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# PROTECTING RIGHTS OR WAIVING THEM? WHY “NEGOTIATED RISK” SHOULD BE REMOVED FROM ASSISTED LIVING LAW

ERIC M. CARLSON\*

## INTRODUCTION

Assisted living facilities care for approximately one million elderly Americans.<sup>1</sup> According to assisted living supporters, a key facet of assisted living is the value placed on residents’ autonomy. Supporters praise “negotiated risk” as an important tool for promoting and supporting that autonomy.<sup>2</sup>

This article demonstrates that negotiated risk actually is harmful to assisted living residents. The central problem is that negotiated risk has no settled definition. Discussions of—or arguments about—negotiated risk tend to careen back and forth fruitlessly due to the discussants’ continued inability or unwillingness to define negotiated risk in the first place.<sup>3</sup>

In general, the shape-shifting of negotiated risk occurs between two shapes. In one shape, negotiated risk signifies a resident’s decision to pursue an arguably risky course of action over the expressed concerns of the facility’s staff. In the other shape, negotiated risk is an agreement in which a resident waives the facility’s liability for certain inadequacies of care.

In the first shape, for example, a negotiated risk agreement might document a diabetic resident’s decision to eat sweets against medical advice. In the second

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1. Assisted Living Federation of America, Frequently Asked Questions About Assisted Living, <http://www.alfa.org/i4a/pages/index.cfm?pageid=3285> (last visited Mar. 30, 2007).

2. See *infra* Part V.

3. See generally ROBERT JENKENS ET AL., A STUDY OF NEGOTIATED RISK AGREEMENTS IN ASSISTED LIVING: FINAL REPORT 8-24 (2006) (discussing the difficulty in reaching a consensus among patients, advocates, providers, and policy makers regarding the appropriate purpose of “negotiated risk” agreements and the resulting inability to constructively address related issues).

shape, the negotiated risk agreement would release the facility from any liability related to a resident's falls or pressure sores.

This article explores the various shapes assumed by the term "negotiated risk." The article first describes the assisted living model and explains how negotiated risk agreements were theorized initially as a mechanism to allow assisted living facilities to retain ill and frail residents longer, without risking legal liability for providing inadequate care. The article then examines how negotiated risk proponents have attempted to move the debate away from the consideration of liability waivers, by recasting negotiated risk in public as a tool for protecting residents' decision-making rights.

The result has been confusion in public policy discussions and, most conspicuously, in state law. Currently, fifteen states' laws refer to "negotiated risk" or a comparable term,<sup>4</sup> and one additional state has developed a standard form for a "Negotiated Risk Contract."<sup>5</sup> In general, the relevant state laws refer ambiguously to disputes, agreements, and risk, without indicating whether negotiated risk involves inadequate facility care or, at the other extreme, a resident's decision to refuse the facility's services or advice. This article examines the state laws and places each state into one of eight categories, depending generally on the extent to which the state law relates to care planning, disputes, inadequate care, and/or waiver of liability.

This article recommends that the term "negotiated risk" be abandoned. Proponents' professed goal—allowing residents to make decisions that conflict with professional recommendations—can be accomplished without negotiated risk through established care planning procedures.

Also, any waiver of facility liability is likely unenforceable. Courts uniformly refuse to enforce consumer liability waivers in health care.<sup>6</sup> A court almost certainly would find a public policy violation in any agreement that waived an assisted living facility's liability for care provided to a resident.

Finally, the term "negotiated risk" at this point has no settled meaning. It is used at the extremes to refer to two very different types of situations: when a facility is unable to provide needed care, but also when a resident refuses care that a facility is willing and able to provide. Compounding the problem, most of the relevant law fails even to stake out a position between these two extremes, and instead speaks only in lofty generalities that often fail to rule out either extreme.

Assisted living law should be rewritten across the country to eliminate any mention of negotiated risk. Due to the term's vagueness and misuse, it can be used

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4. See discussion *infra* Part VI.

5. UTAH BUREAU OF HEALTH FACILITY LICENSING, UTAH DEP'T OF HEALTH, NEGOTIATED RISK CONTRACT, <http://health.utah.gov/hflcra/forms/risk.pdf> (last visited Mar. 30, 2007).

6. See *infra* Part VIII.B.2-3.

as justification for an inadequate quality of care. Negotiated risk endangers the health and safety of elderly assisted living residents across the country.

### I. ASSISTED LIVING FACILITIES CARE FOR ONE MILLION VULNERABLE RESIDENTS

Assisted living is a form of long-term care provided to older persons who cannot live independently. Generally, residents live together in a facility comprised of living units that may be either private or shared.<sup>7</sup>

Initially, assisted living occupied the range of care between independent living and nursing home care. In recent years, however, assisted living has moved increasingly to provide care for residents whose needs previously would have required residence in a nursing home.<sup>8</sup> This change, along with the growing popularity of assisted living, has led to increases in the numbers of facilities and residents. The United States presently has 20,000 to 36,000 assisted living facilities, with a total of approximately one million residents.<sup>9</sup>

Federal law contains essentially no care standards for assisted living. As a result, the definition and regulation of assisted living is done almost entirely at the state level.<sup>10</sup> Terminology varies from state to state, and although the most common term is “assisted living facility,” other terms in use include “residential care facility for the elderly” in California, “home for the aged” in Michigan, “housing with services establishment” in Minnesota, and “personal care home” in Mississippi.<sup>11</sup>

### II. “ASSISTED LIVING” IS LOOSELY DEFINED

#### A. *Assisted Living Operators Advocate for a Broad, Inclusive Definition*

Surprisingly, defining “assisted living” can be difficult and contentious.<sup>12</sup> One problem is the perhaps inevitable “big tent” philosophy among lobbyists for

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7. ROBERT MOLLIKA & HEATHER JOHNSON-LAMARCHE, NAT'L ACAD. OF STATE HEALTH POL'Y, STATE RESIDENTIAL CARE AND ASSISTED LIVING POLICY: 2004, at 1-19 (2005).

8. *Id.* at 1-7 to -11.

9. *Id.* at 1-2 (reporting that, as of 2004, a total of 36,451 facilities contained approximately 937,000 units/beds); Assisted Living Federation of America, *supra* note 1 (reporting that 20,000 assisted living facilities house over one million residents). The large discrepancy in the number of facilities stems from the fact that assisted living is not easily defined, as well as the fact that various state laws use different definitions and terminology. *See infra* notes 12-13 and accompanying text.

10. *See, e.g.*, ERIC CARLSON, LONG-TERM CARE ADVOCACY §§ 5.101-5.152 (2006) (summarizing states' assisted living laws); Patrick A. Bruce, Note, *The Ascendancy of Assisted Living: The Case for Federal Regulation*, 14 ELDER L.J. 61, 67-82 (2006).

11. *E.g.*, ERIC M. CARLSON, NAT'L SENIOR CITIZENS LAW CTR., CRITICAL ISSUES IN ASSISTED LIVING: WHO'S IN, WHO'S OUT, AND WHO'S PROVIDING THE CARE 72-73 (2005).

12. *E.g.*, ASSISTED LIVING WORKGROUP, ASSURING QUALITY IN ASSISTED LIVING: GUIDELINES FOR FEDERAL AND STATE POLICY, STATE REGULATIONS, AND OPERATIONS 12-19 (2003) (noting the inability to reach a consensus regarding the definition of “assisted living”); Paula C. Carder, *The Social*

assisted living providers. No facility wants to be left out of the assisted living tent so providers tend to push for broad definitions of assisted living that include, for example, both a 200-bed facility that provides extensive health care services, and a six-bed facility that provides only room, board, and minimal assistance with activities of daily living.<sup>13</sup>

In 2006, the Empire State Association of Assisted Living, a New York assisted living trade association, commissioned a report advocating that routine nursing services not be required of the state's "enhanced assisted living residences."<sup>14</sup> In arguments that duplicate those made by other trade associations across the country, the report asserts that a nursing service requirement would "overmedicalize" assisted living and make it unaffordable.<sup>15</sup> The report recommends that nursing services *not* be part of a facility's services, and instead "be provided [by] or arranged for and charged to the individual resident."<sup>16</sup>

#### *B. Assisted Living Is Based on Purportedly Attractive, but Ethereal, Concepts*

Another problem in defining "assisted living" is the ethereal nature of much of the literature on assisted living policy.<sup>17</sup> Consider this explanation by a prominent assisted living proponent:

Perhaps the most radical aspect of assisted living is a shift in values orientation, which results in redefinitions of consumer empowerment, best practice concepts, and quality. This shift in thinking supports

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*World of Assisted Living*, 16 J. AGING STUDIES 1 (2002), reprinted in GRAY AREAS: ETHNOGRAPHIC ENCOUNTERS WITH NURSING HOME CULTURE 263, 278-79 (Phillip B. Stafford ed., 2003) ("[B]oth policy makers and researchers . . . are frustrated with the lack of a standard definition").

13. See, e.g., GA. COMP. R. & REGS. 290-5-35-.04(o) (2006) (defining "Personal Care Home" as "any dwelling, whether operated for profit or not, which undertakes through its ownership or management to provide or arrange for the provision of housing, food service, and one or more personal services for two or more adults who are not related to the owner or administrator by blood or marriage"); S.D. CODIFIED LAWS § 34-12-1.1 (1994 & Supp. 2003) (defining "Assisted living center" as "any institution, rest home, boarding home, place, building, or agency which is maintained and operated to provide personal care and services which meet some need beyond basic provision of food, shelter, and laundry in a free standing, physically separate facility which is not otherwise required to be licensed under this chapter").

14. LORI SIEVERS, HINMAN STRAUB, P.C., ASSISTED LIVING THAT FEW CAN AFFORD: AN EXAMINATION OF THE OVER-MEDICALIZATION OF THE ENHANCED ASSISTED LIVING RESIDENCE AND A SENSIBLE ALTERNATIVE 15 (2006), available at [http://www.ny-assisted-living.org/pdf/ESAAL\\_EALRReport.pdf](http://www.ny-assisted-living.org/pdf/ESAAL_EALRReport.pdf).

15. *Id.* at 13.

16. *Id.* at 15.

17. See, e.g., ROSALIE A. KANE & KEREN BROWN WILSON, AM. ASS'N RETIRED PERSS., ASSISTED LIVING IN THE UNITED STATES: A NEW PARADIGM FOR RESIDENTIAL CARE FOR FRAIL OLDER PERSONS? 8 (1993) (discussing assisted living as "based on principles of individuality, independence, privacy, dignity, choice, and a homelike environment"); Marshall B. Kapp, *Who Is Responsible For This? Assigning Rights and Consequences in Elder Care*, 1997 J. AGING & SOC. POL'Y 51, 57 (characterizing assisted living as employing an "underlying philosophical paradigm of homelike individual autonomy and self-determination").

human principles, such as dignity, choice, and privacy, that are easily violated when individuals are dependent on others for care. . . .

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. . . Empowerment is the redistribution or restoration of opportunities to promote reciprocity and autonomy for those in society labeled as disabled, disenfranchised, or dependent. Assisted living is uniquely positioned to support fundamental change to achieve empowerment of frail, often significantly impaired adults. This empowerment is achieved by embracing the concepts of shared responsibility, bounded choice, and managed risk. Without these grounding precepts, empowerment cannot be achieved. They enhance the potential for reciprocal actions and reduce objections to autonomy for individuals whose ability to act independently is compromised. Shared responsibility assumes that rights and responsibilities are balanced. The degree of autonomy exercised in the decision-making process is weighed against the degree of responsibility accepted for the outcome of the decision. Bounded choice reflects the recognition that personal capacity, societal limits, organizational capacity, and situational circumstances set the parameters of autonomy for all individuals. Managed risk is a process that defines the responsibilities and choices associated with empowerment.<sup>18</sup>

Of course, such worthy but elusive concepts as dignity, choice, and privacy are not easily put into practice. These appealing terms are mentioned commonly in state assisted living law, but in most cases references to these terms occur in definitional sections that have little real-world significance.<sup>19</sup>

The most obvious example of the gap between theory and practice is the presence of shared units in assisted living. Much of the initial enthusiasm for assisted living was based on the image of a person receiving necessary care in her own home or apartment.<sup>20</sup> Today, however, state assisted living laws routinely

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18. Keren Brown Wilson, *Assisted Living as a Model of Care Delivery*, in *ENHANCING AUTONOMY IN LONG-TERM CARE: CONCEPTS AND STRATEGIES* 139, 145-46 (Lucia M. Gamroth et al. eds., 1995).

19. *See, e.g.*, ILL. ADM. CODE tit. 77, § 295.100(a) (2001) (identifying the purpose of assisted living law as, in part, “to permit the development and availability of assisted living establishments and shared housing establishments based on a social model that promotes the dignity, individuality, privacy, independence, autonomy, and decision-making ability and the right to negotiated risk of those persons”); N.J. STAT. ANN. § 26:2H-7.15 (West 2007) (defining assisted living services as a means to “promote resident self-direction and participation in decisions that emphasize independence, individuality, privacy, dignity and homelike surroundings to residents who have been assessed to need these services, including residents who require formal long-term care”); VT. STAT. ANN. tit. 33, § 7102(11) (2001) (describing assisted living as promoting “resident self-direction and active participation in decision-making while emphasizing individuality, privacy and dignity”).

20. *See, e.g.*, Wilson, *supra* note 18, at 141; Rosalie A. Kane, *Autonomy and Regulation in Long-Term Care: An Odd Couple, An Ambiguous Relationship*, in *ENHANCING AUTONOMY IN LONG-TERM CARE: CONCEPTS AND STRATEGIES*, *supra* note 18, at 68, 80-81 (“In my view, the minimum requirements in the U.S. cultural context includes a singly occupied room with a self-contained bath.”).

allow an assisted living unit to be shared occupancy, sometimes by as many as four residents.<sup>21</sup>

Similarly difficult to implement are concepts such as “shared responsibility,” “bounded choice,” and “managed risk.” Like many terms related to negotiated risk, the meaning of these terms is far from settled.

### C. *The Assisted Living Model Relies on Individual Negotiations*

A third problem in defining assisted living is that the academic model often abstains on important issues, and instead dictates that specifics be negotiated with the facility by the resident or resident’s representative.<sup>22</sup> As a result, state-law definitions are likely to gloss over difficult issues in defining assisted living, by assuming explicitly or implicitly that those issues will be resolved by the resident and the facility.

Perhaps the purest example of a negotiation-based model is Michigan’s system for housing-with-services establishments; a license is not required,<sup>23</sup> and the relevant statutes do little more than specify certain unremarkable requirements for a contract with a resident.<sup>24</sup> More commonly, negotiation-based models appear in state assisted living laws through disclosure requirements.<sup>25</sup> The basic premise of

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21. MOLLIKA & JOHNSON-LAMARCHE, *supra* note 7, at 1-16 (“Ten states have licensing categories that allow four people to share a room; three states allow three people to share units.”); *see, e.g.*, GA. COMP. R. & REGS. 290-5-35-.07(11)(b) (1994) (restricting total residents per bedroom to “no more than four”); 410 IND. ADMIN. CODE 16.2-5-1.6(g)(5) (2003) (requiring no more than four beds per room for facility construction plans submitted for approval after July 1, 1984); OHIO ADMIN. CODE 3701-17-64(B)(3) (2007) (establishing a limit of no more than four residents per unit).

