dr. Allison Spencer accepted Ida as a patient. Raven wrote to Dr. Spencer prior to the appointment:

~~At this point 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.~~

Br. of Appellant, App. A at 127.

Following the appointment, Dr. Spencer recommended a new hospice provider, Providence Home Care/Hospice. When Providence hospice took over Ida's care in November 2006, Ida had no areas of skin breakdown. But shortly thereafter, she developed new pressure ulcers. An Aging Agency representative informed Raven that Providence hospice was

No. 40809-1-II

considering terminating its services because the medical social worker and clinical manager believed that in-home care was inadequate and that Ida should be admitted to a nursing home. Although Raven agreed that a nursing home would be best, she believed she could not admit Ida without a mental health professional's finding that Ida was eligible for involuntary detention. Raven arranged for an assessment, but the mental health professional found that Ida was not detainable because her symptoms were primarily medical.

A nurse delegation still had not been provided in November 2006. Raven contacted Catholic Services about the delay and learned that the paperwork had been lost but that the process was back on track.

By late November 2006, Ida's skin condition had significantly worsened; her new hospice nurse noted pressure ulcers ranging from stages I - IV. The nurse thought that Ida should be receiving 24-hour care and that Ida's mattress was contributing to the breakdown on her skin because it was not remaining inflated. Providence hospice replaced the mattress with a continuous-flow air mattress. By December 2006, DSHS approved 280 hours of in-home care a month, but Catholic Services could provide only 189 of those hours and the remaining in-home care hours were not filled.

In mid-December 2006, a severe winter storm caused power outages at both Ida's apartment and Raven's home. When the hospice worker and nurse arrived at Ida's apartment, the mattress had deflated and Ida was lying on the floor soaked in urine. Some of her pressure ulcers had progressed to stage IV and had become infected. Providence hospice contacted Raven about Ida's condition but Raven was unable to leave her house due to fallen trees. Because of Ida's deteriorating condition, Raven consented to hospitalizing her on December 30, 2006.

No. 40809-1-II

On January 5, 2007, Catholic Services gave notice that it would no longer provide care to Ida because it believed her home care had become unsafe. The Aging Agency also discussed terminating its services. With Raven's consent, Ida was transferred to a rehabilitation center on January 8, 2007. Although Ida's skin integrity improved following an aggressive turning program, she died on April 24, 2007.

PROCEDURE

DSHS's Protective Services issued notices of neglect to Raven in April 2007, June 2007, and January 2008, alleging that she failed to obtain medical care for Ida on two specific occasions and generally failed to ensure that Ida received the care she needed.⁵ After notifying Raven of its investigation, Protective Services informed Raven that it had determined she neglected a vulnerable adult under RCW 74.34.020.

A. Administrative Hearing

Raven requested an administrative hearing to contest DSHS's neglect finding. After a five-day hearing, the administrative law judge (ALJ) reversed DSHS. DSHS appealed and the Board reversed the ALJ and affirmed the finding of neglect.

B. The DSHS Board's Conclusions

The Board upheld the ALJ's dismissal of the two specific instances of neglect, but it found that Raven had generally committed neglect by failing to ensure that Ida received the care she needed. Specifically, the Board held that Raven had a duty to ensure that Ida's basic medical needs were met in her home in light of the decision not to place Ida in a residential treatment

⁵ The two specific instances were (1) in August 2006, when Raven decided not to take Ida to the emergency room when her leg appeared broken, and (2) in December 2006, when Raven did not make contact with Ida for several days after wide-spread power outages caused by the storm.

facility. The Board reasoned that Raven had a duty to become knowledgeable of Ida's medical needs so she could make informed decisions on her behalf to regularly meet with Ida to ensure that she was getting proper care, and to release her guardianship if she could not meet Ida's medical needs. The Board concluded that "[a]ttempts at remedying Ida's untenable situation were not enough—effective results or turning the responsibility over to others who could obtain the necessary results was required." Br. of Appellant, App. A at 167 (emphasis omitted). But the Board also concluded that Raven's duty was "*to the extent possible*, to select residential placement for Ida that enhanced her quality of life, [and] provid[ed] for Ida's physical comfort and safety." Br. of Appellant, App. A at 163 (emphasis added).

The Board further determined that, although Raven appropriately considered Ida's resistance to nursing home care, the decision was not "etch[ed] in stone." Br. of Appellant, App. A at 161. Accordingly, Raven should have continued to test the strength of Ida's opposition when it became obvious that in-home care could not cope with her "stage IV . . . ulcers, [with] skin burns caused by urine saturation, and the pain associated with such afflictions." Br. of Appellant, App. A at 161. The Board specifically noted that Ida had agreed to a nursing home stay when she fractured her fibula in 1996, and she accepted nursing home care in January 2007 after her condition had been in the "crisis stage . . . for some time." Br. of Appellant, App. A at 162.

The Board concluded that Raven had a duty to have meaningful in-person contacts with Ida to observe her circumstances. Raven's log of her visits evidenced only six in 2004, two in 2005 (both when Ida was hospitalized), and five in 2006. The Board reasoned that more frequent visits would have allowed Raven to re-evaluate her decision not to place Ida in a full-time

No. 40809-1-II

residential facility for rehabilitative care and Raven may have better appreciated the “emergent need to remedy the shortfalls in the day-to-day care being provided for Ida.”⁶ Br. of Appellant, App. A at 166.

The Board concluded that Raven could not excuse herself from “procuring independent caregivers to provide necessary bi-hourly repositioning and timely personal bath care [because] . . . she was not experienced in supervising such staff.” Br. of Appellant, App. A at 167. The Board reasoned that if Raven lacked knowledge or experience, she had a duty to retain qualified persons who could supply the knowledge and experience.

The Board found that Raven’s duty to remain knowledgeable about Ida’s medical condition was “especially critical” when Raven learned that Ida had no primary care physician, that certain caregivers resisted positioning Ida bi-hourly and ensuring that she got her pain medicines, and that staffing shortages prevented adequate repositioning and bathing. Br. of Appellant, App. A at 164. The Board found it “perplexing” that although Raven spoke of an “impending crisis of care” in her May petition to the court and was aware that Ida was lying in urine and feces with open wounds, the “status quo” continued until the late December hospitalization. Br. of Appellant, App. A at 165.

Finally, the Board found that Raven’s lack of attention and remedial action contributed to Ida’s inadequate pain management, re-positioning, and personal care. The Board concluded that Raven was responsible for ensuring that these three critical medical care needs were met, and that her failure to do so constituted “a pattern of conduct or inaction that failed to provide the

⁶ Raven’s expert testified that although Washington law did not require a certain number of visits, it would have been better if Raven had visited Ida more often.

No. 40809-1-II

services to maintain Ida's physical health and failed to avoid and prevent physical harm to her." Br. of Appellant, App. A at 168.

On review, the superior court reversed the Board and awarded Raven \$25,000 in attorney fees and costs.

ANALYSIS

I. STANDARD OF REVIEW

Under the Administrative Procedures Act, a reviewing court may reverse a government agency's adjudicative decision if, among other reasons, the agency erroneously interpreted or applied the law or substantial evidence does not support the order. RCW 34.05.570(3)(d)-(e); *Timberlane Mobile Home Park v. Wash. State Human Rights Comm'n*, 122 Wn. App. 896, 900, 95 P.3d 1288 (2004). We apply the Act's standards directly to the government agency's record without regard to the superior court's decision. *Timberlane*, 122 Wn. App. at 900. A party challenging an agency's decision must demonstrate its invalidity. RCW 34.05.570(1)(a). We review an agency's legal conclusions de novo to determine whether the hearing judge correctly applied the law. *Timberlane*, 122 Wn. App. at 900. Although we give substantial weight to an agency's interpretation of the law where it has special expertise in applying it, the agency's interpretation does not bind us. *Bowers v. Pollution Control Hearings Bd.*, 103 Wn. App. 587, 596, 13 P.3d 1076 (2000).

We review an agency's factual findings for substantial supporting evidence. RCW 34.05.570(3)(e); *Superior Asphalt and Concrete Co. v. Dep't of Labor and Indus.*, 112 Wn. App. 291, 296, 49 P.3d 135 (2002). We will find evidence substantial if it is sufficient to persuade a fair-minded person of the truth or correctness of the order. *Brighton v. Dep't of Transp.*, 109

No. 40809-1-II

Wn. App. 855, 862, 38 P.3d 344 (2001) (citing *City of Redmond v. Cent. Puget Sound Growth Mgmt. Hearings Bd.*, 136 Wn.2d 38, 46, 959 P.2d 1091 (1998)). We do not weigh the witnesses' credibility. *Brighton*, 109 Wn. App. at 862 (citing *U.S. West Commc'ns, Inc. v. Utils. & Transp. Comm'n*, 134 Wn.2d 48, 62, 949 P.2d 1321 (1997)).

II. THE ABUSE OF VULNERABLE ADULTS ACT

The Abuse of Vulnerable Adults Act, chapter 74.34 RCW, requires DSHS to investigate allegations of abandonment, abuse, exploitation, and neglect of vulnerable adults. A vulnerable adult is a person over the age of 60 who lacks the functional, mental, or physical ability to care for herself. RCW 74.34.020(16)(a).

The Act defines "neglect" as:

(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, including but not limited to conduct prohibited under RCW 9A.42.100.

RCW 74.34.020(12).