22. ROBERT L. MOLLIKA & KIMBERLY IRVIN SNOW, NAT’L ACAD. FOR STATE HEALTH POL’Y, STATE ASSISTED LIVING POLICY: 1996, at i (1996) (noting that states set minimum standards and assume that market forces will produce an adequate quality of care); *see, e.g.*, ILL. ADM. CODE tit. 77, 295.100(a) (2007) (“Assisted living . . . should be based on a contract model designed to result in a negotiated agreement between the resident or the resident’s representative and the provider, clearly identifying the services to be provided.”).

23. *See generally* MAUREEN MICKUS, COMPLEXITIES AND CHALLENGES IN THE LONG TERM CARE POLICY FRONTIER: MICHIGAN’S ASSISTED LIVING FACILITIES (2002), *available at* <http://www.ippsr.msu.edu/Publications/ARAssistedLiving.pdf> (noting that licensure is not required under Michigan law for all facilities contained within the broad category of assisted living facilities).

24. MICH. COMP. LAWS ANN. § 333.26503 (West Supp. 2001). Michigan also licenses homes for the aged which, in comparison to housing-with-services establishments, are subject to more detailed regulatory requirements. *Id.* § 333.20106(3) (West 2001).

25. *See, e.g.*, TEX. HEALTH & SAFETY CODE ANN. § 247.026(b)(4)(B) (Vernon 2001 & Supp. 2006) (requiring that a state-developed standardized disclosure form be provided to each prospective resident or their representative); 40 TEX. ADMIN. CODE § 92.3(13) (2007) (outlining the required elements of the Texas standardized disclosure form); 13-110-007 VT. CODE R. § 6.11 (2007) (describing the “Uniform Consumer Disclosure” requirements which include, *inter alia*, disclosure of services, rates, and admission and discharge criteria).

these laws is that consumers will be protected if facilities are required at admission to disclose certain important aspects of the care that will be provided.<sup>26</sup>

The lack of a coherent and consistent assisted living definition is important context for this article's discussion of negotiated risk. Because assisted living law is often ambiguous as to whether certain care can or must be provided, a facility may have significant leeway to argue that a resident assumes a legal risk by living there.

### III. THE DEFINITION OF "NEGOTIATED RISK" IS MURKY

A thorough analysis of "negotiated risk" is hampered by confusion as to what negotiated risk is, most importantly, whether or not negotiated risk includes waiver of a facility's legal liability.<sup>27</sup> As acknowledged in a leading article advocating negotiated risk, there is "no consensus among commentators, regulators and accreditation bodies of what a negotiated risk agreement actually is—or should be."<sup>28</sup> Additionally, the term "negotiated risk" itself is not always employed—increasingly, "negotiated risk" is being replaced with references to "managed risk" or "shared responsibility."

By and large, the lack of consensus is not attributable to state-to-state variations. Evasiveness regarding legal liability is the most prominent commonality in states' negotiated risk laws.<sup>29</sup> By using terms such as "accepting responsibility," state laws enable negotiated risk to be defended as a care planning device, but also allow facilities in other, less public situations to claim that negotiated risk agreements waive a facility's liability.<sup>30</sup>

This same evasiveness appears in public defenses of negotiated risk. For example, the negotiated risk manual commissioned by the Assisted Living Federation of America (ALFA) argues that "the primary purpose of risk agreements is not to shield providers from liability."<sup>31</sup> This argument, however, is contrary to the explanation given earlier in the manual that "[i]n a true negotiated risk

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26. See, e.g., Assisted Living Fed'n of Am., ALFA Public Policy Platform (2004), <http://www.alfa.org/i4a/pages/index.cfm?pageid=3325> (referencing "informed choice," and stating that "[f]ull mutual disclosure helps to ensure that residents and families are aware of all rights and options for care"); see also Bruce, *supra* note 10, at 73-74 (discussing state disclosure requirements and concluding that "[l]ack of disclosure can have severe consequences for consumers").

27. See, e.g., JENKENS ET AL., *supra* note 3, at 9-11, 14-15.

28. Allen A. Lynch, II & Sarah A. Teachworth, *Risky Business: The Enforceability and Use of Negotiated Risk Agreements*, 10 SENIORS HOUSING & CARE J. 3, 5 (2002).

29. See *infra* Part VI.

30. See, e.g., 016-06-001 ARK. CODE R. § 704 (Weil 2007) (regulating "acceptance of responsibility" in Level I assisted living facilities); 016-06-002 ARK. CODE R. § 704 (Weil 2007) (regulating the same in Level II assisted living facilities); WIS. STAT. ANN. § 50.034(3)(d) (West 2003 & Supp. 2006) (requiring that negotiated risk agreements establish that each resident "accepts responsibility").

31. KENNETH L. BURGESS, NEGOTIATED RISK AGREEMENTS IN ASSISTED LIVING COMMUNITIES 60 (1999).



agreement, the ‘consideration’ the resident gives back to the community is a willingness to release the community from liability for harm or injury to the extent that harm results from the resident’s exercise of his free choice and autonomy.”<sup>32</sup> One year after the manual’s release, its author wrote that a state’s prohibition of liability waivers had “fatally curtailed” negotiated risk.<sup>33</sup>

As a result of this confusion, there now are two negotiated risks: the “true” negotiated risk and a perverse doppelgänger.<sup>34</sup> Unfortunately, most explanations of assisted living fail to recognize the two sides of negotiated risk and, if pressed on the issue, assisted living stakeholders typically differ on which negotiated risk version is true, and which is the doppelgänger.<sup>35</sup> In general, assisted living facility representatives argue that true negotiated risk is about honoring resident preferences and, in response, resident advocates claim that the resident autonomy argument is a Trojan horse for bringing liability waivers into assisted living.<sup>36</sup>

#### IV. NEGOTIATED RISK WAS PROPOSED TO WAIVE A FACILITY’S LIABILITY FOR INADEQUATE CARE

Waiver of liability generally arises in what this article terms the “inadequate care” scenario. In this scenario, negotiated risk allows an assisted living facility to retain a resident whose needs exceed the facility’s care-providing capabilities.<sup>37</sup>

The backdrop for this scenario is the amorphousness of an assisted living standard of care. Because, as discussed above, the definition of assisted living is difficult to pin down, it can be equally or even more difficult to specify what type

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32. *Id.* at 42.

33. Kenneth L. Burgess, *Negotiated Risk Agreements—One Year Later*, ASSISTED LIVING TODAY, Nov.-Dec. 2001, at 35, 36.

34. See Stephanie Edelstein, *Assisted Living: Recent Developments and Issues for Older Consumers*, 9 STAN. L. & POL’Y REV. 373, 379-80 (1998) (noting that negotiated risk agreements are likely to involve residents choosing to act against facility advice, but may waive a facility’s liability for inadequate care); Rosalie A. Kane & Carrie A. Levin, *Who’s Safe? Who’s Sorry? The Duty to Protect the Safety of Clients in Home- and Community-Based Care*, 22 GENERATIONS 76, 80 (1998) (indicating that a negotiated risk agreement is sometimes used when a “consumer’s preference counters that of the provider” and, at other times, “clarifies what kind of assistance can and cannot be expected in the setting”); Gregory Hendrickson & Kenneth Burgess, *Creating Enforceable Negotiated Risk Agreements*, CONTEMPORARY LONG TERM CARE, Feb. 1999, at 49 (asserting that negotiated risk agreement are used to allow residents to return to assisted living facilities despite the inadequate care that is provided, but are also used commonly when a facility’s care is adequate).

35. See, e.g., MOLLICA & JOHNSON-LAMARCHE, *supra* note 7, at 1-14 to 1-15. But see Sandi Petersen, *Developing Risk-Management Protocols in Assisted Living*, NURSING HOMES MAGAZINE, Dec. 8, 2005 (asserting that a negotiated risk agreement should be used for “service refusal” but not “as a means of retaining residents who are beyond the scope of care that can be provided in the setting”).

36. See, e.g., JENKENS ET AL., *supra* note 3, at 8-13; Eric M. Carlson, *In the Sheep’s Clothing of Resident Rights: Behind the Rhetoric of “Negotiated Risk” in Assisted Living*, NAELA Q., Spring 2003, at 4; Bruce Vignery & Zita Dresner, *Troubling Assisted Living Facility Issues: Negotiated Risk Agreements*, ELDER LAW FORUM, Nov.-Dec. 1995, at 10.

37. Vignery & Dresner, *supra* note 36, at 10.

or level of service is required.<sup>38</sup> If a facility does not provide a certain type or level of care, the facility may seek a corresponding liability waiver.

Assisted living proponents eschew the medical model for a social model that purportedly emphasizes non-medical services and quality of life.<sup>39</sup> One ramification of this emphasis is the possibility that a facility may be unprepared to provide certain necessary care. Negotiated risk was proposed as a means for a facility to avoid liability for a lack of medical services and expertise, or for a relatively low level of supervision.<sup>40</sup>

Relatively early in the development of the assisted living model, one academic commenter suggested that providers should

Explore the legal ramifications of waivers of liability. Although one cannot waive one's right to quality care,<sup>41</sup> in a nursing home, care should probably not be extended to include every facet of the resident's life. If warned about the risks of various decisions, cannot residents make a decision to take their chances?<sup>42</sup>

A facility attorney in 1995 identified "negotiated risk" as "the first buzzword unique to assisted living."<sup>43</sup> As the article described, some assisted living facilities were using negotiated risk to limit their responsibilities for resident care, "squeezing the concept into the blueprint of written admissions or resident contracts. Others were thinking that if a resident can be persuaded to accept a particular service delivery plan, then the facility will be insulated from regulatory and civil liability."<sup>44</sup>

Other facility attorneys have made similar observations: "Negotiated risk agreements are intended to enable residents to reside in a non-institutional assisted living setting even though they may have care needs that would normally require that they reside in a skilled nursing environment."<sup>45</sup> Similarly, another facility attorney explains that "[a] negotiated risk contract is where the resident agrees to

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38. See *supra* Part III.

39. Wilson, *supra* note 18, at 143.

40. See JENKENS ET AL., *supra* note 3, at 8-11.

41. See *infra* Part VIII.B.

42. Kane, *supra* note 20, at 85; see also Keren Brown Wilson, *Assisted Living: A Model of Supportive Housing*, in 2 ADVANCES IN LONG-TERM CARE 196, 210 (Paul R. Katz et al. eds., 1993) (proposing "managed risk" for assisted living).

43. Joseph L. Bianculli, *Negotiated Risk—An Operational Issue*, PROVIDER, Nov. 1995, at 32; see also JOSEPH L. BIANCULLI & KEREN BROWN WILSON, NEGOTIATED RISK IN ASSISTED LIVING 1 (1996) (asserting that negotiated risk is "a buzzword specific to assisted living").

44. Bianculli, *supra* note 43, at 32.

45. Lynch & Teachworth, *supra* note 28, at 26 n.11 (citing Joel S. Goldman, Potential Legal Roadblocks Ahead for Assisted Living, Address at the ALFA Fall 2001 National Conference & Expo Conference Proceedings 299 (Oct. 21-23, 2001)).

accept a certain setting and they assume the risk that that setting may or may not be appropriate for their care.”<sup>46</sup>

Some assisted living providers have embraced the liability-waiver vision of negotiated risk. According to the public policy director for an assisted living corporation, needs related to “diabetes, skin breakdown, falls, or wandering” can be addressed through use of a negotiated risk agreement.<sup>47</sup>

A “healthcare consulting firm specializing in risk management for the assisted living industry” has recommended negotiated risk agreements as a facility’s response to the fact that “[m]any residents’ acuity levels will exceed what an assisted living community can provide.”<sup>48</sup> In a separate article, the firm’s vice president of clinical operations explained how negotiated risk could be used to address areas in which a facility’s care might be inadequate:

Once residents are assessed, providers should implement shared-risk, or managed-risk, agreements for any potential risk identified for the resident, such as falls, wandering away from the community, or even the potential for skin breakdown. These vitally important agreements document that the resident and family have been advised of the inherent risks that come with choosing a long-term care model that supports quality of life, such as assisted living, as opposed to a primarily quality of care skilled nursing model.

Because assisted living providers may not provide 24-7 care (and are not expected to), these agreements leave no question that the resident and the family understand this concept and accept their share of responsibility in the resident’s plan of care.<sup>49</sup>

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46. John Durso, Testimony to Comm’n on Affordable Housing and Health Facility Needs for Seniors in the 21st Century (Nov. 7, 2001), available at <http://govinfo.library.unt.edu/seniorscommission/pages/hearings/011107/durso.html>; see also N.H. DEP’T OF HEALTH & HUMAN SERVS., FINAL REPORT: H.B. 1319 — NEGOTIATED RISK 2 (2000) (“The issues sparking the debate on negotiated risk appear to focus on transferring clients who may wish to remain in a residential placement environment to which they have grown accustomed when that residence is no longer able to meet their identified care needs.”); Stephanie Kissam et al., *Admission and Continued-Stay Criteria for Assisted Living Facilities*, 51 J. AM. GERIATRICS SOC’Y. 1651, 1652 (2003) (recommending a “managed risk agreement” with liability waiver if a resident remains in an assisted living facility beyond the point at which the facility can meet the resident’s care needs); Elisabeth Belmont et al., *A Guide to Legal Issues in Life-Limiting Conditions*, 38 J. HEALTH L. 145, 188 (2005) (asserting that, in a negotiated risk agreement, a “facility attempts to explain before admittance those services/responsibilities for which it intends to be responsible, as well as those for which it intends not to be responsible”).

47. *Why Your Facility Should Have Negotiated Risk Agreements*, Briefings on Assisted Living, June 2000, <http://www.snfinfo.com/articles/BAL060001.cfm> (last visited Mar. 10, 2003) (copy on file with the *Journal of Health Care Law & Policy*).

48. Assisted Living Providers, <http://www.tagweb.com/aprovider.html> (last visited Nov. 12, 2002) (copy on file with the *Journal of Health Care Law & Policy*).

49. Kendra Case, *Shared Risk Starts with Resident Assessment*, ASSISTED LIVING TODAY, Mar. 2002, at 27, 27.

Similarly, a recent report clearly identifies negotiated risk as a means for a facility to retain a resident for whom it cannot provide adequate care:

“The essential issue [in assisted living policy] is that residents not be allowed to “age in place” if the facility is not able to provide adequate care. The matter is not that straightforward, however, as 19 states allow for the completion of negotiated risk agreements that expressly allow residents to accept certain risks associated with reduced care, so as to maximize their preferences and remain in the facility.”<sup>50</sup>

Consistent with these descriptions, negotiated risk agreements often are portrayed chiefly as a means for an assisted living facility to reduce its legal exposure. As stated in an article defending negotiated risk, “[f]or some providers, risk consultants and lawyers, [liability waivers] are the ‘magic words’ of [a negotiated risk agreement]—the words whereby the resident essentially agrees that the provider is not liable for harm that arises from the subject risk.”<sup>51</sup> The same article suggests negotiated risk agreements as a means of reducing a facility’s exposure to liability claims.<sup>52</sup>

An insurance underwriting firm has recommended negotiated risk contracts as a way of protecting assisted living facilities that provide an inadequate level of care: “[B]ecause [assisted living facilities] do not provide 24/7 care . . . shared-risk agreements can significantly reduce your exposure to litigation from falls. [Facilities] should have the resident and their family members sign a shared-risk agreement for any resident who is either at risk, or who has sustained a fall in the last ninety days.”<sup>53</sup>

In accord, a 2004 article in ALFA’s *Assisted Living Today* listed a “managed risk agreement” as one of ten techniques to be used by assisted living facilities to “avoid costly litigation.”<sup>54</sup> The article’s discussion of managed risk begins with the admonition to “[b]e honest with the resident and the family that there may simply be *unavoidable* injuries during the resident’s stay at your community. Do not

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50. Sheryl Zimmerman et al., *How Good is Assisted Living? Findings and Implications from an Outcomes Study*, 60B JOURNALS OF GERONTOLOGY: SOC. SCI. S195, S195-96 (2005) (citing Robert Mollica, *State Assisted Living Policy 2002* (2002), available at [http://www.nashp.org/Files/ltc\\_15\\_AL\\_2002.pdf](http://www.nashp.org/Files/ltc_15_AL_2002.pdf)). This article, however, concludes that sixteen, not nineteen, states utilize negotiated risk. See *infra* Part VI.

51. Lynch & Teachworth, *supra* note 28, at 10.

52. *Id.* at 4 (“[T]he legal exposure borne by long term care providers has been anything but limited, with the long term care litigation ‘avalanche’ having crippled some operators and impacted nearly all through less liability insurance coverage at a dramatically higher cost.”).

53. *Id.* at 9 (quoting Lighthouse Underwriters, Assisted Living Fed’n of Am., Seminar for the Fall Conference Risk Management (Oct. 2001)). Lynch and Teachworth further summarized a Lighthouse Underwriters’ postulation “that a lack of [negotiated risk agreements] is one reason why the plaintiff’s bar is migrating from nursing homes to assisted living facilities.” *Id.* (emphasis in original).

54. Donna J. Fudge, *Staying Out of Court: Use These 10 Tips to Avoid Costly Litigation*, ASSISTED LIVING TODAY, Jan./Feb. 2004, at 18, 20.

promise that you can keep the resident safe.”<sup>55</sup> The article recommends that facilities consider using contractual clauses that waive a facility’s liability if a resident is injured after failing to wait an adequate period of time for staff assistance, and that residents understand that the facility “cannot guarantee that [the residents] will not experience a fall or an injury from a fall.”<sup>56</sup>

#### V. NEGOTIATED RISK IS CHARACTERIZED BY PROPONENTS AS A RESIDENT’S DECISION TO ACT AGAINST FACILITY ADVICE

Presumably because the “inadequate care” scenario has proven unpopular, negotiated risk increasingly is promoted as a resident’s right to refuse the facility’s offer of services or advice. This “against-facility-advice” scenario focuses on situations in which the facility is prepared to provide adequate care, but the resident wants to act against the facility’s advice in a way that increases risk to the resident. Common examples are residents who eat sweets despite diabetes,<sup>57</sup> refuse baths<sup>58</sup> or medication,<sup>59</sup> smoke,<sup>60</sup> or insist on self-care even though staff assistance is available.<sup>61</sup> In this scenario, the negotiated risk agreement “describes a process by which a resident who engages in risky practices, as identified by a staff member, family member, or health care provider, signs an agreement whereby he or she indicates understanding of risks and agrees to accept responsibility for negative results.”<sup>62</sup>

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55. *Id.* (emphasis in original).

56. *Id.* at 20-21.

57. *E.g.*, KATHERINE BLANCHETTE, 3 NEW DIRECTIONS FOR STATE LONG-TERM CARE SYSTEMS: SUPPORTIVE HOUSING 19 (1997); BURGESS, *supra* note 31, at 56 (advocating the use of negotiated risk agreements for “[d]ietary deviations beyond simply food preferences, such as where medical issues like diabetes are implicated”); JANET O’KEEFFE ET AL., USING MEDICAID TO COVER SERVICES FOR ELDERLY PERSONS IN RESIDENTIAL CARE SETTINGS: STATE POLICY MAKER AND STAKEHOLDER VIEWS IN SIX STATES 27 (2003); Paula C. Carder & Mauro Hernandez, *Consumer Discourse in Assisted Living*, 59B JOURNALS OF GERONTOLOGY: SOC. SCI. 558, S61 (2004); Carder, *supra* note 12, at 278-79; Marshall B. Kapp & Keren Brown Wilson, *Assisted Living and Negotiated Risk: Reconciling Protection and Autonomy*, 1 J. ETHICS, L. & AGING 5, 11-12 (1995) (describing an insulin-dependent diabetic who wishes to eat sweets); David Peete, “Risk Management”: *Heeding the New Mantra*, 50 NURSING HOMES: LONG TERM MGMT. 56, 56 (2001) (recommending “honest dialogue” between providers and residents about negotiated risk agreements that are used for residents not willing to follow a prescribed diet).

58. BURGESS, *supra* note 31, at 56; Lynch & Teachworth, *supra* note 28, at 4.

59. Carder & Hernandez, *supra* note 57, at S61.

60. NATALIE M. DUVAL & CHARLES MOSLEY, NEGOTIATED RISK AGREEMENTS IN LONG-TERM CARE SUPPORT SERVICES 13 (2001); Carder & Hernandez, *supra* note 57, at S61; Michael E. Anderson, *Contract Negotiations: 10 Tips to Consider Before Signing a Residency Agreement*, ASSISTED LIVING TODAY, July/Aug. 2004, at 69, 71.

61. Robert L. Mollica, *State Policy and Regulations*, in ASSISTED LIVING: NEEDS, PRACTICES, AND POLICIES IN RESIDENTIAL CARE FOR THE ELDERLY 9, 22 (Sheryl Zimmerman et al. eds., 2001); MOLLICA & SNOW, *supra* note 22, at 28-29; BURGESS, *supra* note 31, at 16-19.

62. Carder, *supra* note 12, at 278.

A good demonstration of this change of course is found in a “Quality Initiative” released in 1998 by an ad hoc group, entitled the Assisted Living Quality Coalition.<sup>63</sup> The relevant section of the Initiative, entitled “Implementing Resident Autonomy Through Risk Agreements,” includes elements of both the “against-facility-advice” and “inadequate care” scenarios. The “against-facility-advice” scenario is invoked explicitly by the explanation that a risk agreement is used when “a resident decides to pursue an action(s) or refuse service(s) (including healthcare services) that may involve increased risk of personal harm and conflict with a provider’s usual responsibilities . . . .”<sup>64</sup>

On the other hand, the “inadequate care” scenario is suggested obliquely and confusingly, through a requirement that a resident “engage in a risk agreement and . . . secure needed additional services in a manner acceptable to the facility that does not violate any other applicable laws to remain in the current setting when a transfer has been recommended to obtain additional services.”<sup>65</sup> In a similar vein, the Initiative acknowledges a resident’s right to forego:

[A] recommended transfer to obtain additional services as long as the resident contracts for or secures the needed additional services in a nature acceptable to the facility and engages in a risk agreement with the setting which is acceptable to resident and the setting and does not violate any applicable law.<sup>66</sup>

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63. See ASSISTED LIVING QUALITY COALITION, ASSISTED LIVING QUALITY INITIATIVE: BUILDING A STRUCTURE THAT PROMOTES QUALITY app. B at 80-82 (1998) (discussing providers’ recognition of a resident’s autonomy to make decisions regarding personal actions and lifestyle, provided that no presumption of provider fault exists if a resident is harmed because of that resident’s personal decision).

64. *Id.* at app. B at 81. Negotiated risk agreements are described in an earlier part of this report as a means of “govern[ing] behaviors that residents choose against a provider’s advice.” *Id.* at 30.

65. *Id.* at app. B at 81.

66. *Id.* at app. B at 76.

In arguments based on the “against-facility-advice” scenario, negotiated risk generally is justified by a withering portrayal of life in a nursing home.<sup>67</sup> Allegedly, nursing homes follow a prescriptive medical model, whereas assisted living facilities follow a more humanistic social model of care.<sup>68</sup> In the medical model, allegedly, decisions are made by the health care professionals, and the resident or patient has no choice but to comply.<sup>69</sup> One article flatly states, “[i]n a nursing facility, [a diabetic resident] would not be given the option of eating cake.”<sup>70</sup>

As relevant to negotiated risk, the medical model allegedly is noteworthy for the infantilization of those it serves. A negotiated risk policy paper asserts “widespread recognition that in the past, protective provider conduct justified under the traditional protective paradigm often has proceeded beyond beneficence to manifestations of intrusive and restrictive forms of paternalism.”<sup>71</sup>

One critique of traditional nursing home care, in a paper prepared initially for an ALFA-convened conference, bemoaned the “loss of rights and ‘institutionalized’ status [that] occurs when vulnerable people are subject to far-reaching, professionally-controlled plans for care, and when their lives are dominated by restrictive rules or lived out in socially impoverished environments.”<sup>72</sup> The same paper criticized “the current trend for guidelines and standardized care protocols,” suggesting that facilities follow “[a] protocol for

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67. Carder, *supra* note 12, at 271 tbl.10.1. Carder notes a “distancing” process in which assisted living proponents define assisted living facilities, in large part, through facilities’ supposed differences from nursing homes:

Proponents assert that [assisted living facilities] differ from new nursing home facilities and make comparisons when explaining what assisted living is. Nursing facilities are institutional, hospital-like settings that do not respect the individual’s need for independence, dignity, and choice. In contrast, [assisted living facilities] provide home-like environments where respect for the “resident’s” independence, dignity, and choice are the primary concerns.

*Id.*

68. See BURGESS, *supra* note 31, at 14-15 (“[T]he recognition of assisted living as a ‘social model’ of care and services, versus nursing facilities as a ‘medical model,’ has led to both the development and the preservation of these two distinct settings, where, on the one hand (nursing facilities) resident safety is the paramount concern, often to the exclusion of certain ‘social’ attributes like resident autonomy and, on the other (assisted living), resident safety is viewed as a primary function but is balanced against and promoted within the context of equally-important social values, like resident choice.”); Carder, *supra* note 12, at 266.

69. See BURGESS, *supra* note 31, at 14-15, n.9 (explaining that “true risk taking” is limited in “skilled nursing facilities, hospitals and other institutional settings”).

70. Carder, *supra* note 12, at 278.

71. Kapp & Wilson, *supra* note 57, at 7.

72. Rosalie A. Kane & Keren Brown Wilson, *Assisted Living at the Crossroads: Principles for Its Future*, INDEPENDENT LIVING RESEARCH UTILIZATION, Sept. 21, 2001, <http://www.ilru.org/html/training/webcasts/handouts/2002/10-09-JK/crossroads.html>.

when people should get in and out of bed and how they should spend their waking hours . . . .”<sup>73</sup>

## VI. STATE NEGOTIATED RISK LAWS ARE AMBIGUOUS AND INCONSISTENT

State law has been tangled by the increasing unwillingness of assisted living proponents to own up to the “inadequate care” scenario. Instead, proponents generally base their arguments on the “against-facility-advice” scenario, but propose negotiated risk laws that could be used to justify negotiated risk in the “inadequate care” scenario.

Currently, references to “negotiated risk,” “managed risk,” “shared responsibility,” “bounded choice,” “risk agreement,” or “compliance agreement” appear in the assisted living laws of at least fifteen states, including the District of Columbia. Also, Utah has created a standard form for a “Negotiated Risk Contract.” The common denominator in these states’ laws or procedures is the sanctioning or authorizing of a written assisted living agreement that in some way discusses risk.<sup>74</sup>

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73. *Id.* at 29.

74. A recurring question about negotiated risk is how it differs from the care planning that occurs routinely in assisted living facilities and other long-term care facilities. *See* BURGESS, *supra* note 31, at 51 (“[T]he fact that risk agreements, appropriately used, are limited to requested behaviors or activities outside those a community would normally allow suggests that they are not synonymous with service plans.”). As this article discusses subsequently, confusion on this point is caused in great part by ambiguous state statutory and regulatory language that speaks of agreements and signatures, but in the context of issues that generally are determined through care planning processes. *See infra* Part VI.A-H. For the purposes of this article, a *negotiated risk agreement* is distinguished from a *care plan* by whether a written signed document is required and, even if a signature is not required explicitly, whether a document is described in a way that suggests an enforceable contract. In general, a *negotiated risk agreement* is suggested by references to a contract, an agreement, or risk. Also, risk is likely to be the sole topic of a *negotiated risk agreement* whereas, in a *care plan*, risk will be only one of multiple topics addressed.

Alaska’s “assisted living plan,” for example, is not recognized under these definitions as a *negotiated risk agreement*, even though the law discusses a resident’s right to evaluate risks and make choices, along with a facility’s right to accept or reject a resident’s choices regarding risks. *See* ALASKA STAT. § 47.33.230(a)(2)-(3) (2006) (instructing that an assisted living plan must recognize the “right of the resident . . . to evaluate and choose, after discussion with all relevant parties . . . the risks associated with each option when making decisions pertaining to the resident’s abilities, preferences, and service needs”). Alaska’s assisted living plan appears to be a *care plan* because it refers to an assisted living “plan” rather than a contract or agreement. Alaska’s law does not mention signatures or agreements, and the plan is to be developed by the resident or resident’s representative with participation from facility staff. *Id.* § 47.33.220; *see also id.* § 47.22.230(d) (“A resident’s assisted living plan must be in writing, in language that can be understood by the resident.”). Finally, the assisted living plan must “identify and describe” a myriad of issues with little relationship to risk, such as “the resident’s preference in roommates, living environment, food, recreational activities, religious affiliation, and relationships and visitation with friends, family members, and others.” *Id.* § 47.22.230(b)(3). *See* JENKENS ET AL., *supra* note 3, at 5 (“Alaska requires a discussion of risks as part of service planning.”).



Beyond this common denominator, generalizing about negotiated risk is a precarious proposition. The concept of negotiated risk differs greatly from state to state and, within a state, often presses together two or more inconsistent concepts.

The difficulty in categorizing these concepts demonstrates the muddled status quo of state negotiated risk law:

<b>Concept of Negotiated Risk</b>	<b>State(s)</b>
Resolving Disputes with Emphasis on Resident's Acceptance of Risk	District of Columbia Kansas
Care Planning with Emphasis on Resident's Acceptance of Risk	Florida Illinois Utah
Care Planning with Limited References to Acceptance of Risk	Oregon
Care Planning to Reduce Probability of Negative Outcome	Hawaii Oklahoma
Consenting to Inadequate or Insufficient Care	Ohio
Ambiguity as to Whether Agreements Are Used to Resolve Disputes, or to Consent to Inadequate or Insufficient Care	Wisconsin Arkansas
Signed Statement of Facility's Risk Policy	Iowa
Waiver of Liability Forbidden or Disclaimed	Washington Delaware New Jersey Vermont

Each of these categories and states is discussed below.

*A. Resolving Disputes with Emphasis on Resident's Acceptance of Risk*

In the District of Columbia and Kansas, the relevant laws refer to agreements that protect a resident's autonomy when the resident and facility disagree. On their face, the laws appear predicated on the "against-facility-advice" scenario.<sup>75</sup>

In general, the statutory or regulatory language itself does not indicate whether the provisions are fair to residents. A high-level outline of these laws is:

- 1) The resident and the facility disagree;

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75. See *supra* Part V.

- 2) The resident's autonomy deserves protection, as do the facility's interests;
- 3) The facility must put the resident on notice of the dispute; and
- 4) The resident and facility must negotiate and sign an agreement that sets forth each party's respective responsibilities.