A. Duty of Care

Raven maintains that her duty of care did not require her to guarantee Ida's health. She contends that her duties as a guardian were constrained by (1) the substitute decision-making statute, RCW 7.70.065, which requires a guardian to consider whether the patient, if competent, would consent to the proposed health care; (2) RCW 11.92.190, which prohibits a guardian from detaining her ward in a residential treatment facility against her will; and (3) nurse delegation laws, which prohibit caregivers from administering medication without monitoring by a nurse.

No. 40809-1-II

Raven challenges the Board's conclusion that she was ultimately responsible for either ensuring that Ida received all of the services she needed or relinquishing her role as guardian.

Finally, Raven reasons that there were "obstacles beyond [her] control that limited her ability as a guardian to solve" Ida's medical care problems. Br. of Resp't at 34. Specifically, she points to the "prohibition against placing Ida in residential care," the refusal of the mental health professional to involuntarily commit Ida, the loss of a doctor/nurse practitioner and the inability to get a nurse delegation of medications in place earlier, the delay when DSHS lost the nurse delegation paper work, Ida's refusal to be repositioned frequently, the inherent difficulty of filling a one-hour evening shift, a faulty mattress, and then a winter storm that "rapidly accelerated the downturn in Ida's skin condition." Br. of Resp't at 34.

DSHS argues that Raven had a duty to ensure that Ida received the care she needed and that Raven failed to fulfill this duty, largely through a pattern of inattention. More specifically, DSHS points to Raven's failure to (1) secure sufficient in-home care, (2) personally observe, monitor, and consult with Ida on a regular basis, (3) take her to a treatment facility to see if she would agree to stay, and (4) address the situation when no one was administering Ida's medication.

A "guardianship" is "a trust relation of the most sacred character." *In re Guardianship of Eisenberg*, 43 Wn. App. 761, 766, 719 P.2d 187 (1986) (quoting 39 AM JUR. 2D GUARDIAN & WARD, § 1 (1968)). A guardian owes a fiduciary duty to her ward. *Eisenberg*, 43 Wn. App. at 766; *Cummings v. Guardianship Servs. of Seattle*, 128 Wn. App. 742, 755 n.33, 110 P.3d 796 (2005).

A-15

No. 40809-1-II

A court-appointed guardian owes a duty of care to her ward. RCW 11.92.043(4). Specifically, a guardian has a duty “to care for and maintain the incapacitated person in the setting least restrictive to the incapacitated person’s freedom and appropriate to the incapacitated person’s personal care needs, [and to] assert the incapacitated person’s rights and best interests.” RCW 11.92.043(4). In addition, chapter 11.92 RCW requires a medical guardian to file a personal care plan that includes an assessment of the incapacitated person’s medical needs, file an annual update on the incapacitated person’s status, and report to the court any substantial change in the incapacitated person’s condition. RCW 11.92.043(1)-(3).

In providing informed consent to care, a guardian has the duty to reasonably determine what health care the ward, if competent, would have consented to. RCW 7.70.065(1)(c); RCW 11.92.043(5). Involuntary detention in a residential treatment facility is generally prohibited in Washington State. RCW 11.92.190. But the guardianship and involuntary treatment statutes operate independently to achieve different purposes. *In re Schuoler*, 106 Wn.2d 500, 504, 723 P.2d 1103 (1986).

~~In addition to these statutory provisions, the *Washington State Standards of Practice Regulation for Certified Professional Guardians* discuss the substituted judgment standard of RCW 7.70.065, providing that a guardian shall make reasonable efforts to ascertain the incapacitated person’s historic preference and shall give significant weight to those preferences while making decisions in their best interest. REG. 400 – STANDARDS OF PRACTICE REGULATION § 402.1 (2012), WASHINGTON COURTS, available at <http://www.courts.wa.gov/committee>. Specific to making medical decisions, a guardian shall monitor care, treatment, and services to~~

A-16

No. 40809-1-II

ensure that care is appropriate, and actively promote the health of a client by arranging for regular preventative care.

The GAL's report recommending Raven's appointment as medical guardian set out the "steps" she intended Raven to take if appointed: "[Raven] would visit Ida . . . to assess her needs, monitor the care she receives, communicate with her family and caregivers to ensure her needs are being met, and ensure she receives appropriate medical attention." AR, Ex. 24 at 1506. Raven described her duty more generally as "to identify the incapacitated person's medical needs to the best of my ability and . . . access available services to meet those needs." AR, VRP at 755.

B. Breach of Duty - Causation

Raven first argues that to establish neglect, DSHS had to prove that her actions or inactions caused Ida harm. Raven claims that DSHS impermissibly speculates that had she done things differently, Ida would have accepted and received the necessary care.

DSHS counters that the neglect statute does not require it to prove causation. DSHS argues that it can prove neglect by showing that someone with a duty of care repeatedly failed to provide the necessary goods and services to meet the medical needs of a vulnerable adult. DSHS argues that the record demonstrates that Ida suffered pain and harm and lacked sufficient in-home care. Thus, according to DSHS, evidence that Raven repeatedly failed to secure needed medical care is sufficient to show neglect without showing harm.

In a common law negligence claim, a plaintiff must prove that the claimed harm would not have occurred but for the claimed negligence. *Miles v. Child Protective Servs. Dep't*, 102 Wn. App. 142, 159-60, 6 P.3d 112 (2000). The Act creates a separate cause of action from

common law negligence that includes its own standard by which we measure the claimed misconduct or inaction. *Warner v. Regent Assisted Living*, 132 Wn. App. 126, 134, 130 P.3d 865 (2006); *see also Conrad v. Alderwood Manor*, 119 Wn. App. 275, 292, 78 P.3d 177 (2003) (common law negligence and neglect under the Act are two different claims). The Act requires DSHS to prove a pattern of conduct resulting in a deprivation of care. RCW 74.34.020(12); *see, e.g., Bond v. Dep't of Soc. & Health Servs.*, 111 Wn. App. 566, 577, 45 P.3d 1087 (2002). But it plainly does not require DSHS to prove that such pattern of conduct caused Ida harm or that if Raven had offered an alternative care plan, Ida would have accepted it. Raven offers no authority to the contrary. And we will not consider an assignment of error not supported by argument or authority. RAP 10.3(a)(6).

C. Breach of Duty - Neglect Based on a Pattern of Inaction

The events of November 2005 through February 2006 illustrate Raven's pattern of dealing with Ida's medical needs. On November 17, Raven met with Ida's case manager, the hospice nurse, and a social worker to discuss generally the problems with Ida's home care plan. Raven testified that their focus was on the "bereavement issue," which was the "family . . . still adjusting to the idea that Ida was in the dying process." AR, VRP at 575. She asked that the team members "just be thinking about what we needed to do here and talk . . . after the holidays." AR, VRP at 575-76. She explained her reason for the delay: the family was dysfunctional and in turmoil and because the holidays were stressful, it was not the time to make a change. During December, Ida's pressure ulcers were worsening with several stage II ulcers, which were causing her considerable pain. The team met again on January 10, 2006. Raven testified that the issues had changed to "medical ones" because the hospice caregivers were

No. 40809-1-II

documenting Ida's deteriorating skin condition. AR, VRP at 577. Raven described the plan as "more emphasis placed on turning [Ida]," and attempting to get more hours for caregivers. AR, VRP at 578-79. She denied that they discussed looking for independent caregivers. And she had only the "vaguest recollection" that in February she discussed getting more independent caregivers with another team member, and she did not understand that she was to hire them. AR, VRP at 581. Rather, she was "still trying to sort out the issue of whether we could use the existing care agency or not." AR, VRP at 582.

Raven appropriately considered Ida's preference to remain at home. But Raven was obligated to balance this preference against Ida's clear medical needs. Ida had been bedridden since 1996. Her history of pressure ulcers dates back to at least 2001. She became incontinent of bladder and bowel in 2001. She had rheumatoid arthritis, congestive heart failure, allergies, and periodic urinary tract infections, which may have caused or contributed to her dementia and hallucinations. When Raven was appointed Ida's limited guardian in March 2004, she reviewed Ida's records and met with Ida's case manager and some of her caregivers. In November 2004, ~~Ida had 10 pressure ulcers, and the evaluating nurse recommended bi-hourly repositioning but~~ reported that the caregivers resisted this. In August 2005, another nurse found open sores and a urinary tract infection and recommended taking Ida to the emergency room. Ida was discharged under hospice care because she was not expected to live six months. She continued to have pressure ulcers. Although the ulcers sometimes cleared, they always returned and over the months became more serious.

And by late 2005 or early 2006, it was clear to all the caregivers that in-home care was not working for Ida. Catholic Services was able to supply only a morning shift of two hours and

No. 40809-1-II

an afternoon shift of two hours. Although DSHS authorized more hours of coverage for Ida, none of the agencies involved in Ida's care could find staff to fill them; and Raven was not receptive to seeking independent caregivers. Nor did Raven approach Ida with the possibility of reconsidering a nursing home or other residential placement. And the record does not show that Raven consulted with others more experienced in transitioning a home-bound patient to a nursing/rehabilitative residential facility; she also apparently did not follow the superior court's suggestion to talk with an attorney after the May 2006 hearing. Yet, the medical providers were telling Raven that Ida needed to be in a residential facility. In failing to aggressively pursue transitioning Ida from home care to residential care, Raven was not balancing Ida's wishes against her medical needs; rather, she was allowing Ida's historical opposition to residential care to override her critical medical needs. This failure to balance Ida's needs against her stated desires is particularly egregious when Raven knew or should have known that Ida's rejection of medical care in 2004 was based on Ida's delusions that the caregivers were "imposters," that her husband had fled to California, that the emergency room doctor was not a doctor, and that St. Peter's hospital was not St. Peter's hospital. Giving weight to Ida's principled decisions about the kind of care she would want if competent does not include allowing her delusions to control the care she actually needed. This is not a situation where the guardian had to choose between a treatment with a high chance of success that would cause permanent disability or a treatment with lower odds of success without the disability. See *In re Guardianship of Ingram*, 102 Wn.2d 827, 829, 689 P.2d 1363 (1984). Rather, the decision here was whether to continue with the failing home care program or more aggressively pursue the alternative institutional care Ida needed.