The unanswered question is: what are the terms of the agreement? The agreement might memorialize a fair negotiated settlement. On the other hand, the agreement might serve primarily to release the facility from responsibility. Significantly, state laws frequently use terms such as "shared responsibility" that bring to mind images of fairness but could also cover an agreement that shifts liability to the resident.

### 1. *District of Columbia*

District of Columbia law provides for "shared responsibility agreements" to resolve disagreements between a resident and facility regarding "lifestyle, personal behavior, safety, and service plans."<sup>76</sup> On their face, the relevant definitions describe a process respectful of residents' interests. "Shared responsibility" is defined as "a process by which the resident . . . and the [assisted living facility] arrive at an acceptable balance between the resident's desire for independence and the facility's legitimate concerns for safety, where there is a disagreement."<sup>77</sup> In turn, a "shared responsibility agreement" is defined as an agreement that outlines the parties' responsibilities.<sup>78</sup>

The District of Columbia statute is noticeably slippery about whether such a shared responsibility agreement is a care planning document or a waiver of liability. In one breath, the statute identifies a shared responsibility agreement as "a tool for [assisted living facilities] to recognize an individual resident's right to autonomy by respecting his or her right to make individual decisions regarding lifestyle, personal behavior, and [individualized service plans]."<sup>79</sup> The following sentence, however, suggests that the purpose of a shared responsibility agreement is to shift risk from facility to resident, stating that "a resident's decision may involve increased risk of personal harm and therefore potentially increase the risk of liability by the [facility] absent an agreement between the resident and [the facility] concerning such decisions or actions."<sup>80</sup>

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76. D.C. CODE § 44-106.05(a) (2001).

77. *Id.* § 44-102.01(21). In language not included in this article, the statute recognizes the resident's interest may be represented by a representative. *See id.* ("The purpose of 'shared responsibility' is to provide complete information to the resident and the surrogate so that the parties can arrive at an informed agreement of which services are to be provided . . .").

78. *Id.* § 44-102.01(22).

79. *Id.* § 44-106.05(b); *Id.* § 44-102.01(14) (defining ISPs, or Individualized Service Plans).

80. *Id.* § 44-106.05(b).

Use of a shared responsibility agreement is required when “a resident decides to pursue a course of action, such as refusal of services, that may involve increased risk of personal harm and conflict with the [assisted living facility’s] usual responsibilities.”<sup>81</sup> The facility must explain to the resident the range of issues subject to negotiation, and then “[n]egotiate a shared responsibility agreement, with the resident as a full partner.”<sup>82</sup>

The law gives a resident the right to enter into a shared responsibility agreement.<sup>83</sup> However, as discussed above, it is unclear whether a shared responsibility agreement benefits the resident or the facility. A resident’s right to refuse services is conditioned on the signing of a shared responsibility agreement.<sup>84</sup>

## 2. *Kansas*

In most respects, the Kansas “negotiated service agreement” is nothing more than a written care plan that arguably is not negotiated at all.<sup>85</sup> These “agreements” are developed by assisted living facilities, “in collaboration” with a resident or resident’s representative.<sup>86</sup> The agreement describes needed services, and identifies who will be providing and paying for those services.<sup>87</sup>

The concept of risk enters the negotiated service agreement when a resident or resident’s representative refuses a service that is necessary for the resident’s health or safety, in the opinion of the facility operator or nurse, or in the opinion of the resident’s physician or case manager. In this case, a negotiated service agreement must identify the refused service and the negative consequences of

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81. *Id.* § 44-106.05(c).

82. *Id.* § 44-106.05(c)(1)-(2).

83. *Id.* § 44-105.04(4).

84. *Id.* § 44-105.4(5). The requirement of a shared responsibility agreement is qualified by need: a resident has the right “[t]o refuse to participate in any service once the potential consequences of such participation have been explained and a shared responsibility agreement has been reached, *if necessary*, between the resident . . . and the [assisted living facility].” *Id.* (emphasis added); *see also id.* § 44-106.04(a)(6) (explaining that an Individualized Service Plan “shall include a shared responsibility agreement when necessary”). The issue, of course, is who determines when an agreement is needed, and under what standard. As a practical matter, the decision is most likely made by an assisted living facility, and a shared responsibility agreement will be “needed” when a facility demands that such an agreement be signed.

85. *See* JENKENS, *supra* note 3, at 45 n.14 (explaining that Kansas was not included in this particular negotiated risk report because “its regulations pertain only to negotiated *service* agreements and reference only the risk of refusing a recommended service”) (emphasis in original).

86. KAN. ADMIN. REGS. § 28-39-244(a) (2006). The statute provides that “[e]ach individual involved in the development of the negotiated service agreement shall sign the agreement.” *Id.* § 28-39-244(h). In most cases, evidently, a resident or a resident’s representative will not sign such an agreement, because the agreement will have been developed by the facility’s staff.

87. KAN. ADMIN. REGS. § 28-39-244(a)(1)-(3) (2006).

refusing that service, as well as “acceptance by the resident or the resident’s legal representative of the potential risk.”<sup>88</sup>

## *B. Care Planning with Emphasis on Resident’s Acceptance of Risk*

### *1. Florida*

Florida law defines both “managed risk” and “shared responsibility” in its statutory assisted living law. “Managed risk” describes care planning done “in such a way that the consequences of a decision, including any inherent risk, are explained to all parties and reviewed periodically . . . .”<sup>89</sup>

The Florida law’s related definition of “shared responsibility” follows this concept, but then changes direction. The first half of the definition, consistent with the “managed risk” definition, mentions risk obliquely: “‘Shared responsibility’ means exploring the options available to a resident within a facility and the risks involved with each option . . . .”<sup>90</sup> The second half of the definition, however, gives no hint of risk or compromise, indicating that the process of exploring options “enabl[es] the resident and, if applicable, the resident’s representative. . . . , and the facility to develop a service plan which best meets the resident’s needs and seeks to improve the resident’s quality of life.”<sup>91</sup>

The Florida law is much more verbose in defining these terms than in using them, mentioning the terms only once and requiring that “the concept of managed risk” be implemented in those facilities licensed to provide nursing services.<sup>92</sup> A corresponding Florida regulation describes, among other things, service plans at such facilities and shifts the focus away from meeting the resident’s needs and improving the quality of life, towards the idea that the resident is accepting risk.<sup>93</sup>

### *2. Illinois*

Illinois’ version of negotiated risk is wrapped in the language of autonomy and flexibility. Introductory statutory language lists “the right to negotiated risk” as a central assisted living principle, along with “dignity, individuality, privacy,

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88. *Id.* § 28-39-244(f)(1)-(3).

89. FLA. STAT. ANN. § 429.02(15) (West 2001 & Supp. 2007).

90. *Id.* § 429.02(23).

91. *Id.*

92. *Id.* § 429.07(b)(3)(f)-(g) (referencing the Nurse Practice Act, § 464.001 (West 2001) (effective July 1, 2000), and indicating that managed risk is only implemented when “services of a person licensed pursuant to part I of chapter 464” are provided). Specifically, this requirement applies only to those facilities licensed to provide “extended congregate care.” *Id.* § 429.07(b)(3). Such facilities are authorized to provide nursing services and certain supportive services “to persons who otherwise would be disqualified from continued residence in a[n] [assisted living] facility.” *Id.* § 429.07(b).

93. FLA. ADMIN. CODE ANN. r. 58A-5.030(7)(c) (2007).

independence, autonomy, and decision-making ability.”<sup>94</sup> The introductory language further posits “that “there is an acceptable balance between consumer protection and resident willingness to accept risk and . . . most consumers are competent to make their own judgments about the services they are obtaining.”<sup>95</sup>

“Negotiated risk” is defined as “the process by which a resident . . . may formally negotiate with providers what risks each are willing and unwilling to assume in service provision and the resident’s living environment.”<sup>96</sup> A provider is responsible for informing residents of risks and the consequences of assuming those risks.<sup>97</sup> A resident has the right to refuse services, provided that he or she has received clear information regarding risks and benefits.<sup>98</sup> The definition of a “negotiated risk *agreement*,” by contrast, sharpens focus onto the agreement’s enforceability and the possibility of harm. The relevant regulation describes these agreements as “binding” and specifies that they “describ[e] conditions or situations that could put the resident at risk of harm or injury.”<sup>99</sup>

Under Illinois law, a negotiated risk agreement cannot waive any assisted living regulation. This limitation would appear to prevent a facility from using a negotiated risk agreement to authorize an inadequate level of care.<sup>100</sup> Among the non-waivable regulations is a prohibition against an assisted living facility’s admission or retention of a resident if the facility cannot provide adequate care.<sup>101</sup>

### 3. *Utah*

Utah is the one state that most directly links the concept of negotiated risk to waiver of a facility’s liability. Although Utah law does not address negotiated risk or any related concepts, the state’s Bureau of Health Facility Licensing, Certification, and Resident Assessment has created a form for Negotiated Risk Contracts. In these contracts, a resident’s “responsible party” must recognize that the resident has had “difficulty” in certain specified ways, and must authorize the facility to allow the resident to continue the behavior in question, as well as release the facility from liability with regard to such behavior. Both the responsible party and a facility representative must sign this contract.<sup>102</sup>

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94. 210 ILL. COMP. STAT. ANN. 9/5 (West 2000 & Supp. 2007); ILL. ADMIN. CODE tit. 77, § 295.100(a) (2007).

95. 210 ILL. COMP. STAT. ANN. 9/5; ILL. ADMIN. CODE tit. 77, § 295.100(a).

96. 210 ILL. COMP. STAT. ANN. 9/10; ILL. ADMIN. CODE tit. 77, § 295.200.

97. 210 ILL. COMP. STAT. ANN. 9/10; ILL. ADMIN. CODE tit. 77, § 295.200.

98. ILL. ADMIN. CODE tit. 77, § 295.4010(i).

99. *Id.* § 295.200.

100. *See id.* § 295.2070(e).

101. *Id.* § 295.2000(a).

102. UTAH BUREAU OF HEALTH FACILITY LICENSING, *supra* note 5; *see also* Mary Jane Ciccarello & Joanne Wetzler, *Assisted Living in Utah: A Brief Overview for Consumers*, 19 UTAH B.J. 24, 26 (2006) (noting that negotiated risk agreements are “commonly used” in Utah).

### C. Care Planning with Limited References to Acceptance of Risk

#### 1. Oregon

In Oregon, “negotiated risk”—“managed risk” in Oregon law—hews closely to a care-planning model. “Managed risk” is “a process by which a resident’s high-risk behavior or choices are reviewed with the resident.”<sup>103</sup> The facility explains the resident’s options and consequences, and then the managed risk plan documents the resident’s decision either to accept the consequences of current behavior or change behavior.<sup>104</sup> Specifically, the managed risk plan must include an explanation of the “cause of concern,” as well as “possible negative consequences,” a description of the resident’s preferences, possible alternatives, “[a] description of the services the facility will provide to accommodate the resident’s choice or minimize the potential risk,” and the final agreement reached between the resident and the facility.<sup>105</sup>

### D. Care Planning to Reduce Probability of Negative Outcome

#### 1. Hawaii

In Hawaii, negotiated risk is best described as a mechanism for reducing a resident’s risk. However, as is typical in negotiated risk law, such a simple summary is dangerous, and must be qualified by the recognition that relevant Hawaii law is both vague and internally inconsistent.

Under Hawaii law, the relevant term is “managed risk.” Although Hawaii statutory law makes no mention of the term, it receives a prominent position in the state’s assisted living regulations. The initial paragraph of these regulations lists three principles that are to be applied to the regulations: aging in place, negotiated plan of care, and managed risk.<sup>106</sup> The subsequent regulations, however, do little to distinguish “managed risk” from the “negotiated plan of care.” The definition of “managed risk” describes a “formal process of negotiating and developing a plan to address resident needs, decisions, or preferences *to reduce the probability of a poor outcome for the resident or of putting others at risk for adverse consequences.*”<sup>107</sup>

103. OR. ADMIN. R. 411-055-0000(24) (2006) (defining as applicable to residential care facilities); *id.* 411-056-0005(20) (defining as applicable to assisted living facilities). As illustrated by these parallel provisions, the concept of “managed risk” applies both in residential care facilities and assisted living facilities. Assisted living facilities must offer private living units, but residential care facilities may have shared occupancy. OR. REV. STAT. § 443.400(5) (defining “residential care facility”).

104. OR. ADMIN. R. 411-055-0000(24) (defining as applicable to residential care facilities); *id.* 411-056-0005(20) (defining as applicable to assisted living facilities).

105. *Id.* 411-055-0180(j) (defining as applicable to residential care facilities); *id.* 411-056-0015(j) (defining as applicable to assisted living facilities).

106. HAW. CODE R. § 11-90-1(1)-(3) (Weil 1999).

107. *Id.* § 11-90-2 (emphasis added). The same regulation explains that:

Perhaps the most noteworthy aspect of this definition is its twist on risk—the only mention of “risk” pertains not to the resident, but to the relatively unlikely scenario of the resident’s plan harming another resident.<sup>108</sup>

## 2. *Oklahoma*

Oklahoma law is comparatively succinct. The relevant provision applies when “a resident’s preference or decision places the resident or others at risk or is likely to lead to an adverse consequence.”<sup>109</sup> Under this law, assisted living facilities are instructed to discuss these matters with residents or residents’ representatives, and to “attempt to negotiate a written agreement that minimizes risk and adverse consequences and offers alternatives while respecting resident preferences.”<sup>110</sup>

### *E. Consenting to Inadequate Care*

#### 1. *References to “Consequences” or “Responsibility”*

A small minority of states present negotiated risk as a mechanism by which a resident might consent to receiving inadequate care. Generally, liability is not addressed directly; instead, these state laws speak with less precision of, for example, “consequences” or “sharing responsibility.” These laws are similarly ambiguous as to whether the refused service otherwise would be available.

Ohio is the only state in which consent to inadequate care is presented as the primary purpose of—to use Ohio’s terminology—a “risk agreement.” In Wisconsin and Arkansas, by contrast, such consent is one purpose of negotiated risk; the other purpose is the resolution of disputes.<sup>111</sup>

#### 2. *Ohio*

Ohio law refers to written “risk agreements,” in which a resident and facility “agree to share responsibility for making and implementing decisions affecting the scope and quantity of services provided by the facility to the resident.”<sup>112</sup> By requiring that the facility “identify the risks inherent in a decision . . . not to receive

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“Negotiated Plan of Care or Service Plan or Agreement” means a written plan for services developed with the resident or significant others and which includes a recognition of the resident’s capabilities and choices. The plan defines the division of responsibility in the implementation of services and specifies measurable goals.

*Id.*

108. *Id.*

109. OKLA. ADMIN. CODE § 310:663-3-6(a) (2007).

110. *Id.* § 310:663-3-6(b).

111. *See infra* Part VI.F.

112. OHIO REV. CODE ANN. § 3721.012 (LexisNexis 2005); *see also* OHIO ADMIN. CODE § 3701:17-57(E) (2006) (outlining the same provision).

a service *provided by the facility*,”<sup>113</sup> the law suggests that a resident might be refusing an available service, although the definition of “risk agreement” is expansive enough to include the “inadequate care” scenario.

As a practical matter, a resident has little reason to refuse an available service, and therefore the most likely use of a risk agreement would be to acknowledge a service’s unavailability. This observation is reinforced by the only other Ohio statutory provision that mentions risk agreements, which presupposes that a facility that uses risk agreements has a policy of doing so, and requires that such a facility notify prospective residents and their representatives of that policy.<sup>114</sup>

A formal policy of this type could make little sense when applied to residents refusing available services. Residents generally have no reason to refuse needed services. Furthermore, such a policy likely could say nothing meaningful. The policy would say that the resident has a right to refuse services unless the refusal threatens the health and safety of others.<sup>115</sup> Beyond that, the policy could say little else, because the facility could not anticipate the various situations in which a resident might refuse available services. Envisioning a formal policy becomes plausible, however, if the policy would relate to an “inadequate care” scenario. In that situation, a facility clearly would have an interest in delineating the extent of its responsibilities.

The Ohio regulation that governs personal care services contemplates that a risk agreement might pertain to a resident either refusing available services or acknowledging the unavailability of needed services. A refusal of available services is discussed in the regulation’s subsection requiring a facility to provide necessary personal care services, except when the resident and facility have entered into a risk agreement.<sup>116</sup> If, however, a resident requires personal care services that the facility does not provide, the regulation presents three options: (1) the facility or the resident can arrange for the services to be provided; (2) the resident can be transferred; or (3) the facility and the resident can enter into a risk agreement.<sup>117</sup>

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113. OHIO REV. CODE ANN. § 3721.012 (emphasis added).

114. *Id.* § 3721.19(B); *see also* OHIO ADMIN. CODE § 3701:17-57(F) (outlining a similar provision).

115. *See, e.g.*, OHIO REV. CODE ANN. § 3721.16(A)(1)(c)-(d) (LexisNexis 2005) (noting that involuntary transfer or discharge is authorized when “[a]n emergency arises in which the safety [or health] of individuals in the [facility] is endangered”).

116. OHIO ADMIN. CODE § 3701:17-59(B)(2).

117. OHIO ADMIN. CODE § 3701:17-59(C). The option of entering into a risk agreement is only open to those facilities with a policy of using such agreements. *Id.* § 3701:17-59(C)(2). Ohio regulations are inconsistent as to whether a facility may admit or retain a resident for whom it cannot provide adequate care. As discussed in this article, such admission or retention is allowed through the mechanism of risk agreements. However, Ohio regulations instruct more generally that a facility “shall not admit an individual who requires services or accommodations . . . beyond that which the specific facility provides.” *Id.* § 3701:17-57(A).



*F. Ambiguity Whether Agreements Are Used to Resolve Disputes,  
or to Consent to Inadequate Care*

*1. Wisconsin*

Wisconsin law requires facilities to “[e]stablish, with each resident . . . a signed, negotiated risk agreement that identifies situations that could put the resident at risk and for which the resident understands and accepts responsibility.”<sup>118</sup> The risk agreement is indeed mandatory—a resident’s refusal to sign or revise a risk agreement can justify his or her involuntary transfer or discharge.<sup>119</sup> “Risk agreement” is defined in the relevant Wisconsin regulation as “a binding stipulation identifying conditions or situations which could put the tenant at risk of harm or injury and the tenant’s preference for how those conditions or situations are to be handled.”<sup>120</sup> Neither resident nor facility is to “refuse to accept reasonable risk or insist that the other party accept unreasonable risk.”<sup>121</sup>

The regulations refer to both the “against-facility-advice” scenario and the “inadequate care” scenario. The “against-facility-advice” scenario is addressed by the requirement that a risk agreement list any resident action, completed or contemplated, that is “contrary to the practice or advice of the facility and which could put the tenant at risk of harm or injury.”<sup>122</sup> Relevant to the “inadequate care” scenario, a risk agreement must list “[a]ny needs identified in the comprehensive assessment which will not be provided for by the facility, either directly or under contract.”<sup>123</sup> Under either scenario, “[a] risk agreement may not waive any [assisted living regulation] or any other right of the [resident].”<sup>124</sup> This no-waiver rule may be less restrictive to facilities than it appears to be on its face. The rights that matter most to a resident are those pertaining to quality of care and, according to the relevant regulations, those rights can vary with the terms of the resident’s service agreement.<sup>125</sup> Thus to a certain extent, the legal right of a resident is not to adequate care, but to the care identified in the service agreement.

The qualifier “to a certain extent” is important because Wisconsin, like other states discussed in this article, takes inconsistent positions: the state both provides for the enforceability of risk agreements, and requires that care be adequate to meet

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118. WIS. STAT. ANN. § 50.034(3)(d) (West 2003); *see also* WIS. ADMIN. CODE [HFS] § 89.23(3)(e) (2006) (“Services shall be provided in a manner which respects tenant privacy, enhances tenant self-reliance and supports tenant autonomy in decision-making, *including the right to accept risk.*” (emphasis added)).

119. WIS. ADMIN. CODE [HFS] § 89.29(3)(a)(8).

120. *Id.* § 89.13(27).

121. *Id.* § 89.28(4).

122. *Id.* § 89.28(2)(a)(1).

123. *Id.* § 89.28(2)(b).

124. *Id.* § 89.28(3).

125. *See, e.g., id.* §§ 89.23(1), (2)(a)(3), (3)(b).

residents' needs. The portion of the Wisconsin regulation entitled "Services" declares that "[a] facility is not required to provide or be staffed to provide services which are not needed, are not included in the service agreements or are above the minimum required levels," but another subsection of that same regulation requires that a facility be "able to provide the minimum required services to any [resident] who needs or develops a need for those services."<sup>126</sup>

## 2. *Arkansas*

Arkansas law is equally evasive as to whether negotiated risk applies to the "against-facility-advice" scenario, the "inadequate care" scenario, or both. The term used in Arkansas regulations is "compliance agreement," which is defined as "the written formal plan developed in consideration of shared responsibility, choice and assisted living values and negotiated between the resident . . . and the assisted living facility to avoid or reduce the risk of adverse outcomes that may occur in an assisted living environment."<sup>127</sup> Neither "shared responsibility" nor "assisted living values" are defined or even mentioned further in the regulations; "choice" is defined in a manner that is roughly consistent with its dictionary definition, but incorporates references to "resident options," "care planning," and other assisted living concepts.<sup>128</sup>

Arkansas's "compliance agreement" regulation alternates confusingly between discussing a facility's limitations in admitting or retaining residents, and explaining compliance agreements as a mechanism for honoring residents' choices. The regulation's pivotal sentence sets limits on residents' choices:

The choice and independence of action of a resident may need to be limited when a resident's individual choice, preference, or actions, are identified as placing the resident or others at risk, lead to adverse outcomes, or violate the norms of the facility or program or the majority of the residents, or any combination of these events.<sup>129</sup>

A compliance agreement is intended to "minimize the possible risk and adverse consequences while still respecting the resident's preferences."<sup>130</sup> Involuntary transfers or discharges are authorized for failing to comply with risk

126. *Id.* §§ 89.23(2)(a)(1), (2)(a)(5).

127. 016-06-001 ARK. CODE R. § 300 (Weil 2005) (effective Aug. 1, 2003) (defining as applicable to Level I facilities); 016-06-002 ARK. CODE R. § 300 (Weil 2005) (effective Aug. 1, 2002) (defining as applicable to Level II facilities). The primary difference between a Level I facility and a Level II facility is that a Level II facility may admit and retain residents who need a nursing home level of care. *Id.* § 400.2. The law for Level I facilities and Level II facilities regarding compliance agreements, however, is almost identical. 016-06-001 ARK. CODE R. § 300 (Weil 2005).

128. *Id.* § 300.

129. *Id.* § 704.

130. *Id.* The Arkansas regulations suggest, for example, the use of a compliance agreement when a facility feels that a resident may be at risk if he or she is given a key, a code, or another other exit device for leaving the facility. *See, e.g., id.* § 904(b)(1).

agreements or, as is the case in Wisconsin, refusing to negotiate or revise such agreements.<sup>131</sup> Arkansas's compliance agreement provisions are flanked by two provisions addressing facilities' levels of care: (1) a list of the health care conditions that cannot be accommodated in that level of assisted living facility, and (2) an admonition that an individual is prohibited from residing in an assisted living facility if he or she needs around-the-clock nursing care or requires services that, by law, cannot be provided in an assisted living facility.<sup>132</sup> Significantly, this prohibition applies even if a resident is willing to waive the facility's liability.<sup>133</sup> Overall, the law's structure—the flanking of the negotiated risk provisions by provisions relating to facilities' admission and retention limitations—suggests that negotiated risk also relates to facilities' abilities—or inabilities—to care for residents with particular care needs.

### G. *Signed Statement of Facility's Risk Policy*

#### 1. *Iowa*

Iowa law is particularly ambiguous regarding the concept of “shared risk,” even though this concept is purportedly a central feature of assisted living under the relevant state regulations. The definition of assisted living encourages resident decision-making and indicates that decisions should emphasize shared risk as well as choice, dignity, privacy, individuality, and independence.<sup>134</sup>

Under Iowa law, the most tangible manifestation of shared risk is a requirement that an incoming resident sign the facility's “managed risk policy disclosure statement.”<sup>135</sup> This statement is defined vaguely as a “signed acknowledgment of the shared responsibility for identifying and meeting the needs of the tenant and the process for managing risk and upholding tenant autonomy when tenant decision making may result in poor outcomes for the tenant or others.”<sup>136</sup>

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131. *Id.* §§ 602.1(g), 704(7); *see Wis. ADMIN. CODE [HFS] § 89.29(3)(a)(8)* (2006).

132. 016-06-001 ARK. CODE R. § 704 (Weil 2005) (effective Aug. 1, 2003) (defining as applicable to Level I facilities); 016-06-002 ARK. CODE R. § 704 (Weil 2005) (effective Aug. 1, 2002) (defining as applicable to Level II facilities).

133. *Id.* §§ 601.4, 704; *see also* ARK. CODE ANN. § 20-10-1704(c)(2) (2005).

134. IOWA CODE ANN. § 231C.2(2) (West 2006); IOWA ADMIN. CODE r. 321-25.1 (2007).

135. IOWA ADMIN. CODE r. 321-25.22(1).

136. *Id.* 321-25.36; *see also id.* 321-25.4(11) (noting that, in a certification application, a facility must submit “[t]he current policy and procedure for managing risk and upholding [resident] autonomy when [resident] decision making may result in poor outcomes for the [resident] or others”).

### H. *Waiver of Liability Explicitly Forbidden or Disclaimed*

Yet again, generalization is difficult. Although Washington, Delaware, New Jersey, and Vermont do not allow negotiated risk to waive a facility's liability, these states' laws differ in many ways. In Washington, the negotiated risk process closely resembles care planning. In Delaware and New Jersey, by contrast, negotiated risk ("managed risk" in New Jersey) is an internally inconsistent combination of dispute resolution and risk assumption. Finally, Vermont is an exception—in a positive way—the relevant law succinctly sets out a dispute-resolution focus, and specifies that negotiated risk does not include waiver of a facility's liability.

#### 1. *Washington*

Under Washington law, the negotiated risk process closely resembles care planning. The "negotiated service agreement" draws from assessments and the initial service plan, and is not an agreement per se. Instead, it is completed by the facility, with possible involvement from a resident or the resident's representative.<sup>137</sup>

The negotiated service agreement determines the care that is to be provided in virtually every context, whether the issue is basic services, activities, medication, nutrition, nursing services, tube feeding, staffing, or safety measures.<sup>138</sup> Allusions to risk are limited and oblique<sup>139</sup> and, in contrast, another regulation explicitly states that negotiated service agreements may not be used "to waive any rights of the resident or . . . to place responsibility or liability for losses of personal property or injury on the resident."<sup>140</sup>

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137. WASH. REV. CODE ANN. § 18.20.370(1) (West 2005); *see also* WASH. ADMIN. CODE 388-78A-2130 (2006); *id.* 388-78A-2170(1)-(2) (describing that a facility provides services consistent with the relevant negotiated service agreement). A negotiated service agreement must be signed by a resident or resident's representative, but the signature requirement appears to be designed to develop a consensus among persons involved in the resident's care, rather than to create an agreement that is enforceable in court. The signature requirement applies not only to the facility and the resident, but also to any public or private case manager for that resident. *Id.* 388-78A-2150.

138. WASH. ADMIN. CODE 388-78A-2170 (basic services); *id.* 388-78A-2180 (activities); *id.* 388-78A-2210 (medication); *id.* 388-78A-2300 (nutrition); *id.* 388-78A-2320 (nursing services); *id.* 388-78A-2330 (tube feeding); *id.* 388-78A-2450 (staffing); *id.* 388-78A-2700 (safety measures).

139. *See, e.g., id.* 388-78A-2380(4) ("Each resident who is assessed as being unsafe to leave [the facility] unescorted is able to leave [the facility] consistent with his or her negotiated service agreement.").

140. *Id.* 388-78A-2140(8).

## 2. Delaware

Under Delaware law, the definition of a negotiated risk agreement is typically ambiguous. The agreement is “[a] signed document between the resident and the facility, and any other involved party, which describes mutually agreeable action balancing resident choice and independence with the health and safety of the resident or others.”<sup>141</sup> Delaware law benignly defines “shared responsibility” as “[t]he concept that residents and assisted living facilities share responsibility for planning and decision-making affecting the resident.”<sup>142</sup> A negotiated risk agreement is appropriate only if risks are “tolerable to all parties” to the agreement, the agreement provides for “the greatest amount of resident autonomy with the least amount of risk,” and the resident is capable of making informed choices.<sup>143</sup>

Under Delaware law, negotiated risk agreements appear designed for dispute resolution rather than liability waiver. A negotiated risk agreement, in fact, cannot be used to waive a facility’s liability.<sup>144</sup> A related regulation states that a “facility shall not use managed/negotiated risk agreements to provide care to residents with needs beyond the capability of the facility.”<sup>145</sup> The agreement must describe the issue and the choices available to the resident, along with the risks and benefits associated with each choice, the facility’s recommendation, and the resident’s preference. Then, the agreement indicates the agreed-upon option, and in relation to that option, describes the responsibilities of the resident, the facility, and any relevant third parties.<sup>146</sup>

## 3. New Jersey

New Jersey law is roughly comparable to Delaware law—in each state, the relevant laws are ambiguous stewards of dispute resolution concepts and risk references, clarified by prohibitions against any waivers of facility liability. New Jersey law suggests that a resident’s autonomy and health may be in conflict, and defines “managed risk” as a “process of balancing resident choice and independence with the health and safety of the resident and other persons in the

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141. 40-300-005 DEL. CODE REGS. § 63.218 (Weil 2007). The Delaware regulations generally refer to “Managed/Negotiated Risk Agreement[s]” but, for simplicity, this article condenses the term to “negotiated risk agreements.”

142. *Id.* § 63.229.

143. *Id.* § 63.1208.

144. *Id.* § 63.1212.