A - 20

By November 2005, Raven had been Ida's guardian for 20 months. During that time, Ida had been repeatedly treated for pressure ulcers. The treating nurses had recorded their complaints that the caregivers were not cooperating in turning Ida and ensuring that Ida's husband gave her the medicines she needed. Ida had also been hospitalized for open sores and a urinary tract infection and discharged to hospice care. And several treating nurses had recommended that Ida be placed in residential care. In short, Ida's needs were immediate and critical. Raven's response was to postpone decisions and to try to make the long-failing home care plan work, a pattern that did not change until January 2007 when Ida was admitted, apparently without objection, to a rehabilitation facility.

We reject Raven's attempt to place the blame for Ida's plight on "obstacles" beyond her control. We agree that Ida's case presented difficult problems. But as Raven succeeds in demonstrating insurmountable "obstacles" associated with the home care program, she also demonstrates that aggressively pursuing residential care for Ida was her only reasonable choice. Moreover, Raven's obstacle argument frustrates the very purpose of her appointment as Ida's guardian. ~~When Raven reached the conclusion that obstacles were beyond her control, she~~ should have stepped aside. We are satisfied that the Board did not err in finding this two-and-a-half year pattern of inaction to be neglect.⁷

⁷ We do not discuss the Board's conclusions that Raven had specific "duties," including making frequent visits, procuring independent caregivers, and becoming knowledgeable about Ida's treatment. These are more appropriately considered as evidence of Raven's breach of her general duty to provide, to the extent possible, the care Ida needed.

III. SUBSTANTIAL EVIDENCE

Raven argues that DSHS's decision lacks substantial evidence to support its findings of fact 6, 59,⁸ and 75, and conclusions of law 17 and 46, finding and concluding that Ida's poor nutrition and lack of repositioning every two hours may have caused her skin breakdown and that Raven was asked to hire independent providers to assist with this care.⁹

We review an agency's order for substantial supporting evidence. RCW 34.05.570(3)(e). We review an agency's conclusions of law under the error of law standard. RCW 34.05.570(3)(d). *Dep't of Ecology v. Lundgren*, 94 Wn. App. 236, 241, 971 P.2d 948 (1999). Substantial evidence is evidence sufficient to persuade a fair-minded person of the truth or correctness of the matter. *King County v. Cent. Puget Sound Growth Mgmt. Hearings Bd.*, 142 Wn.2d 543, 553, 14 P.3d 133 (2000).

Finding of fact 6 provides that Ida needed repositioning every two hours to minimize skin breakdown. The record establishes that Ida's assessments and care plan documented her skin issues and that she needed to be repositioned because she was bed bound. The record provides substantial supporting evidence for this finding.

Finding of fact 59 provides that Raven was asked to hire independent providers. An agency case manager testified that she asked Raven to find independent providers because the

⁸ While Raven assigns error to finding of fact 59, in briefing, both parties specifically cite to the content of finding of fact 62. We may waive technical violations of RAP 10.3(g) where, as here, both party's briefs make the nature of the challenge clear and include the challenged findings in the text. *Daughtry v. Jet Aeration Co.*, 91 Wn.2d 704, 709-10, 592 P.2d 631 (1979); RAP 1.2(a).

⁹ Unchallenged findings of fact are verities on appeal from administrative board rulings. *Dep't of Labor & Indus. v. Tyson Foods, Inc.*, 143 Wn. App. 576, 582, 178 P.3d 1070 (2008). Raven limits her challenges to a small number of findings of fact.

No. 40809-1-II

care plan was not working due to the lack of caregivers for repositioning. Thus, the record provides substantial evidence for this finding.

Finding of fact 75 provides that poor nutrition and lack of repositioning caused Ida's skin breakdown in November 2006. Nurse Zaire testified that Ida's ulcers were caused by poor nutrition and lack of repositioning. The record provides substantial evidence for this finding.

Conclusions of law 17 and 46 recite that Raven failed to make in-person contacts with Ida and failed to pay attention to Ida's medical needs. The Board concluded that Raven had a duty to ensure Ida's medical care needs were met, including: bi-hourly repositioning, timely bathing, and administration of medication. These conclusions are a mixture of factual and legal conclusions. To the extent they can be read to mean that Raven had a duty to guarantee that Ida's needs were met, the statements are too broad. But the conclusions are not important or necessary to our decision because, as we have explained, we hold that Raven's duty generally was to provide, to the extent reasonably possible, all the care Ida needed. We view the specific acts, such as infrequent visits, which the Board characterized as duties, to be evidence of Raven's failure to meet her general duty.

IV. STANDARD OF PROOF

Raven argues that the administrative law judge denied her due process of law by requiring DSHS to prove neglect by a preponderance of the evidence, rather than by clear, cogent, and convincing evidence. She asserts that a finding of neglect will seriously threaten her future employment by barring her from working unsupervised with children or vulnerable adults. Raven concludes that a finding of neglect "will have a devastating impact" on her counseling

license, tantamount to a revocation, and that due process thus requires the higher standard. Br. of Resp't at 46.

The evidentiary standard for a finding of neglect is preponderance of the evidence as codified in WAC 388-71-01255(1).¹⁰ Agencies and courts have consistently applied this standard in administrative hearings when determining if a vulnerable adult has been neglected. See e.g., *Kabbae v. Dep't of Soc. & Health Servs.*, 144 Wn. App. 432, 437-38, 192 P.3d 903 (2008). In determining whether due process requires an agency to meet a higher standard, we consider three factors: (1) the private interest affected by the official action; (2) the risk of an erroneous deprivation and the probable value of additional safeguards; and (3) the government's interest. *Mathews v. Eldridge*, 424 U.S. 319, 334-35, 96 S. Ct. 893, 47 L. Ed. 2d 18 (1976). We review constitutional questions of law de novo. *Amunrud v. Bd. of Appeals*, 158 Wn.2d 208, 215, 143 P.3d 571 (2006).

Here, the purpose of the administrative hearing was to determine whether Raven had neglected Ida, not to revoke her mental health counselor license. Raven argues that a finding of neglect is tantamount to a license revocation because RCW 74.39A.050(8) would prevent Raven from working unsupervised with vulnerable adults.¹¹ Raven is partially correct; a finding of

¹⁰ "The [administrative law judge] shall decide if a *preponderance of the evidence* in the hearing record supports a determination that the alleged perpetrator committed . . . neglect of a vulnerable adult." WAC 388-71-01255(1) (emphasis added).

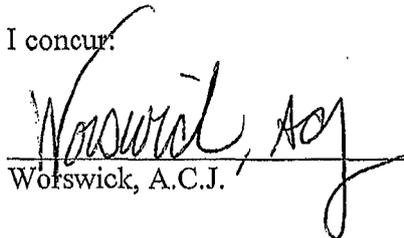
¹¹ Division Three addressed a similar argument in *Kraft v. Dep't of Social and Health Services*, 145 Wn. App. 708, 716, 187 P.3d 798 (2008), a case involving abuse of a vulnerable adult. The court held the proper standard of proof under chapter 74.34 RCW was preponderance of the evidence. *Kraft*, 145 Wn. App. at 716. The State argues that *Kraft's* finding of neglect cannot be equivalent to a license revocation. But *Kraft* actually held that the proceeding was not equivalent to revocation because *Kraft* did not hold a license to work with vulnerable adults and did not establish that a finding of neglect would cause her to lose her teaching certification.

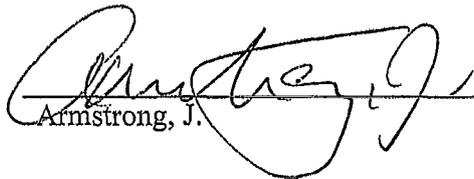
No. 40809-1-II

neglect would legally bar her from working with any organization that contracts with DSHS under RCW 74.39A.050(8). Based on the record, however, it is not clear whether this would entirely prohibit Raven from using her license or whether it would merely preclude her from working in one sector of the industry. In addition, Raven cites no authority that a finding of neglect amounts to a license revocation. Thus, we hold that the neglect finding is not equivalent to a revocation and uphold application of the preponderance standard to prove neglect under chapter 74.34 RCW.

We affirm the Board's final order and reverse the superior court. We also reverse the superior court's award of attorney fees to Raven.

I concur:


Worswick, A.C.J.


Armstrong, J.

Kraft, 145 Wn. App. at 716. Notably, Raven does rely on her license to work with vulnerable adults and she has provided support that a finding would impair her ability to employ her license.

QUINN-BRINTNALL, J. (concurring in the result) — In my opinion, the majority's acknowledgment that "Ida's^[12] case presented difficult problems" severely understates the enormity of the task Resa Raven took on. Majority at 20. I write separately because the record before us is replete with accounts of Ida's delusions, her hostile and abusive manner towards her care providers, and her husband's unwillingness to administer medications as directed. Nevertheless, Raven agreed to take on the duty to facilitate Ida's medical health care needs and advocate with care providers and I agree she has failed to perform that duty.

I recognize that Raven had no duty to provide care for Ida herself and that Washington law did not require her to visit Ida any specific number of times per year. Yet here, the record shows that despite Ida's deteriorating condition, Raven neglected to make home visits necessary to assess personally the consequences of the caregivers' unwillingness or unavailability to reposition Ida as required. Raven's absence prevented her from building rapport with Ida and her family to better discern Ida's emergent needs and possibly obtain Ida's consent to residential treatment facility care. The facts of Ida's growing urgent need for additional care demanded frequent meaningful home visits and Raven should have made such visits to satisfy her guardianship duties. Raven's inaction after May 2006, when Ida had no primary physician and received inadequate in-home care, was a blatant dereliction of her duties.

Accordingly, I concur in the result that substantial evidence supports the Department of Social & Health Services Board of Appeals' finding that Raven did not reasonably perform her guardianship duties especially after it became clear that she was unable to obtain the care and support Ida required. If, because of her own inexperience or for any other reason, Raven could

¹² For purposes of confidentiality, I refer to Ida by her first name only.

No. 40809-1-II

no longer facilitate Ida's necessary medical care (either by hiring the funded additional independent care providers or placing Ida in a residential treatment facility), then implicit in her guardianship duties was her duty to release herself as guardian and ask the trial court that she be replaced with someone better qualified.


QUINN-BRINTNALL, J.

Raven v. DSHS

No. 40809-1-II

Petition for Review

Petitioner's Appendix – Relevant Statutes



WASHINGTON STATE LEGISLATURE

Legislature Home | Senate | House of Representatives | Contact Us | Search | Help

Inside the Legislature

- * Find Your Legislator
- * Visiting the Legislature
- * Agendas, Schedules and Calendars
- * Bill Information
- * Laws and Agency Rules
- * Legislative Committees
- * Legislative Agencies
- * Legislative Information Center
- * E-mail Notifications (Listserv)
- * Civic Education
- * History of the State Legislature

Outside the Legislature

- * Congress - the Other Washington
- * TVW
- * Washington Courts
- * OFM Fiscal Note Website

[RCWs](#) > [Title 11](#) > [Chapter 11.92](#) > [Section 11.92.190](#)

[11.92.185](#) << 11.92.190 >> End of Chapter

RCW 11.92.190

Detention of person in residential placement facility against will prohibited — Effect of court order — Service of notice of residential placement.

No residential treatment facility which provides nursing or other care may detain a person within such facility against their will. Any court order, other than an order issued in accordance with the involuntary treatment provisions of chapters [10.77](#), [71.05](#), and [72.23](#) RCW, which purports to authorize such involuntary detention or purports to authorize a guardian or limited guardian to consent to such involuntary detention on behalf of an incapacitated person shall be void and of no force or effect. This section does not apply to the detention of a minor as provided in chapter [70.96A](#) or [71.34](#) RCW.

Nothing in this section shall be construed to require a court order authorizing placement of an incapacitated person in a residential treatment facility if such order is not otherwise required by law: PROVIDED, That notice of any residential placement of an incapacitated person shall be served, either before or after placement, by the guardian or limited guardian on such person, the guardian ad litem of record, and any attorney of record.

[1996 c 249 § 11; 1977 ex.s. c 309 § 14.]

Notes:

Intent -- 1996 c 249: See note following RCW [2.56.030](#).

Severability -- 1977 ex.s. c 309: See note following RCW [11.88.005](#).



A - 28

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

WASHINGTON STATE DSHS,

Appellant,

v.

RESA RAVEN,

Respondent.

No. 40809-1-II

ORDER DENYING MOTION FOR RECONSIDERATION

COURT OF APPEALS
DIVISION II
12 MAY -7 AM 10:04
STATE OF WASHINGTON
BY REPBY

RESPONDENT, Resa Raven, moves for reconsideration of the Court's **March 27, 2012**

opinion. Upon consideration, the Court denies the motion. Accordingly, it is

SO ORDERED.

PANEL: Jj. Armstrong, Quinn-Brintnall, Worswick

DATED this 7th day of May, 2012.

FOR THE COURT:

Worswick, Jcj
ACTING CHIEF JUDGE

Susan L Kas
Disability Rights Washington
315 5th Ave S Ste 850
Seattle, WA, 98104-2691

Jeff B. Crollard
Crollard Law Office, PLLC
1904 3rd Ave Ste 1030
Seattle, WA, 98101-1170

Carol S. Vaughn
Thompson & Howle Downtown Office
601 Union St Ste 3232
Seattle, WA, 98101-2331

Karen Marie Thompson
Attorney at Law
4115 Roosevelt Way NE Ste B
Seattle, WA, 98105-6473

Catherine Roubal Hoover
Attorney General of Washington
7141 Cleanwater Dr SW
PO Box 40124
Olympia, WA, 98504-0124

A - 1



Inside the Legislature

- * Find Your Legislator
- * Visiting the Legislature
- * Agendas, Schedules and Calendars
- * Bill Information
- * Laws and Agency Rules
- * Legislative Committees
- * Legislative Agencies
- * Legislative Information Center
- * E-mail Notifications (Listserv)
- * Civic Education
- * History of the State Legislature

Outside the Legislature

- * Congress - the Other Washington
- * TVW
- * Washington Courts
- * OFM Fiscal Note Website



[RCWs](#) > [Title 7](#) > [Chapter 7.70](#) > [Section 7.70.065](#)

[7.70.060](#) << [7.70.065](#) >> [7.70.068](#)

RCW 7.70.065

Informed consent — Persons authorized to provide for patients who are not competent — Priority.

(1) Informed consent for health care for a patient who is not competent, as defined in RCW [11.88.010\(1\)\(e\)](#), to consent may be obtained from a person authorized to consent on behalf of such patient.

(a) Persons authorized to provide informed consent to health care on behalf of a patient who is not competent to consent, based upon a reason other than incapacity as defined in RCW [11.88.010\(1\)\(d\)](#), shall be a member of one of the following classes of persons in the following order of priority:

- (i) The appointed guardian of the patient, if any;
- (ii) The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions;
- (iii) The patient's spouse or state registered domestic partner;
- (iv) Children of the patient who are at least eighteen years of age;
- (v) Parents of the patient; and
- (vi) Adult brothers and sisters of the patient.

(b) If the health care provider seeking informed consent for proposed health care of the patient who is not competent to consent under RCW [11.88.010\(1\)\(e\)](#), other than a person determined to be incapacitated because he or she is under the age of majority and who is not otherwise authorized to provide informed consent, makes reasonable efforts to locate and secure authorization from a competent person in the first or succeeding class and finds no such person available, authorization may be given by any person in the next class in the order of descending priority. However, no person under this section may provide informed consent to health care:

- (i) If a person of higher priority under this section has refused to give such authorization; or
- (ii) If there are two or more individuals in the same class and the decision is not unanimous among all available members of that class.

(c) Before any person authorized to provide informed consent on behalf of a patient not competent to consent under RCW [11.88.010\(1\)\(e\)](#), other than a person determined to be incapacitated because he or she is under the age of majority and who is not otherwise authorized to provide informed consent, exercises that authority, the person must first determine in good faith that that patient, if competent, would consent to the proposed health care. If such a determination cannot be made, the decision to consent to the proposed health care may be made only after determining that the proposed health care is in the patient's best interests.

(2) Informed consent for health care, including mental health care, for a patient who is not competent, as defined in RCW [11.88.010\(1\)\(e\)](#), because he or she is under the age of majority and who is not otherwise authorized to provide informed consent, may be obtained from a person authorized to consent on behalf of such a patient.

(a) Persons authorized to provide informed consent to health care, including mental health care, on behalf of a patient who is incapacitated, as defined in RCW [11.88.010\(1\)\(e\)](#), because he or she is under the age of majority and who is not otherwise authorized to provide informed consent, shall be a member of one of the following classes of persons in the following order of priority:

- (i) The appointed guardian, or legal custodian authorized pursuant to Title [26](#) RCW, of the minor patient, if any;

A-29

(ii) A person authorized by the court to consent to medical care for a child in out-of-home placement pursuant to chapter 13.32A or 13.34 RCW, if any;

(iii) Parents of the minor patient;

(iv) The individual, if any, to whom the minor's parent has given a signed authorization to make health care decisions for the minor patient; and

(v) A competent adult representing himself or herself to be a relative responsible for the health care of such minor patient or a competent adult who has signed and dated a declaration under penalty of perjury pursuant to RCW 9A.72.085 stating that the adult person is a relative responsible for the health care of the minor patient. Such declaration shall be effective for up to six months from the date of the declaration.

(b) A health care provider may, but is not required to, rely on the representations or declaration of a person claiming to be a relative responsible for the care of the minor patient, under (a)(v) of this subsection, if the health care provider does not have actual notice of the falsity of any of the statements made by the person claiming to be a relative responsible for the health care of the minor patient.

(c) A health care facility or a health care provider may, in its discretion, require documentation of a person's claimed status as being a relative responsible for the health care of the minor patient. However, there is no obligation to require such documentation.

(d) The health care provider or health care facility where services are rendered shall be immune from suit in any action, civil or criminal, or from professional or other disciplinary action when such reliance is based on a declaration signed under penalty of perjury pursuant to RCW 9A.72.085 stating that the adult person is a relative responsible for the health care of the minor patient under (a)(v) of this subsection.