145. *Id.* § 63.1211. This same regulation also indicates that “[a] managed/negotiated risk agreement shall not be used to supersede any requirements of these regulations.” *Id.*

146. *Id.* § 63.1209; *see also* 40-800-124 DEL. CODE REGS. § 5.1.3 (noting that the state is obligated to participate, as appropriate, in the development of negotiated risk agreements, when payment for assisted living care is provided at least in part through the state’s Assisted Living Medicaid Waiver Program).

facility or program.”<sup>147</sup> The very next sentence of the regulation, however, abandons this concept of balancing and explains that “[i]f a resident’s preference or decision places the resident or others at risk or is likely to lead to adverse consequences, such risks or consequences are discussed with the resident . . . and a formal plan to avoid or reduce negative or adverse outcomes is negotiated . . . .”<sup>148</sup>

Similarly, the defined purpose of a “managed risk agreement” in the regulation is “to avoid or reduce the risk of adverse outcomes.”<sup>149</sup> The definition of a “managed risk agreement” provides that such an agreement is “developed in consideration of shared responsibility, bounded choice and assisted living values.”<sup>150</sup> These definitions are, in part, innocuous, but intimate that a resident is accepting risk. “Assisted living values” is also defined in the regulation as including “each resident’s choice, dignity, independence, individuality and privacy in a homelike environment,” as well as “aging in place” and—from a resident’s point of view, the only discordant note—“shared responsibility.”<sup>151</sup> Another term defined in the regulation, “bounded choice,” puts some brakes on the resident’s choice and independence, acknowledging “limits placed on a resident’s choice as a result of an assessment . . . which indicates that such resident’s choices or preferences place the resident or others at a risk of harm or lead to consequences which violate the norms of the facility or program or the rights of others.”<sup>152</sup>

The regulation’s definition of “shared responsibility” similarly combines conflicting images. The first image is communitarian: “‘Shared responsibility’ means that residents . . . and providers of assisted living services share responsibility for planning and decision making affecting residents.”<sup>153</sup> This broad principle is unobjectionable from a resident’s point of view, but its suggestion of communitarianism is reversed by the risk-evoking instruction that follows: “[t]o participate fully in shared responsibility, residents shall be provided with clear and understandable information about the possible consequences of their decision-making.”<sup>154</sup>

A separate New Jersey regulation explains how managed risk agreements are to be developed. Consistent with “bounded choice,” the regulation focuses on how a resident’s autonomy can be limited—“when a resident’s individual choice, preference and/or actions are identified as placing the resident or others at risk, lead to adverse outcome and/or violate the norms of the facility or program or the

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147. N.J. ADMIN. CODE § 8:36-1.3 (2007).

148. *Id.*

149. *Id.*

150. *Id.*

151. *Id.*

152. *Id.*

153. *Id.*

154. *Id.*

majority of the residents.”<sup>155</sup> The agreement is intended to “minimize the possible risk and adverse consequences while still respecting the resident’s preferences,” although the regulation recognizes that in some instances the facility and the resident or the resident’s representative will not be able to reach agreement.<sup>156</sup>

Although the New Jersey regulations leave open the possibility that a managed risk agreement could waive or reduce a facility’s liability, that possibility is foreclosed by a New Jersey statute. A provision applicable both to assisted living facilities and nursing homes voids “[a]ny provision or clause waiving or limiting the right to sue for negligence or malpractice in any admission agreement or contract.”<sup>157</sup>

#### 4. Vermont

Compared to the other state laws discussed in this article, Vermont’s definition of negotiated risk is notably lucid. Vermont law addresses the waiver of liability issue explicitly, providing that “[n]egotiated risk does not constitute a waiver of liability.”<sup>158</sup> Additionally, “negotiated risk” is defined in a relatively straightforward manner as “a formal, mutually-agreed upon, written understanding that results after balancing a resident’s choices and capabilities with the possibility that those choices will place the resident at risk of harm.”<sup>159</sup>

If a resident has entered into an applicable negotiated risk agreement, she cannot be discharged involuntarily for being a danger to herself.<sup>160</sup> However, it is unclear how meaningful this protection might be in practice. For example, a diabetic would be allowed to eat candy, but as discussed subsequently, such individual choices are allowed routinely in long-term care without need for negotiated risk.<sup>161</sup> Also, negotiated risk does *not* provide an exception to an involuntary discharge based on a facility’s inability to meet a resident’s care needs.<sup>162</sup> Even less likely is the probability, as suggested by the Vermont regulations, that a negotiated risk agreement might eliminate the need for an involuntary discharge predicated on “a serious threat to residents or staff.”<sup>163</sup> Obviously, a resident signing the negotiated risk agreement has no ability to consent to risk on others’ behalf.

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155. *Id.* § 8:36-4.17(a).

156. *Id.* § 8:36-4.17(a)(3), (4).

157. N.J. STAT. ANN. § 30:13-8.1 (West Supp. 2006).

158. 13-110-007 VT. CODE R. § 3.4 (2006).

159. *Id.*

160. *Id.* § 6.5(a).

161. See *infra* Part VIII.A.

162. 13-110-007 VT. CODE R. § 6.5(f).

163. *Id.*

### I. State Law Overall

This analysis illustrates that state-negotiated risk law is generally ambiguous and inconsistent, whether viewed solely within a single state, or viewed across several or all of the sixteen states that explicitly recognize negotiated risk. This ambiguity is demonstrated, for example, by ubiquitous, vague references to risk in virtually every state's laws, and by the states' failures to distinguish between "against-facility-advice" scenarios and "inadequate care" scenarios.

In both Wisconsin and Arkansas, for example, the inconsistency is shown by laws referring both to dispute resolution and a resident's consent to inadequate care. Iowa law is similarly inconsistent, mandating disclosure of risk policies but never defining a risk policy in a meaningful way. Furthermore, the law is not even consistent in the four states that prohibit liability waivers, because the prohibition conflicts with the laws' discussions of risk and risk agreements. Inter-state ambiguities and inconsistencies are demonstrated by this article's need to create eight separate categories to describe sixteen states. Negotiated risk differs greatly from one state to another and, depending on the state, negotiated risk may refer to dispute resolution, care planning, or a resident's consent to inadequate care. The law may refer to a resident's acceptance of risk or instead may prohibit any waiver of a facility's liability.

## VII. EMPIRICAL EVIDENCE IS SCANT

Negotiated risk literature is theoretical rather than empirical, with two exceptions. One of these exceptions, a survey of facility administrators, found eighty-two instances in which negotiated risk agreements were used.<sup>164</sup> "Falling" and "wandering"—each from the "inadequate care" scenario—were identified as the most common issues addressed in negotiated risk agreements.<sup>165</sup> The survey, however, did not describe the terms of the agreements or the types of situations involved, or whether agreements arose from "inadequate care" scenarios or "against-facility-advice" scenarios.<sup>166</sup>

A recent study reviewed thirty-one negotiated risk agreements in three states: Florida, Oregon, and Wisconsin.<sup>167</sup> The majority of the reviewed agreements evidently would be classified under the "against-facility-advice" scenario, because they pertained to "noncompliance with diabetic diets, refusing a prescribed pureed diet, refusing monitoring of vital signs (pulse and blood pressure), refusing to use a walker or wheelchair, choosing to use bedrails, taking unaccompanied walks, self-

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164. Keren Brown Wilson et al., *Negotiated Risk Agreements: Opportunity or Exploitation?*, 7 ETHICS L. & AGING REV. 59, 76 (2001).

165. *Id.* at 76. "Falling" was addressed in 21.95 percent of the agreements, while "wandering" was addressed in 13.41 percent of the agreements. *Id.*

166. *Id.* at 71-77.

167. JENKENS ET AL., *supra* note 3, at 31-32.



managing medications, refusing housekeeping, and assisting another resident who uses a wheelchair.”<sup>168</sup>

In the study, some negotiated risk agreements focused on a resident’s condition rather than his or her decisions. For a resident who was blind, as well as another resident with spinal stenosis,<sup>169</sup> a negotiated risk agreement identified a risk of falling. For a morbidly obese resident who could not wear shoes, a negotiated risk agreement identified a risk of falling, skin breakdown, and foot infection. “Possible alternatives” for the obese residents were weight reduction programs, foot protection, weight-loss medication, surgery, and transfer to a nursing home.<sup>170</sup> In one Wisconsin facility, all residents at high risk for falling were required, at admission, to sign a negotiated risk agreement pertaining to the risk of falling.<sup>171</sup> In Oregon, several of the negotiated risk agreements concerned smoking in non-smoking areas,<sup>172</sup> even though smoking can be a risk to persons other than the smoker. Most of the other Oregon agreements concerned behaviors that were offensive to others but not dangerous, such as yelling, playing loud music, being intoxicated, and watching pornography in the presence of housekeeping staff.<sup>173</sup> Examination of the content of the Oregon negotiated risk agreements revealed that many followed the “against-facility-advice” scenario—a resident’s behavior or choice presenting a potential risk, as well as the agreement being written to “protect the resident’s autonomy” but in an unspecified way.<sup>174</sup>

In several Oregon negotiated risk agreements, however, the identified risk was the risk of eviction if the resident failed to comply with facility rules. Interviews with Oregon assisted living experts revealed that negotiated risk agreements were used commonly to support an eviction, by demonstrating a facility’s pre-eviction efforts to warn a resident.<sup>175</sup>

The study found in Wisconsin that some negotiated risk agreements were used to document what a facility would *not* do to address a particular risk. Regarding one resident’s refusal to comply with a diabetic diet, a negotiated risk agreement specified that the facility could not supervise the resident’s dietary intake on a 24-hour basis, prevent the resident’s purchases at the facility’s store, or

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168. *Id.* at 31.

169. “Spinal stenosis is a narrowing of spaces in the spine (backbone) that results in pressure on the spinal cord and/or nerve roots. . . . Pressure on the lower part of the spinal cord or on nerve roots branching out from that area may give rise to pain or numbness in the legs.” Questions and Answers about Spinal Stenosis, National Institute of Arthritis and Musculoskeletal and Skin Diseases (2006), [www.niams.nih.gov/hi/topics/spinalstenosis/spinal\\_sten.htm](http://www.niams.nih.gov/hi/topics/spinalstenosis/spinal_sten.htm).

170. JENKENS ET AL., *supra* note 3, at 31.

171. *Id.*

172. *Id.* at 32.

173. *Id.*

174. *Id.*

175. *Id.*

remove candy from the resident's living quarters.<sup>176</sup> Another agreement pertained to a resident who took walks, stating that the facility could not provide escorts for walks and did not offer 24-hour monitoring of residents' whereabouts.<sup>177</sup>

### VIII. WHY NEGOTIATED RISK SHOULD BE REMOVED FROM LAW

#### A. *Negotiated Risk is Unnecessary; Residents Can Refuse Available Services Without Signing Agreements*

As discussed previously, proponents of negotiated risk recommend it as a mechanism to allow residents to refuse unwanted services or advice. This argument's flaw is that residents of assisted living facilities should have the right to refuse services or advice without signing any agreement. Proponents' arguments are based in significant part on comparisons with nursing homes, but the "against-facility-advice" scenario mischaracterizes life in a nursing home. For example, an earlier-cited negotiated risk policy paper alleges that "classic" flaws in nursing home care include "the use of restraints to prevent falls and 'mandated' participation in social activities."<sup>178</sup> Actually, restraints can be used in a nursing home only with a physician's order and the consent of the resident or resident's representative.<sup>179</sup> Use of restraints must be "to treat the resident's medical symptoms" and never for the staff's convenience.<sup>180</sup> Likewise, activities must be offered<sup>181</sup> but "resident choice" is a recognized reason for a resident to forego participation.<sup>182</sup>

In the words of one health policy specialist, "regulations are often blamed unfairly for autonomy incursions that are not regulatorily mandated."<sup>183</sup> Providers and their representatives not infrequently exaggerate the stringency of regulatory requirements, due to a general risk aversion and "law-related anxieties"<sup>184</sup> that often are not well founded:

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176. *Id.*

177. *Id.*

178. Kapp & Wilson, *supra* note 57, at 7.

179. 42 U.S.C. §§ 1395i-3(c)(1)(A)(ii), 1396r(c)(1)(A)(ii) (2000).

180. 42 U.S.C. §§ 1395i-3(c)(1)(A)(ii), 1396r(c)(1)(A)(ii) (2000); 42 C.F.R. § 483.13(a) (2006).

181. 42 C.F.R. § 483.15(f)(1).

182. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., PUBL'N NO. 100-07, APPENDIX PP TO STATE OPERATIONS MANUAL, SURVEYOR'S GUIDELINE TO 42 C.F.R. § 483.15(f)(1) (2006), <http://www.cms.hhs.gov/Manuals/IOM/list.asp>. It is worth noting that the offered activities must be "designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident." 42 C.F.R. § 483.15(f)(1).

183. Kane, *supra* note 20, at 83.

184. Kapp & Wilson, *supra* note 57, at 8; Kapp, *supra* note 17, at 58 (discussing "law-related anxiety").

If it is taken as a given that most residents should not go outside unaccompanied, be in a bathtub in privacy, have a glass of wine without a doctor's prescription, or stay awake in a chair watching a late movie, it is not because specific regulations prohibit these events. Rather, it is because providers fear that untoward consequences will be judged as neglectful or substandard care. They may also believe that only an unaffordable level of staff supervision and attention would make individualization of schedules possible on a widespread basis and that residents should not be left alone on any account.<sup>185</sup>

For example, nursing home staff members frequently force residents to wake up at early hours with the explanation that the federal nursing home law requires that no more than fourteen hours elapse between the evening meal and the following day's breakfast.<sup>186</sup> In one case study,<sup>187</sup> the "real" reasons for this practice included various institutional and staff needs, along with an improperly paternalistic fear that the resident might stay in bed all day if not awakened at the crack of dawn.<sup>188</sup> The author found that it was:

[D]ifficult to view [the regulations] as any more than a rationalization—even a form of "bad faith"—for the nursing home's conduct. . . . At a minimum the federal regulation regarding the time between meals establishes the institution's obligation to *provide* meals at those intervals, but it would be surprising if the regulation also required that residents accept or receive all meals. And yet that is how the nursing home interpreted the regulation. The logic of this interpretation would even require force-feeding of resistant autonomous residents, not only to protect their life and health. The implausibility of such an interpretation is another reason to suspect that the institution is displaying bad faith in its conflict with [the resident].<sup>189</sup>

Under the federal Nursing Home Reform Law (Reform Law),<sup>190</sup> as well as constitutional and common law pertaining to health care decision-making,<sup>191</sup>

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185. Kane, *supra* note 20, at 78.

186. See 42 C.F.R. § 483.35(f)(2) ("There must be no more than 14 hours between a substantial evening meal and breakfast the following day.").

187. The case is one of eighteen cases derived from study data. Each of these cases "may illustrate the predicament of more than one resident and perhaps of several staff members as well." Rosalie A. Kane & Arthur L. Caplan, *Preface to EVERYDAY ETHICS: RESOLVING DILEMMAS IN NURSING HOME LIFE*, at xi, xii (Rosalie A. Kane & Arthur L. Caplan eds., 1990).

188. James F. Childress, *If You Let Them, They'd Stay in Bed All Morning: The Tyranny of Regulation in Nursing Home Life*, in *EVERYDAY ETHICS: RESOLVING DILEMMAS IN NURSING HOME LIFE*, *supra* note 187, at 79, 85.

189. *Id.* at 86-88 (emphasis in original).