(3) For the purposes of this section, "health care," "health care provider," and "health care facility" shall be defined as established in RCW 70.02.010.

[2007 c 156 § 11; 2006 c 93 § 1; 2005 c 440 § 2; 2003 c 283 § 29; 1987 c 162 § 1.]

Notes:

Intent -- 2005 c 440: "(1) It is the intent of the legislature to assist children in the care of kin to access appropriate medical services. Children being raised by kin have faced barriers to medical care because their kinship caregivers have not been able to verify that they are the identified primary caregivers of these children. Such barriers pose an especially significant challenge to kinship caregivers in dealing with health professionals when children are left in their care.

(2) It is the intent of the legislature to assist kinship caregivers in accessing appropriate medical care to meet the needs of a child in their care by permitting such responsible adults who are providing care to a child to give informed consent to medical care." [2005 c 440 § 1.]

Severability -- Part headings not law--2003 c 283: See RCW 71.32.900 and 71.32.901.

A - 30

Raven v. DSHS

No. 40809-1-II

Petition for Review

Petitioner's Appendix



Inside the Legislature

- * Find Your Legislator
- * Visiting the Legislature
- * Agendas, Schedules and Calendars
- * Bill Information
- * Laws and Agency Rules
- * Legislative Committees
- * Legislative Agencies
- * Legislative Information Center
- * E-mail Notifications (Listserv)
- * Civic Education
- * History of the State Legislature

Outside the Legislature

- * Congress - the Other Washington
- * TVW
- * Washington Courts
- * OFM Fiscal Note Website



[RCWs](#) > [Title 11](#) > [Chapter 11.92](#) > [Section 11.92.043](#)

[11.92.040](#) << [11.92.043](#) >> [11.92.050](#)

RCW 11.92.043 Additional duties.

It shall be the duty of the guardian or limited guardian of the person:

(1) To file within three months after appointment a personal care plan for the incapacitated person which shall include (a) an assessment of the incapacitated person's physical, mental, and emotional needs and of such person's ability to perform or assist in activities of daily living, and (b) the guardian's specific plan for meeting the identified and emerging personal care needs of the incapacitated person.

(2) To file annually or, where a guardian of the estate has been appointed, at the time an account is required to be filed under RCW [11.92.040](#), a report on the status of the incapacitated person, which shall include:

- (a) The address and name of the incapacitated person and all residential changes during the period;
- (b) The services or programs which the incapacitated person receives;
- (c) The medical status of the incapacitated person;
- (d) The mental status of the incapacitated person;
- (e) Changes in the functional abilities of the incapacitated person;
- (f) Activities of the guardian for the period;
- (g) Any recommended changes in the scope of the authority of the guardian;
- (h) The identity of any professionals who have assisted the incapacitated person during the period;

(i)(i) Evidence of the guardian or limited guardian's successful completion of any standardized training video or web cast for guardians or limited guardians made available by the administrative office of the courts and the superior court when the guardian or limited guardian: (A) Was appointed prior to July 22, 2011; (B) is not a certified professional guardian or financial institution authorized under RCW [11.88.020](#); and (C) has not previously completed the requirements of RCW [11.88.020](#)(3). The training video or web cast must be provided at no cost to the guardian or limited guardian.

(ii) The superior court may, upon (A) petition by the guardian or limited guardian; or (B) any other method as provided by local court rule:

(i) For good cause, waive this requirement for guardians appointed prior to July 22, 2011. Good cause shall require evidence that the guardian already possesses the requisite knowledge to serve as a guardian without completing the training. When determining whether there is good cause to waive the training requirement, the court shall consider, among other facts, the length of time the guardian has been serving the incapacitated person; whether the guardian has timely filed all required reports with the court; whether the guardian is monitored by other state or local agencies; and whether there have been any allegations of abuse, neglect, or a breach of fiduciary duty against the guardian; or

(ii) Extend the time period for completion of the training requirement for ninety days; and

(j) Evidence of the guardian or limited guardian's successful completion of any additional or updated training video or web cast offered by the administrative office of the courts and the superior court as is required at the discretion of the superior court unless the guardian or limited guardian is a certified professional guardian or financial institution authorized under RCW [11.88.020](#). The training video or web cast must be provided at no cost to the guardian or limited guardian.

(3) To report to the court within thirty days any substantial change in the incapacitated person's condition, or any changes in residence of the incapacitated person.

A-31

(4) Consistent with the powers granted by the court, to care for and maintain the incapacitated person in the setting least restrictive to the incapacitated person's freedom and appropriate to the incapacitated person's personal care needs, assert the incapacitated person's rights and best interests, and if the incapacitated person is a minor or where otherwise appropriate, to see that the incapacitated person receives appropriate training and education and that the incapacitated person has the opportunity to learn a trade, occupation, or profession.

(5) Consistent with RCW 7.70.065, to provide timely, informed consent for health care of the incapacitated person, except in the case of a limited guardian where such power is not expressly provided for in the order of appointment or subsequent modifying order as provided in RCW 11.88.125 as now or hereafter amended, the standby guardian or standby limited guardian may provide timely, informed consent to necessary medical procedures if the guardian or limited guardian cannot be located within four hours after the need for such consent arises. No guardian, limited guardian, or standby guardian may involuntarily commit for mental health treatment, observation, or evaluation an alleged incapacitated person who is unable or unwilling to give informed consent to such commitment unless the procedures for involuntary commitment set forth in chapter 71.05 or 72.23 RCW are followed. Nothing in this section shall be construed to allow a guardian, limited guardian, or standby guardian to consent to:

(a) Therapy or other procedure which induces convulsion;

(b) Surgery solely for the purpose of psychosurgery;

(c) Other psychiatric or mental health procedures that restrict physical freedom of movement, or the rights set forth in RCW 71.05.217.

A guardian, limited guardian, or standby guardian who believes these procedures are necessary for the proper care and maintenance of the incapacitated person shall petition the court for an order unless the court has previously approved the procedure within the past thirty days. The court may order the procedure only after an attorney is appointed in accordance with RCW 11.88.045 if no attorney has previously appeared, notice is given, and a hearing is held in accordance with RCW 11.88.040.

[2011 c 329 § 3; 1991 c 289 § 11; 1990 c 122 § 21.]

Notes:

Effective date -- 1990 c 122: See note following RCW 11.88.005.

A - 32



Legislature Home | Senate | House of Representatives | Contact Us | Search | Help

Inside the Legislature

- * Find Your Legislator
- * Visiting the Legislature
- * Agendas, Schedules and Calendars
- * Bill Information
- * Laws and Agency Rules
- * Legislative Committees
- * Legislative Agencies
- * Legislative Information Center
- * E-mail Notifications (Listserv)
- * Civic Education
- * History of the State Legislature

Outside the Legislature

- * Congress - the Other Washington
- * TVW
- * Washington Courts
- * OFM Fiscal Note Website



[RCWs](#) > [Title 74](#) > [Chapter 74.34](#) > [Section 74.34.020](#)

[74.34.005](#) << [74.34.020](#) >> [74.34.025](#)

RCW 74.34.020

Definitions. (*Effective until January 1, 2012.*)

*** CHANGE IN 2012 *** (SEE [2056-S.SL](#)) ***

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Abandonment" means action or inaction by a person or entity with a duty of care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.

(2) "Abuse" means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a vulnerable adult, which have the following meanings:

(a) "Sexual abuse" means any form of nonconsensual sexual contact, including but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under chapter [71A.12](#) RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under chapter [71A.12](#) RCW, whether or not it is consensual.

(b) "Physical abuse" means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately.

(c) "Mental abuse" means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.

(d) "Exploitation" means an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another.

(3) "Consent" means express written consent granted after the vulnerable adult or his or her legal representative has been fully informed of the nature of the services to be offered and that the receipt of services is voluntary.

(4) "Department" means the department of social and health services.

(5) "Facility" means a residence licensed or required to be licensed under chapter [18.20](#) RCW, boarding homes; chapter [18.51](#) RCW, nursing homes; chapter [70.128](#) RCW, adult family homes; chapter [72.36](#) RCW, soldiers' homes; or chapter [71A.20](#) RCW, residential habilitation centers; or any other facility licensed or certified by the department.

(6) "Financial exploitation" means the illegal or improper use, control over, or withholding of the property, income, resources, or trust funds of the vulnerable adult by any person or entity for any person's or entity's profit or advantage other than for the vulnerable adult's profit or advantage. "Financial exploitation" includes, but is not limited to:

(a) The use of deception, intimidation, or undue influence by a person or entity in a position of trust and confidence with a vulnerable adult to obtain or use the property, income, resources, or trust funds of the vulnerable adult for the benefit of a person or entity other than the vulnerable adult;

A - 33

(b) The breach of a fiduciary duty, including, but not limited to, the misuse of a power of attorney, trust, or a guardianship appointment, that results in the unauthorized appropriation, sale, or transfer of the property, income, resources, or trust funds of the vulnerable adult for the benefit of a person or entity other than the vulnerable adult; or

(c) Obtaining or using a vulnerable adult's property, income, resources, or trust funds without lawful authority, by a person or entity who knows or clearly should know that the vulnerable adult lacks the capacity to consent to the release or use of his or her property, income, resources, or trust funds.

(7) "Financial institution" has the same meaning as in RCW 30.22.040 and 30.22.041. For purposes of this chapter only, "financial institution" also means a "broker-dealer" or "investment adviser" as defined in RCW 21.20.005.

(8) "Incapacitated person" means a person who is at a significant risk of personal or financial harm under RCW 11.88.010(1) (a), (b), (c), or (d).

(9) "Individual provider" means a person under contract with the department to provide services in the home under chapter 74.09 or 74.39A RCW.

(10) "Interested person" means a person who demonstrates to the court's satisfaction that the person is interested in the welfare of the vulnerable adult, that the person has a good faith belief that the court's intervention is necessary, and that the vulnerable adult is unable, due to incapacity, undue influence, or duress at the time the petition is filed, to protect his or her own interests.

(11) "Mandated reporter" is an employee of the department; law enforcement officer; social worker; professional school personnel; individual provider; an employee of a facility; an operator of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to chapter 18.130 RCW.

(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, including but not limited to conduct prohibited under RCW 9A.42.100.

(13) "Permissive reporter" means any person, including, but not limited to, an employee of a financial institution, attorney, or volunteer in a facility or program providing services for vulnerable adults.

(14) "Protective services" means any services provided by the department to a vulnerable adult with the consent of the vulnerable adult, or the legal representative of the vulnerable adult, who has been abandoned, abused, financially exploited, neglected, or in a state of self-neglect. These services may include, but are not limited to case management, social casework, home care, placement, arranging for medical evaluations, psychological evaluations, day care, or referral for legal assistance.

(15) "Self-neglect" means the failure of a vulnerable adult, not living in a facility, to provide for himself or herself the goods and services necessary for the vulnerable adult's physical or mental health, and the absence of which impairs or threatens the vulnerable adult's well-being. This definition may include a vulnerable adult who is receiving services through home health, hospice, or a home care agency, or an individual provider when the neglect is not a result of inaction by that agency or individual provider.

(16) "Vulnerable adult" includes a person:

(a) Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself; or

(b) Found incapacitated under chapter 11.88 RCW; or

(c) Who has a developmental disability as defined under RCW 71A.10.020; or

(d) Admitted to any facility; or

(e) Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under chapter 70.127 RCW; or

(f) Receiving services from an individual provider; or

(g) Who self-directs his or her own care and receives services from a personal aide under chapter 74.39 RCW.

A-34

[2011 c 170 § 1; 2010 c 133 § 2; 2007 c 312 § 1; 2006 c 339 § 109; 2003 c 230 § 1; 1999 c 176 § 3; 1997 c 392 § 523; 1995 1st sp.s. c 18 § 84; 1984 c 97 § 8.]

Notes:

Intent -- Part headings not law -- 2006 c 339: See notes following RCW 70.96A.325.

Effective date -- 2003 c 230: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [May 12, 2003]." [2003 c 230 § 3.]

Findings -- Purpose -- Severability -- Conflict with federal requirements -- 1999 c 176: See notes following RCW 74.34.005.

Short title -- Findings -- Construction -- Conflict with federal requirements -- Part headings and captions not law -- 1997 c 392: See notes following RCW 74.39A.009.

Conflict with federal requirements -- Severability -- Effective date -- 1995 1st sp.s. c 18: See notes following RCW 74.39A.030.

RCW 74.34.020

Definitions. (*Effective January 1, 2012.*)

*** CHANGE IN 2012 *** (SEE 2056-S.SL) ***

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Abandonment" means action or inaction by a person or entity with a duty of care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.

(2) "Abuse" means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a vulnerable adult, which have the following meanings:

(a) "Sexual abuse" means any form of nonconsensual sexual contact, including but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under chapter 71A.12 RCW, whether or not it is consensual.

(b) "Physical abuse" means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately.

(c) "Mental abuse" means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.

(d) "Exploitation" means an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another.

(3) "Consent" means express written consent granted after the vulnerable adult or his or her legal representative has been fully informed of the nature of the services to be offered and that the receipt of services is voluntary.

(4) "Department" means the department of social and health services.

(5) "Facility" means a residence licensed or required to be licensed under chapter 18.20 RCW, boarding



Inside the Legislature

- * Find Your Legislator
- * Visiting the Legislature
- * Agendas, Schedules and Calendars
- * Bill Information
- * Laws and Agency Rules
- * Legislative Committees
- * Legislative Agencies
- * Legislative Information Center
- * E-mail Notifications (Listserv)
- * Civic Education
- * History of the State Legislature

Outside the Legislature

- * Congress - the Other Washington
- * TVW
- * Washington Courts
- * OFM Fiscal Note Website



[RCWs](#) > [Title 74](#) > [Chapter 74.39A](#) > [Section 74.39A.051](#)

[74.39A.040](#) << [74.39A.051](#) >> [74.39A.056](#)

RCW 74.39A.051

Quality improvement principles.

*** CHANGE IN 2012 *** (SEE [2314-S.SL](#)) ***

The department's system of quality improvement for long-term care services shall use the following principles, consistent with applicable federal laws and regulations:

(1) The system shall be client-centered and promote privacy, independence, dignity, choice, and a home or home-like environment for consumers consistent with chapter 392, Laws of 1997.

(2) The goal of the system is continuous quality improvement with the focus on consumer satisfaction and outcomes for consumers. This includes that when conducting licensing or contract inspections, the department shall interview an appropriate percentage of residents, family members, resident case managers, and advocates in addition to interviewing providers and staff.

(3) Providers should be supported in their efforts to improve quality and address identified problems initially through training, consultation, technical assistance, and case management.

(4) The emphasis should be on problem prevention both in monitoring and in screening potential providers of service.

(5) Monitoring should be outcome-based and responsive to consumer complaints and based on a clear set of health, quality of care, and safety standards that are easily understandable and have been made available to providers, residents, and other interested parties.

(6) Prompt and specific enforcement remedies shall also be implemented without delay, pursuant to RCW [74.39A.080](#), RCW [70.128.160](#), chapter [18.51](#) RCW, or chapter [74.42](#) RCW, for providers found to have delivered care or failed to deliver care resulting in problems that are serious, recurring, or uncorrected, or that create a hazard that is causing or likely to cause death or serious harm to one or more residents. These enforcement remedies may also include, when appropriate, reasonable conditions on a contract or license. In the selection of remedies, the safety, health, and well-being of residents shall be of paramount importance.

(7) All long-term care workers shall be screened through background checks in a uniform and timely manner to ensure that they do not have a criminal history that would disqualify them from working with vulnerable persons. Long-term care workers who are hired after January 1, 2012, are subject to background checks under *RCW [74.39A.055](#). This information will be shared with the department of health in accordance with *RCW [74.39A.055](#) to advance the purposes of chapter 2, Laws of 2009.

(8) No provider, or its staff, or long-term care worker, or prospective provider or long-term care worker, with a stipulated finding of fact, conclusion of law, an agreed order, or finding of fact, conclusion of law, or final order issued by a disciplining authority, a court of law, or entered into a state registry finding him or her guilty of abuse, neglect, exploitation, or abandonment of a minor or a vulnerable adult as defined in chapter [74.34](#) RCW shall be employed in the care of and have unsupervised access to vulnerable adults.

(9) The department shall establish, by rule, a state registry which contains identifying information about long-term care workers identified under this chapter who have substantiated findings of abuse, neglect, financial exploitation, or abandonment of a vulnerable adult as defined in RCW [74.34.020](#). The rule must include disclosure, disposition of findings, notification, findings of fact, appeal rights, and fair hearing requirements. The department shall disclose, upon request, substantiated findings of abuse, neglect, financial exploitation, or abandonment to any person so requesting this information. This information will also be shared with the department of health to advance the purposes of chapter 2, Laws of 2009.

(10) Until December 31, 2010, individual providers and home care agency providers must satisfactorily complete department-approved orientation, basic training, and continuing education within the time period specified by the department in rule. The department shall adopt rules by March 1, 2002, for the implementation of this section. The department shall deny payment to an individual provider or a home care provider who does

not complete the training requirements within the time limit specified by the department by rule.

(11) Until December 31, 2010, in an effort to improve access to training and education and reduce costs, especially for rural communities, the coordinated system of long-term care training and education must include the use of innovative types of learning strategies such as internet resources, videotapes, and distance learning using satellite technology coordinated through community colleges or other entities, as defined by the department.

(12) The department shall create an approval system by March 1, 2002, for those seeking to conduct department-approved training.

(13) The department shall establish, by rule, background checks and other quality assurance requirements for long-term care workers who provide in-home services funded by medicaid personal care as described in RCW 74.09.520, community options program entry system waiver services as described in RCW 74.39A.030, or chore services as described in RCW 74.39A.110 that are equivalent to requirements for individual providers. Long-term care workers who are hired after January 1, 2012, are subject to background checks under *RCW 74.39A.055.

(14) Under existing funds the department shall establish internally a quality improvement standards committee to monitor the development of standards and to suggest modifications.

(15) Within existing funds, the department shall design, develop, and implement a long-term care training program that is flexible, relevant, and qualifies towards the requirements for a nursing assistant certificate as established under chapter 18.88A RCW. This subsection does not require completion of the nursing assistant certificate training program by providers or their staff. The long-term care teaching curriculum must consist of a fundamental module, or modules, and a range of other available relevant training modules that provide the caregiver with appropriate options that assist in meeting the resident's care needs. Some of the training modules may include, but are not limited to, specific training on the special care needs of persons with developmental disabilities, dementia, mental illness, and the care needs of the elderly. No less than one training module must be dedicated to workplace violence prevention. The nursing care quality assurance commission shall work together with the department to develop the curriculum modules. The nursing care quality assurance commission shall direct the nursing assistant training programs to accept some or all of the skills and competencies from the curriculum modules towards meeting the requirements for a nursing assistant certificate as defined in chapter 18.88A RCW. A process may be developed to test persons completing modules from a caregiver's class to verify that they have the transferable skills and competencies for entry into a nursing assistant training program. The department may review whether facilities can develop their own related long-term care training programs. The department may develop a review process for determining what previous experience and training may be used to waive some or all of the mandatory training. The department of social and health services and the nursing care quality assurance commission shall work together to develop an implementation plan by December 12, 1998.