190. The federal Nursing Home Reform Law applies to every nursing home that is certified to accept reimbursement from the federal Medicare program, the federal Medicaid program, or both. 42 U.S.C. § 1395i-3 (2000) (defining as applicable to Medicare-certified facilities); *id.* § 1396r (defining as applicable to Medicaid-certified facilities); 42 C.F.R. §§ 483.5-483.75 (outlining the regulations for facilities that are certified for Medicare reimbursement, Medicaid reimbursement, or both). Because of

nursing home residents generally have the right to make decisions regarding their health care and their day-to-day lives, subject on occasion to certain commonsense limitations. Under the Reform Law's regulations, a nursing home "must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality."<sup>192</sup> The Reform Law itself specifies that a nursing home resident has the right "to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered."<sup>193</sup> A regulation implementing the Reform Law specifies that a resident may "[c]hoose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care."<sup>194</sup>

In fact, under the Reform Law, a diabetic nursing home resident can choose to eat cake.<sup>195</sup> A nursing home resident can also self-administer medication, as long as the facility's interdisciplinary team determines that self-administration will be safe.<sup>196</sup> Regarding baths, the federal Surveyor's Guidelines to the federal nursing home regulations go into great detail regarding a nursing home's obligations to accommodate a resident's preferences:

The facility must demonstrate that it accommodates residents' needs. For example, if the resident refuses a bath because he or she prefers a shower, prefers it at a different time of day or on a different day, does not feel well that day, is uneasy about the aide assigned to help or is worried about falling, the staff should make the necessary adjustments realizing the resident is not refusing to be clean but refusing the bath under the circumstance provided. The facility staff should meet with the resident to make adjustments in the care plan to accommodate his or her needs.<sup>197</sup>

Exercise of each of these rights in a nursing home does not require the resident to sign any type of agreement, or release the nursing home from liability.

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the ubiquity of Medicare and Medicaid reimbursement in nursing home care, over ninety-seven percent of the nation's nursing homes are subject to the Reform Law. CTRS. FOR DISEASE CONTROL & PREVENTION, U.S. DEP'T OF HEALTH & HUMAN SERVS., THE NATIONAL NURSING HOME SURVEY: 1999 SUMMARY 7.

191. See, e.g., *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 269 (1990).

192. 42 C.F.R. § 483.15(a) (2006).

193. 42 U.S.C. §§ 1395i-3(c)(1)(A)(v)(I), 1396r(c)(1)(A)(v)(I); see also 42 C.F.R. § 483.15(e)(1).

194. 42 C.F.R. § 483.15(b)(1).

195. 42 C.F.R. § 483.10(b)(4) (describing a resident's right to refuse medical treatment). The federal nursing home regulations do not directly address the issue of whether a diabetic resident could choose to eat sweets; rather, it can be presumed that the right to refuse medical treatment encompasses the right to eat food that is medically contraindicated, such as a diabetic resident's right to eat sweets.

196. 42 C.F.R. § 483.10(n).

197. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T. OF HEALTH & HUMAN SERVS., *supra* note 182, at § 483.15(e).

All the necessary arrangements can take place in the care plan meetings that nursing homes conduct for each resident.<sup>198</sup>

Admittedly, the right to choose in the nursing home is not unlimited. In the examples cited above, a resident who refused *all* baths undoubtedly would be pressured to clean up. And self-administration of medication could be denied by the facility's interdisciplinary team, which includes the resident's physician, a registered nurse that cares for the resident, and other facility staff as appropriate.<sup>199</sup>

These limitations, presumably affecting a minuscule percentage of nursing home residents, are an unconvincing justification for negotiated risk. It is arguable whether any resident should be allowed to forego bathing entirely. It also is arguable whether a resident who is incompetent to administer her own medication, in the opinion of an interdisciplinary team, should be allowed to self-administer regardless in a long-term care facility. In that instance, self-administration could endanger both the self-administering resident and other residents as well, if the self-administering resident were to leave medication accessible to residents with dementia.

Indeed, states' assisted living rules frequently contain similar limitations on the ability of residents to self-administer medication.<sup>200</sup> Similarly, negotiated risk laws often specify that other residents are not to be put at risk.<sup>201</sup> For these reasons, negotiated risk limits rather than enhances autonomy. In nursing homes across the country, a resident generally has the right to reject a facility's recommendations as long the resident does not endanger the health or safety of others.<sup>202</sup> In negotiated risk, however, a resident can reject a facility's recommendations only after negotiating and signing an agreement that likely waives certain of the resident's rights.

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198. 42 U.S.C. §§ 1395i-3(b)(2); 1396r(b)(2); 42 C.F.R. § 483.20(k)(2).

199. 42 C.F.R. § 483.20(k)(2)(ii).

200. *See, e.g.*, KAN. ADMIN. REGS. § 28-39-147(p) (2006) (“[A] resident may self-administer drugs unless a registered professional nurse or a physician has determined that this practice is unsafe.”).

201. *See, e.g.*, HAW. ADMIN. R. 11-90-2 (1999) (“‘Managed risk’ means a formal process of negotiating and developing a plan . . . to reduce the probability of a poor outcome for the resident or of putting others at risk for adverse consequences” (emphasis added)); 016-06-001 ARK. CODE R. § 704 (Weil 2005) (effective Aug. 1, 2003) (“The choice and independence of action of a resident may need to be limited when a resident’s individual choice, preference, or actions, are identified as placing the resident or others at risk, lead to adverse outcomes, or violate the norms of the facility or program or the majority of the residents, or any combination of these events.” (emphasis added)) (defining as applicable to Level I facilities); 016-06-002 ARK. CODE R. § 704 (Weil 2005) (effective Aug. 1, 2002) (stating the same) (defining as applicable to Level II facilities).

202. 42 U.S.C. §§ 1395i-3(c)(2)(A)(iii)-(iv) (2000); 1396r(c)(2)(A)(iii)-(iv) (2000) (justifying involuntary transfers or discharge from nursing home if residents are endangering the health or safety of others); 42 C.F.R. § 483.12(a)(2)(iii)-(iv) (discussing the same).

## B. *Negotiated Risk Agreements Violate Public Policy*

### 1. *Assumption of Risk*

Negotiated risk laws frequently speak of a resident accepting risk.<sup>203</sup> In Oregon, a resident may decide to “accept the consequences” of his or her behavior.<sup>204</sup> Florida law refers to a resident’s right to “assume risks.”<sup>205</sup> A resident “accepts responsibility” in Wisconsin,<sup>206</sup> and, in Arkansas, acknowledges “acceptance of responsibility for the outcome from the agreed-upon course of action.”<sup>207</sup>

Negotiated risk proponents frequently cite a resident’s “acceptance” or “assumption” to argue that negotiated risk is justified by the legal doctrine of assumption of risk.<sup>208</sup> The legal analysis behind these arguments tends to be little more than an assertion that assuming responsibility in negotiated risk is necessarily equivalent to assuming the legal risk.

The term “assumption of risk” is particularly vulnerable to misinterpretation or manipulation. What might seem at first glance to be simple and commonsense—that an individual be responsible for his own choices—is not. Justice Frankfurter warned against confusing the vernacular sense of “assuming risk” with the legal doctrine:

The phrase “assumption of risk” is an excellent illustration of the extent to which uncritical use of words bedevils the law. A phrase begins life as a literary expression; its felicity leads to its lazy repetition; and repetition soon establishes it as a legal formula, indiscriminately used to express different and sometimes contradictory ideas.<sup>209</sup>

In fact, to a significant extent the doctrine of assumption of risk is a relic. In the same case, the majority of the Supreme Court stated:

Assumption of risk is a judicially created rule which was developed in response to the general impulse of common law courts at the beginning of [the industrial revolution] to insulate the employer as much as possible from bearing the “human overhead” which is an inevitable part of the cost—to someone—of the doing of industrialized business. The

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203. See *supra* notes 17-35 and accompanying text.

204. OR. ADMIN. R. 411-055-0000(24) (2006) (defining as applicable to residential care facilities); *id.* 411-056-0005 (20) (defining as applicable to assisted living facilities).

205. FLA. ADMIN. CODE ANN. r. 58A-5.030(7)(c) (2007).

206. WIS. STAT. ANN. § 50.034 (3) (d) (West 2003 & Supp. 2006).

207. 016-06-001 ARK. CODE R. § 704 (Weil 2005) (effective Aug. 1, 2003) (defining as applicable to Level I facilities), 016-06-002 ARK. CODE R. § 704 (Weil 2005) (effective Aug. 1, 2002) (defining as applicable to Level II facilities).

208. See, e.g., BURGESS, *supra* note 31, at 21; Lynch & Teachworth, *supra* note 28, at 14-15; Kapp & Wilson, *supra* note 57, at 9-10.

209. *Tiller v. Atl. Coast Line R.R. Co.*, 318 U.S. 54, 68-69 (1943) (Frankfurter, J., concurring).

general purpose behind this development in the common law seems to have been to give maximum freedom to expanding industry.<sup>210</sup>

As one prominent treatise states, “the whole spirit of the traditional defense [of assumption of risk] and of the reasoning it employs bears the strong imprint of laissez faire and its concomitant philosophy of individualism that has passed its prime.”<sup>211</sup> This attitude is well represented by Justice Cardozo’s oft-quoted but outdated admonition: “The timorous may stay at home.”<sup>212</sup>

Now, of course, tort law has evolved on the premise that even the timorous should feel free to leave the house. The doctrine of assumption of risk remains, however, although its parameters have changed greatly over the years.

## 2. *Express Assumption of Risk*

Assumption of risk can be either express or implied. This distinction is not difficult to describe or grasp. An “express” assumption of risk involves a written document in which one party assumes the risk of harm resulting from the other party’s negligence.<sup>213</sup> The doctrine of *express* assumption of risk thus applies to negotiated risk under the “inadequate care” scenario—the resident signs a negotiated risk agreement that expressly waives the facility’s liability. Implied assumption of risk will not be discussed in this article.

Express assumption of risk is justified by an individual’s freedom to contract.<sup>214</sup> This freedom is not insignificant—in general, “parties are free to enter into any contract at their will, provided that the particular contract does not violate the law or contravene public policy.”<sup>215</sup>

Freedom of contract must be weighed against another important value—responsibility for one’s negligent acts.<sup>216</sup> Denying recovery to an injured plaintiff is a harsh result, and liability waivers thus are subject to a jaundiced judicial eye.<sup>217</sup>

At one extreme is Virginia, which, pursuant to an 1890 decision of the Virginia Supreme Court, declines enforcement of any liability waiver relating to

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210. *Id.* at 58-59 (majority opinion).

211. 4 FOWLER HARPER ET AL., THE LAW OF TORTS § 21.3, at 225 (2d ed. 1986).

212. *Murphy v. Steeplechase Amusement Co., Inc.*, 166 N.E. 173, 174 (N.Y. 1929).

213. *See, e.g.*, W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 68, at 482 (W. Page Keeton ed., 5th ed. 1984); *Knight v. Jewett*, 834 P.2d 696, 703 n.4 (Cal. 1992); *Schmidt v. United States*, 912 P.2d 871, 873 n.8 (Okla. 1996) (“Express assumption of the risk occurs in those cases where the plaintiff expressly contracts with another not to sue for any future injuries which may be caused by that person’s negligence.”) (emphasis omitted).

214. *See, e.g.*, HARPER ET AL., *supra* note 211, at 248; *Ransburg v. Richards*, 770 N.E.2d 393, 395 (Ind. Ct. App. 2002); *White v. Vill. of Homewood*, 628 N.E.2d 616, 618 (Ill. App. Ct. 1993).

215. *Cudnik v. William Beaumont Hosp.*, 525 N.W.2d 891, 894 (Mich. Ct. App. 1994); *see also* HARPER ET AL., *supra* note 211, at 248-50.

216. *Heil Valley Ranch, Inc. v. Simkin*, 784 P.2d 781, 784 (Colo. 1989).

217. *Cornell v. Council of Unit Owners Haw. Vill. Condos., Inc.*, 983 F. Supp. 640, 643 (D. Md. 1997); *Simkin*, 784 P.2d at 783-84.

personal injury.<sup>218</sup> At the other extreme is Missouri, which does not consider liability waivers to be contrary to public policy, but nonetheless strictly construes such waivers against the party claiming waiver of liability.<sup>219</sup>

In most states, liability waivers are not per se unenforceable but, to varying extents, they are not looked upon favorably. Some courts characterize the clauses as generally enforceable but nonetheless unpalatable.<sup>220</sup> Other courts reverse the emphasis, stating that liability waivers are suspect or generally unenforceable.<sup>221</sup> Liability for intentional torts or gross negligence is not waivable.<sup>222</sup> Any obligations imposed by statute or regulation are also non-waivable.<sup>223</sup> The disfavored nature of liability waivers is most broadly expressed through invocations of “public policy”: in general, enforcement of a liability waiver will be denied if the waiver violates public policy.<sup>224</sup>

Courts articulate the relevant factors in a variety of ways. Colorado courts, for example, examine four factors: (1) duty to the public; (2) nature of services performed; (3) fairness of the contracting process, and (4) clarity of the exculpatory language.<sup>225</sup> In Oklahoma, a liability waiver must navigate “a gauntlet of judicially-crafted hurdles,” including requirements that the language of the clause be clear and unambiguous, that there be no vast difference in bargaining power, and that enforcement of the clause not be “injurious to public health, public morals or confidence in administration of the law,” and also not “undermine the security of individual rights vis-à-vis personal safety or private property as to violate public policy.”<sup>226</sup>

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218. *Johnson's Adm'x v. Richmond & Danville R.R. Co.*, 11 S.E. 829, 829-30 (Va. 1890); *see Hiett v. Lake Barcroft Community Ass'n, Inc.*, 418 S.E.2d 894, 895 (Va. 1992) (confirming continued validity of *Johnson's Adm'x*).

219. *Alack v. Vic Tanny Int'l of Mo., Inc.*, 923 S.W.2d 330, 334 (Mo. 1996).

220. *See, e.g., Burd v. KL Shangri-La Owners, L.P.*, 67 P.3d 927, 929 (Okla. Civ. App. 2002) (“While these exculpatory promise-based obligations are *generally enforceable*, they are *distasteful* to the law.”) (emphasis in original); *Ransburg v. Richards*, 770 N.E.2d 393, 396 (Ind. Ct. App. 2002) (upholding the general validity of exculpatory clauses unless parties have unequal bargaining power, the contract is unconscionable, or the transaction affects public interest).

221. *See, e.g., Barnes v. N.H. Karting Ass'n, Inc.*, 509 A.2d 151, 154 (N.H. 1986) (“In New Hampshire, exculpatory contracts are generally prohibited.”).

222. *See, e.g., Lamp v. Reynolds*, 645 N.W.2d 311, 314 (Mich. Ct. App. 2002); *Alack*, 923 S.W.2d at 337; *Vodopest v. MacGregor*, 913 P.2d 779, 785 (Wash. 1996); *Sommer v. Fed. Signal Corp.*, 593 N.E.2d 1365, 1370-71 (N.Y. 1992).

223. *See, e.g., HARPER ET AL., supra* note 211, at 252.

224. *See, e.g., Perez v. McConkey*, 872 S.W.2d 897, 904 (Tenn. 1994).

225. *Jones v. Dressel*, 623 P.2d 370, 376 (Colo. 1981); *see also Boehm v. Cody Country Chamber of Commerce*, 748 P.2d 704, 710 (Wyo. 1987) (employing the same four factors used by the *Dressel* court).

226. *Schmidt*, 912 P.2d at 874 (emphasis omitted).