[2012 c 1 § 106 (Initiative Measure No. 1163, approved November 8, 2011).]

Notes:

Reviser's note: *(1) RCW 74.39A.055 was repealed by 2012 c 1 § 115. A new section using identical language was enacted by 2012 c 1 § 101 and is codified as RCW 74.39A.056.

(2) The language of this section, as enacted by 2012 c 1 § 106, is identical to RCW 74.39A.050 as amended by 2009 c 580 § 7, which was repealed by 2012 c 1 § 115.

Intent -- Findings -- Performance audits -- Spending limits -- Contingent effective dates - Application -- Construction -- Effective date -- Short title -- 2012 c 1 (Initiative Measure No. 1163): See notes following RCW 74.39A.056.

A - 37



Inside the Legislature

- * Find Your Legislator
- * Visiting the Legislature
- * Agendas, Schedules and Calendars
- * Bill Information
- * Laws and Agency Rules
- * Legislative Committees
- * Legislative Agencies
- * Legislative Information Center
- * E-mail Notifications (Listserv)
- * Civic Education
- * History of the State Legislature

Outside the Legislature

- * Congress - the Other Washington
- * TVW
- * Washington Courts
- * OFM Fiscal Note Website



[RCWs](#) > [Title 43](#) > [Chapter 43.43](#) > [Section 43.43.834](#)

[43.43.833](#) << [43.43.834](#) >> [43.43.836](#)

RCW 43.43.834

Background checks by business, organization, or insurance company — Limitations — Civil liability.

(1) A business or organization shall not make an inquiry to the Washington state patrol under [RCW 43.43.832](#) or an equivalent inquiry to a federal law enforcement agency unless the business or organization has notified the applicant who may be offered a position as an employee or volunteer, that an inquiry may be made.

(2) A business or organization shall require each applicant to disclose to the business or organization whether the applicant:

(a) Has been convicted of a crime;

(b) Has had findings made against him or her in any civil adjudicative proceeding as defined in [RCW 43.43.830](#); or

(c) Has both a conviction under (a) of this subsection and findings made against him or her under (b) of this subsection.

(3) The business or organization shall pay such reasonable fee for the records check as the state patrol may require under [RCW 43.43.838](#).

(4) The business or organization shall notify the applicant of the state patrol's response within ten days after receipt by the business or organization. The employer shall provide a copy of the response to the applicant and shall notify the applicant of such availability.

(5) The business or organization shall use this record only in making the initial employment or engagement decision. Further dissemination or use of the record is prohibited, except as provided in [RCW 28A.320.155](#). A business or organization violating this subsection is subject to a civil action for damages.

(6) An insurance company shall not require a business or organization to request background information on any employee before issuing a policy of insurance.

(7) The business and organization shall be immune from civil liability for failure to request background information on an applicant unless the failure to do so constitutes gross negligence.

[2005 c 421 § 3; 1999 c 21 § 2; 1998 c 10 § 3; 1990 c 3 § 1103. Prior: 1989 c 334 § 3; 1989 c 90 § 3; 1987 c 486 § 3.]

Notes:

Index, part headings not law -- Severability -- Effective dates -- Application -- 1990 c 3:
See [RCW 18.155.900](#) through [18.155.902](#).

A-38



Inside the Legislature

- * Find Your Legislator
- * Visiting the Legislature
- * Agendas, Schedules and Calendars
- * Bill Information
- * Laws and Agency Rules
- * Legislative Committees
- * Legislative Agencies
- * Legislative Information Center
- * E-mail Notifications (Listserv)
- * Civic Education
- * History of the State Legislature

Outside the Legislature

- * Congress - the Other Washington
- * TVW
- * Washington Courts
- * OFM Fiscal Note Website



[RCWs](#) > [Title 43](#) > [Chapter 43.43](#) > [Section 43.43.830](#)

[43.43.825](#) << [43.43.830](#) >> [43.43.832](#)

RCW 43.43.830

Background checks — Access to children or vulnerable persons — Definitions.

*** CHANGE IN 2012 *** (SEE [6167-S.SL](#)) ***

Unless the context clearly requires otherwise, the definitions in this section apply throughout RCW [43.43.830](#) through [43.43.845](#).

(1) "Agency" means any person, firm, partnership, association, corporation, or facility which receives, provides services to, houses or otherwise cares for vulnerable adults, juveniles, or children, or which provides child day care, early learning, or early childhood education services.

(2) "Applicant" means:

(a) Any prospective employee who will or may have unsupervised access to children under sixteen years of age or developmentally disabled persons or vulnerable adults during the course of his or her employment or involvement with the business or organization;

(b) Any prospective volunteer who will have regularly scheduled unsupervised access to children under sixteen years of age, developmentally disabled persons, or vulnerable adults during the course of his or her employment or involvement with the business or organization under circumstances where such access will or may involve groups of (i) five or fewer children under twelve years of age, (ii) three or fewer children between twelve and sixteen years of age, (iii) developmentally disabled persons, or (iv) vulnerable adults;

(c) Any prospective adoptive parent, as defined in RCW [26.33.020](#); or

(d) Any prospective custodian in a nonparental custody proceeding under chapter [26.10](#) RCW.

(3) "Business or organization" means a person, business, or organization licensed in this state, any agency of the state, or other governmental entity, that educates, trains, treats, supervises, houses, or provides recreation to developmentally disabled persons, vulnerable adults, or children under sixteen years of age, or that provides child day care, early learning, or early learning childhood education services, including but not limited to public housing authorities, school districts, and educational service districts.

(4) "Civil adjudication proceeding" is a judicial or administrative adjudicative proceeding that results in a finding of, or upholds an agency finding of, domestic violence, abuse, sexual abuse, neglect, abandonment, violation of a professional licensing standard regarding a child or vulnerable adult, or exploitation or financial exploitation of a child or vulnerable adult under any provision of law, including but not limited to chapter [13.34](#), [26.44](#), or [74.34](#) RCW, or rules adopted under chapters [18.51](#) and [74.42](#) RCW. "Civil adjudication proceeding" also includes judicial or administrative findings that become final due to the failure of the alleged perpetrator to timely exercise a legal right to administratively challenge such findings.

(5) "Conviction record" means "conviction record" information as defined in RCW [10.97.030](#) and [10.97.050](#) relating to a crime committed by either an adult or a juvenile. It does not include a conviction for an offense that has been the subject of an expungement, pardon, annulment, certificate of rehabilitation, or other equivalent procedure based on a finding of the rehabilitation of the person convicted, or a conviction that has been the subject of a pardon, annulment, or other equivalent procedure based on a finding of innocence. It does include convictions for offenses for which the defendant received a deferred or suspended sentence, unless the record has been expunged according to law.

(6) "Crime against children or other persons" means a conviction of any of the following offenses: Aggravated murder; first or second degree murder; first or second degree kidnapping; first, second, or third degree assault; first, second, or third degree assault of a child; first, second, or third degree rape; first, second, or third degree rape of a child; first or second degree robbery; first degree arson; first degree burglary; first or second degree manslaughter; first or second degree extortion; indecent liberties; incest; vehicular homicide;

first degree promoting prostitution; communication with a minor; unlawful imprisonment; simple assault; sexual exploitation of minors; first or second degree criminal mistreatment; endangerment with a controlled substance; child abuse or neglect as defined in RCW 26.44.020; first or second degree custodial interference; first or second degree custodial sexual misconduct; malicious harassment; first, second, or third degree child molestation; first or second degree sexual misconduct with a minor; commercial sexual abuse of a minor; child abandonment; promoting pornography; selling or distributing erotic material to a minor; custodial assault; violation of child abuse restraining order; child buying or selling; prostitution; felony indecent exposure; criminal abandonment; or any of these crimes as they may be renamed in the future.

(7) "Crimes relating to drugs" means a conviction of a crime to manufacture, delivery, or possession with intent to manufacture or deliver a controlled substance.

(8) "Crimes relating to financial exploitation" means a conviction for first, second, or third degree extortion; first, second, or third degree theft; first or second degree robbery; forgery; or any of these crimes as they may be renamed in the future.

(9) "Financial exploitation" means "financial exploitation" as defined in RCW 74.34.020.

(10) "Peer counselor" means a nonprofessional person who has equal standing with another person, providing advice on a topic about which the nonprofessional person is more experienced or knowledgeable, and who is a counselor for a peer counseling program that contracts with or is otherwise approved by the department, another state or local agency, or the court.

(11) "Unsupervised" means not in the presence of:

(a) Another employee or volunteer from the same business or organization as the applicant; or

(b) Any relative or guardian of any of the children or developmentally disabled persons or vulnerable adults to which the applicant has access during the course of his or her employment or involvement with the business or organization.

With regard to peer counselors, "unsupervised" does not include incidental contact with children under age sixteen at the location at which the peer counseling is taking place. "Incidental contact" means minor or casual contact with a child in an area accessible to and within visual or auditory range of others. It could include passing a child while walking down a hallway but would not include being alone with a child for any period of time in a closed room or office.

(12) "Vulnerable adult" means "vulnerable adult" as defined in chapter 74.34 RCW, except that for the purposes of requesting and receiving background checks pursuant to RCW 43.43.832, it shall also include adults of any age who lack the functional, mental, or physical ability to care for themselves.

[2011 c 253 § 5; 2007 c 387 § 9; 2005 c 421 § 1; 2003 c 105 § 5; 2002 c 229 § 3; 1999 c 45 § 5; 1998 c 10 § 1; 1996 c 178 § 12; 1995 c 250 § 1; 1994 c 108 § 1; 1992 c 145 § 16. Prior: 1990 c 146 § 8; 1990 c 3 § 1101; prior: 1989 c 334 § 1; 1989 c 90 § 1; 1987 c 486 § 1.]

Notes:

Reviser's note: The definitions in this section have been alphabetized pursuant to RCW 1.08.015(2)(k).

Effective date -- 2002 c 229: See note following RCW 9A.42.100.

Effective date -- 1996 c 178: See note following RCW 18.35.110.

Index, part headings not law -- Severability -- Effective dates -- Application -- 1990 c 3: See RCW 18.155.900 through 18.155.902.

At-risk children volunteer program: RCW 43.150.080.

State hospitals: RCW 72.23.035.

A - 40



Inside the Legislature

- * [Find Your Legislator](#)
- * [Visiting the Legislature](#)
- * [Agendas, Schedules and Calendars](#)
- * [Bill Information](#)
- * [Laws and Agency Rules](#)
- * [Legislative Committees](#)
- * [Legislative Agencies](#)
- * [Legislative Information Center](#)
- * [E-mail Notifications \(Listserv\)](#)
- * [Civic Education](#)
- * [History of the State Legislature](#)

Outside the Legislature

- * [Congress - the Other Washington](#)
- * [TVW](#)
- * [Washington Courts](#)
- * [OFM Fiscal Note Website](#)



[RCWs](#) > [Title 43](#) > [Chapter 43.43](#) > [Section 43.43.832](#)

[43.43.830](#) << [43.43.832](#) >> [43.43.8321](#)

RCW 43.43.832

Background checks — Disclosure of information — Sharing of criminal background information by health care facilities.

*** CHANGE IN 2012 *** (SEE [2056-S.SL](#)) ***

*** CHANGE IN 2012 *** (SEE [6167-S.SL](#)) ***

(1) The legislature finds that businesses and organizations providing services to children, developmentally disabled persons, and vulnerable adults need adequate information to determine which employees or licensees to hire or engage. The legislature further finds that many developmentally disabled individuals and vulnerable adults desire to hire their own employees directly and also need adequate information to determine which employees or licensees to hire or engage. Therefore, the Washington state patrol identification and criminal history section shall disclose, upon the request of a business or organization as defined in RCW [43.43.830](#), a developmentally disabled person, or a vulnerable adult as defined in RCW [43.43.830](#) or his or her guardian, an applicant's conviction record as defined in chapter [10.97](#) RCW.

(2) The legislature also finds that the Washington professional educator standards board may request of the Washington state patrol criminal identification system information regarding a certificate applicant's conviction record under subsection (1) of this section.

(3) The legislature also finds that law enforcement agencies, the office of the attorney general, prosecuting authorities, and the department of social and health services may request this same information to aid in the investigation and prosecution of child, developmentally disabled person, and vulnerable adult abuse cases and to protect children and adults from further incidents of abuse.

(4) The legislature further finds that the secretary of the department of social and health services must establish rules and set standards to require specific action when considering the information listed in subsection (1) of this section, and when considering additional information including but not limited to civil adjudication proceedings as defined in RCW [43.43.830](#) and any out-of-state equivalent, in the following circumstances:

(a) When considering persons for state employment in positions directly responsible for the supervision, care, or treatment of children, vulnerable adults, or individuals with mental illness or developmental disabilities;

(b) When considering persons for state positions involving unsupervised access to vulnerable adults to conduct comprehensive assessments, financial eligibility determinations, licensing and certification activities, investigations, surveys, or case management; or for state positions otherwise required by federal law to meet employment standards;

(c) When licensing agencies or facilities with individuals in positions directly responsible for the care, supervision, or treatment of children, developmentally disabled persons, or vulnerable adults, including but not limited to agencies or facilities licensed under chapter [74.15](#) or [18.51](#) RCW;

(d) When contracting with individuals or businesses or organizations for the care, supervision, case management, or treatment, including peer counseling, of children, developmentally disabled persons, or vulnerable adults, including but not limited to services contracted for under chapter [18.20](#), [70.127](#), [70.128](#), [72.36](#), or [74.39A](#) RCW or Title [71A](#) RCW;

(e) When individual providers are paid by the state or providers are paid by home care agencies to provide in-home services involving unsupervised access to persons with physical, mental, or developmental disabilities or mental illness, or to vulnerable adults as defined in chapter [74.34](#) RCW, including but not limited to services provided under chapter [74.39](#) or [74.39A](#) RCW.

A-41

(5) The director of the department of early learning shall investigate the conviction records, pending charges, and other information including civil adjudication proceeding records of current employees and of any person actively being considered for any position with the department who will or may have unsupervised access to children, or for state positions otherwise required by federal law to meet employment standards. "Considered for any position" includes decisions about (a) initial hiring, layoffs, reallocations, transfers, promotions, or demotions, or (b) other decisions that result in an individual being in a position that will or may have unsupervised access to children as an employee, an intern, or a volunteer.

(6) The director of the department of early learning shall adopt rules and investigate conviction records, pending charges, and other information including civil adjudication proceeding records, in the following circumstances:

(a) When licensing or certifying agencies with individuals in positions that will or may have unsupervised access to children who are in child day care, in early learning programs, or receiving early childhood education services, including but not limited to licensees, agency staff, interns, volunteers, contracted providers, and persons living on the premises who are sixteen years of age or older;

(b) When authorizing individuals who will or may have unsupervised access to children who are in child day care, in early learning programs, or receiving early childhood learning education services in licensed or certified agencies, including but not limited to licensees, agency staff, interns, volunteers, contracted providers, and persons living on the premises who are sixteen years of age or older;

(c) When contracting with any business or organization for activities that will or may have unsupervised access to children who are in child day care, in early learning programs, or receiving early childhood learning education services;

(d) When establishing the eligibility criteria for individual providers to receive state paid subsidies to provide child day care or early learning services that will or may involve unsupervised access to children.

(7) Whenever a state conviction record check is required by state law, persons may be employed or engaged as volunteers or independent contractors on a conditional basis pending completion of the state background investigation. Whenever a national criminal record check through the federal bureau of investigation is required by state law, a person may be employed or engaged as a volunteer or independent contractor on a conditional basis pending completion of the national check. The Washington personnel resources board shall adopt rules to accomplish the purposes of this subsection as it applies to state employees.

(8)(a) For purposes of facilitating timely access to criminal background information and to reasonably minimize the number of requests made under this section, recognizing that certain health care providers change employment frequently, health care facilities may, upon request from another health care facility, share copies of completed criminal background inquiry information.

(b) Completed criminal background inquiry information may be shared by a willing health care facility only if the following conditions are satisfied: The licensed health care facility sharing the criminal background inquiry information is reasonably known to be the person's most recent employer, no more than twelve months has elapsed from the date the person was last employed at a licensed health care facility to the date of their current employment application, and the criminal background information is no more than two years old.

(c) If criminal background inquiry information is shared, the health care facility employing the subject of the inquiry must require the applicant to sign a disclosure statement indicating that there has been no conviction or finding as described in RCW 43.43.842 since the completion date of the most recent criminal background inquiry.

(d) Any health care facility that knows or has reason to believe that an applicant has or may have a disqualifying conviction or finding as described in RCW 43.43.842, subsequent to the completion date of their most recent criminal background inquiry, shall be prohibited from relying on the applicant's previous employer's criminal background inquiry information. A new criminal background inquiry shall be requested pursuant to RCW 43.43.830 through 43.43.842.

(e) Health care facilities that share criminal background inquiry information shall be immune from any claim of defamation, invasion of privacy, negligence, or any other claim in connection with any dissemination of this information in accordance with this subsection.

(f) Health care facilities shall transmit and receive the criminal background inquiry information in a manner that reasonably protects the subject's rights to privacy and confidentiality.

(g) For the purposes of this subsection, "health care facility" means a nursing home licensed under chapter 18.51 RCW, a boarding home licensed under chapter 18.20 RCW, or an adult family home licensed under chapter 70.128 RCW.

A-42

[2011 c 253 § 6; 2007 c 387 § 10; 2006 c 263 § 826; 2005 c 421 § 2; 2000 c 87 § 1; 1997 c 392 § 524; 1995 c 250 § 2; 1993 c 281 § 51; 1990 c 3 § 1102. Prior: 1989 c 334 § 2; 1989 c 90 § 2; 1987 c 486 § 2.]

Notes:

Findings -- Purpose -- Part headings not law -- 2006 c 263: See notes following RCW 28A.150.230.

Short title--Findings -- Construction--Conflict with federal requirements--Part headings and captions not law--1997 c 392: See notes following RCW 74.39A.009.

Effective date -- 1993 c 281: See note following RCW 41.06.022.

Index, part headings not law -- Severability -- Effective dates -- Application -- 1990 c 3: See RCW 18.155.900 through 18.155.902.

A - 43