The most frequently cited test is the one articulated by the California Supreme Court in *Tunkl v. Regents of University of California*.<sup>227</sup> As might be expected, the test is a list of factors, rather than an algorithm. The *Tunkl* court characterized the relevant “social forces” as “volatile and dynamic,” and concluded that, as a result, “[n]o definition of the concept of public interest can be contained within the four corners of a formula.”<sup>228</sup>

Under the *Tunkl* test, a liability waiver violates public policy if the clause “involves a transaction which exhibits some or all of the following characteristics:”

[B]usiness of a type generally thought suitable for public regulation; . . .  
[S]ervice of great public importance to the public, which is often a matter of practical necessity for some members of the public; . . . [Seller] holds himself out as willing to perform this service for any member of the public who seeks it; . . . [Seller] possesses a decisive advantage of bargaining strength; . . . [Seller] confronts the public with a standardized adhesion contract of exculpation, and makes no provision whereby a purchaser may pay [a higher price to] obtain protection against negligence; [and Buyer’s] person or property . . . is placed under the control of the seller, subject to the risk of [the seller’s] carelessness.<sup>229</sup>

Many states explicitly follow the factors set forth in *Tunkl*.<sup>230</sup> Other states cite the *Tunkl* factors in a mix-and-match fashion, discussing only some of the *Tunkl* factors and often adding other factors to the balancing process.<sup>231</sup> Some states ignore the *Tunkl* factors entirely, and instead apply an intuitive “totality of the circumstances” test.<sup>232</sup>

Overall, there is significant overlap between states’ tests for determining the enforceability of liability waivers. The *Tunkl* test itself is an amalgam of factors used by other states<sup>233</sup> and, as discussed, the *Tunkl* test has been used and modified by other states.

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227. 383 P.2d 441 (Cal. 1963). See also *Dalury v. S-K-I, Ltd.*, 670 A.2d 795, 797 (Vt. 1995) (stating that *Tunkl* sets forth “[t]he leading judicial formula for determining whether an exculpatory agreement violates public policy”).

228. *Tunkl*, 383 P.2d at 444.

229. *Id.* at 445-46.

230. See, e.g., *Wagenblast v. Odessa Sch. Dist.*, 758 P.2d 968, 971 (Wash. 1988); *Olson v. Molzen*, 558 S.W.2d 429, 431 (Tenn. 1977) (“We think these criteria are sound and we adopt them.”).

231. See, e.g., *Milligan v. Big Valley Corp.*, 754 P.2d 1063, 1066 (Wyo. 1988) (discussing certain *Tunkl* factors, to determine whether a duty to the public existed, in order to apply the four-part test); *Jones v. Dressel*, 623 P.2d 370, 376 (Colo. 1981) (discussing the same).

232. *Wolf v. Ford*, 644 A.2d 522, 527 (Md. 1994) (applying a test based on “the totality of the circumstances of any given case against the backdrop of current societal expectations”); *Dalury*, 670 A.2d at 798 (discussing the same, quoting from *Wolf*).

233. *Tunkl*, 383 P.2d at 445-46 nn.11-13; see also *Belshaw v. Feinstein*, 65 Cal. Rptr. 788, 798 (Cal. Ct. App. 1968) (citing *Tunkl* and invalidating liability waivers used by neurosurgeons).

### 3. *Liability Waivers in Health Care*

Since negotiated risk deals with care provided—or not provided—to a resident, the relevant cases are those drawn from the health care arena. ALFA's negotiated risk manual claims that liability waivers "are routinely used by hospitals and physicians when discussing with seniors the risks of specific medical procedures or treatments,"<sup>234</sup> but the opposite is true. Across the board, courts have invalidated liability waivers that purport to release a health care provider from liability for negligence. "In the field of medical risks," notes one commenter, "courts have generally rejected out-of-hand attempts by physicians and hospitals to shift the risk of negligence to patients."<sup>235</sup>

*Tunkl* dealt with surgery conducted at the UCLA Medical Center.<sup>236</sup> The consent form for Tunkl's surgery acknowledged that the hospital was a research and education center and waived any liability claim that Tunkl otherwise might have had against the hospital.<sup>237</sup> The hospital asserted the liability waiver, in a lawsuit brought subsequently by Tunkl, but the California Supreme Court found the waiver unenforceable.<sup>238</sup> The court noted that unenforceability did not require that each *Tunkl* factor be present but that, in this case, each factor was present: the hospital was subject to public regulation, surgery was a necessary and important service performed by the hospital, the hospital held itself out as providing services to the general public, the hospital had a decisive advantage of bargaining strength, the hospital used a standardized adhesion contract of exculpation, and Tunkl put himself under the hospital's control.<sup>239</sup>

Using similar reasoning—that each of the *Tunkl* factors was present—the Michigan Court of Appeals in *Cudnick v. William Beaumont Hospital* refused to enforce a liability waiver in a case stemming from a post-radiation ulcer burn.<sup>240</sup> The court noted an "overwhelming majority of other jurisdictions" that had previously refused to enforce liability waivers signed by hospital patients, based on the reasoning that "medical treatment involves a particularly sensitive area of public interest."<sup>241</sup>

Indeed, courts have had little difficulty finding violations of public policy in liability waivers for patients' health care. Regarding a failed abortion—the patient remained pregnant—the Tennessee Supreme Court in *Olson v. Molzen* reasoned

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234. BURGESS, *supra* note 31, at 44.

235. Glen O. Robinson, *Rethinking the Allocation of Medical Malpractice Risks Between Patients and Providers*, 49 LAW & CONTEMP. PROBS. 173, 184 (1986).

236. *Tunkl*, 383 P.2d at 442.

237. *Id.*

238. *Id.* at 448.

239. *Id.* at 446-47.

240. *Cudnik v. William Beaumont Hosp.*, 525 N.W.2d 891, 895-96 (Mich. Ct. App. 1994).

241. *Id.* at 895.

that “it beg[ged] the question to say [the plaintiff] could have gone to another doctor or that she elected to undergo a surgical procedure that was not mandatory.”<sup>242</sup> Another physician also might have required a liability waiver, and the plaintiff had a right to have a legal surgical procedure performed, even without a “compelling medical necessity.”<sup>243</sup> Overall, the court had little patience for liability waivers in health care, stating that: “[a] professional person should not be permitted to hide behind the protective shield of an exculpatory contract and insist that he or she is not answerable for his or her own negligence. We do not approve the procurement of a license to commit negligence in professional practice.”<sup>244</sup>

#### 4. *Public Policy Test Applied to Negotiated Risk*

##### a. *Analysis*

This section of the article applies the relevant legal tests to negotiated risk. This article has already explained why negotiated risk is unnecessary in the “against-facility-advice” scenario,<sup>245</sup> and subsequently will discuss why confusion caused by two differing scenarios is an independent reason for removing negotiated risk from law.<sup>246</sup> This article’s analysis assumes that a negotiated risk agreement’s language is clear and unambiguous, and that the agreement is signed by a resident who has the mental capacity to do so.<sup>247</sup> In truth, however, these assumptions may be false more often than not and, in practice, an agreement’s invalidity may be based primarily on its confusing nature or the resident’s lack of capacity. This article makes these assumptions, however, in order to move past agreement-specific or resident-specific considerations, and focus instead on the general question of whether a liability waiver in a negotiated risk agreement could be enforced.

To review, the *Tunkl* factors for determining a violation of public policy are: 1) a business suitable for public regulation; 2) a service of great public importance;

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242. *Olson v. Molzen*, 558 S.W.2d 429, 431 (Tenn. 1977).

243. *Id.*

244. *Id.* at 432; see also *Porubiansky v. Emory Univ.*, 275 S.E.2d 163, 167-69 (Ga. Ct. App. 1980) (invalidating a liability waiver used by a university dental clinic (citing *Tunkl*, 383 P.2d 441)); *Ash v. New York Univ. Dental Ctr.*, 564 N.Y.S.2d 308, 310 (N.Y. App. Div. 1990) (invalidating a dental waiver); *Smith v. Hosp. Auth. of Walker, Dade and Catoosa Counties*, 287 S.E.2d 99, 101-02 (Ga. Ct. App. 1981) (invalidating a liability waiver signed by a blood donor (citing *Porubiansky*, 275 S.E.2d 163)); *Meiman v. Rehabilitation Ctr., Inc.*, 444 S.W.2d 78, 80 (Ky. Ct. App. 1969) (invalidating a liability waiver related to a broken leg suffered during physical therapy (citing *Tunkl*, 383 P.2d 441)).

245. See *supra* Part VIII.A.

246. See *infra* Part VIII.C.

247. Guardians generally may not waive liability on a ward’s behalf. See, e.g., *Gibson v. Anderson*, 92 So. 2d 692, 696 (Ala. 1956) (“It is the prevailing view that a guardian may not waive legal rights in behalf of his ward, or surrender or impair rights vested in the ward, or impose any legal burden thereon.”); *Ortman v. Kane*, 60 N.E.2d 93, 98 (Ill. 1945) (“Neither a guardian nor a conservator may do anything which will operate as a waiver or estoppel against the ward.”).

3) a seller willing to perform a service for any member of public; 4) a seller with a decisive bargaining advantage; 5) an adhesion contract; and 6) a buyer under the seller's control. In assisted living, factors 1, 2, 3, and 6 will be met, regardless of the waiver's specific language. Assisted living is suitable for regulation, assisted living services are of public importance, assisted living facilities offer their services to the general public, and residents are under a facility's control.

If a negotiated risk agreement waives a facility's liability for the facility's potential inability to meet a resident's needs—this is the “inadequate care” scenario—the agreement likely also meets the remaining *Tunkl* factors, relating to a seller with a decisive bargaining advantage (factor 4) who uses an adhesion contract (factor 5). Most likely, the resident would have little ability to negotiate different or better terms. As discussed above, courts recognize that health care professionals have the upper hand when negotiating with patients.<sup>248</sup> Thus, a court would likely recognize that an assisted living resident could not be expected to refuse a facility's request, or demand, to sign a negotiated risk agreement.

The same analysis holds true if a liability waiver is assumed in the “against-facility-advice” scenario. For example, if an insulin-dependent diabetic resident signs a liability waiver in return for the facility allowing her to eat chocolate desserts, factors 1, 2, 3, and 6 are met because the resident signs the waiver in the context of assisted living care; similarly, factors 4 and 5 are also met because the resident will not realistically be able to refuse to sign the waiver.<sup>249</sup>

With regard to overreaching business practices, assisted living residents are at least as vulnerable as—and, in reality, likely *more* vulnerable than—the surgery patients, job applicants, abortion patients, and dental patients whose liability waivers were invalidated in the cases discussed earlier.<sup>250</sup> Assisted living residents rely on the facility for assistance with simple daily necessities such as dressing,

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248. See *Olson*, 558 S.W.2d at 431 (“It begs the question to say [the patient] could have gone to another doctor . . . .”); *Porubiansky*, 275 S.E.2d at 167-69 (citing *Tunkl*, 383 P.2d at 445-46, and explaining that laypersons have little leverage to negotiate with health care professionals).

249. This is not to say that an assisted living facility automatically would be liable if, for example, an insulin-dependent diabetic resident were to suffer adverse consequences from consuming sugar. Even without a liability waiver, a court would take note of a resident's decision to consume sugar against the facility's advice. See, e.g., *Neville v. True*, 900 F. Supp. 972, 976, 980 (N.D. Ill. 1995) (finding no medical malpractice, due in part to the patient's refusal of recommended pacemaker surgery); *Davis v. United States*, 629 F. Supp. 1, 4-6 (E.D. Ark. 1986) (taking refusal of blood transfusions into account in finding no medical malpractice).

250. See *Tunkl*, 383 P.2d 441 (invalidating a hospital's liability waiver where the patient suffered injuries caused by a physician's negligence); *Eelbode v. Chec Med. Ctrs., Inc.*, 984 P.2d 436 (Wash. Ct. App. 1999) (invalidating a medical clinic's liability waiver where a job applicant sustained injuries during his pre-employment lifting test); *Olson*, 558 S.W.2d 429 (invalidating an abortion clinic's liability waiver where an abortion procedure failed and the patient remained pregnant); *Porubiansky*, 275 S.E.2d 163 (invalidating a university dental clinic's liability waiver where a patient suffered injuries caused by a dentist's negligence).

eating, and bathing. Once a resident has been admitted to a facility, moving to another facility is especially difficult and traumatic.

Stepping back from the *Tunkl* factors leads to a slightly different perspective, but yields the same result. As discussed, *Tunkl* recognizes that the concept of “public interest” cannot be captured completely in a formula.<sup>251</sup> Some states accordingly follow a “totality of the circumstances” test to determine a violation of public policy.<sup>252</sup> Under such a test, the relevant question may be rephrased as whether society should condone contracts that release an assisted living facility from liability for negligent care of residents. The answer, this article suggests, should be no. Residents cannot live independently, and, consequently, are dependent upon the facility for numerous daily necessities. It is hard to imagine a setting less appropriate for liability waivers.

In a recent personal injury case, a Delaware court issued a ruling consistent with this article’s analysis.<sup>253</sup> A resident’s fall in an assisted living facility had caused the resident to suffer irreversible brain damage and permanent physical impairments.<sup>254</sup> Based on the resident’s signed admission agreement, the facility moved for summary judgment under assumption of risk.<sup>255</sup> The admission agreement’s relevant language was a *mélange* drawn from both the “inadequate care” and “against-facility-advice” scenarios, and included an explicit waiver of liability:

The Resident acknowledges that these principles of independence, control, and choice will result in a higher quality of life for each resident in the community, recognizes the additional risk that results from the ability of the Resident to make such choices, and agrees to mutually accept and share this risk. . . . Resident agrees that [the facility] shall not be liable to Resident for personal injuries or damage to property, even if resulting from the negligence of [the facility] or its employees, unless resulting from its gross negligence or willful misconduct. Resident acknowledges that the independence, control and choice afforded within [the facility] requires that the Resident assume responsibility for any loss, injury or damage resulting from Resident’s personal actions and conduct.<sup>256</sup>

The Delaware court’s analysis distinguished assisted living from a group of sports-related cases in which assumption of risk has most commonly been

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251. 383 P.2d at 444.

252. *See, e.g.,* *Wolf v. Ford*, 644 A.2d 522, 527 (Md. 1994); *Dalury v. S-K-I, Ltd.*, 670 A.2d 795, 798 (Vt. 1995) (quoting *Wolf*, 644 A.2d at 527).

253. *Storm v. NSL Rockland Place, LLC*, 898 A.2d 874 (Del. Super. Ct. 2005).

254. *Id.* at 876, 878.

255. *Id.* at 876, 878-79.

256. *Id.* at 878-79.

applied.<sup>257</sup> “[T]wo common themes” were present in the sports-related cases. First, the injured party had chosen “to engage in the activity, not out of necessity but out of a desire to satisfy a personal preference.”<sup>258</sup> Second, the injured party must have participated in the sport with knowledge, and he and other participants may not have acted with ordinary care.<sup>259</sup> In these sports cases, “the absence of such a defense would chill vigorous participation in the sporting activity and have a deleterious effect on the nature of the sport as a whole.”<sup>260</sup> The court mentioned the example of a recreational hockey league.<sup>261</sup>

Neither of the common themes found in the sports cases was present in the resident’s allegations against the assisted living facility. The resident had entered assisted living not out of choice, but because he required care due to multiple sclerosis and an alcohol addiction.<sup>262</sup> Also, a recipient of health care cannot agree to less than “ordinary care”:

[T]here is virtually no scenario in which a patient can consent to allow a healthcare provider to exercise less than “ordinary care” in the provision of services. Even if given, a patient’s consent to allow a healthcare provider to exercise less than ordinary care would be specious when considered against the strict legal, ethical and professional standards that regulate the healthcare profession. Regardless of whether the patient elects to have healthcare or requires it, the patient appropriately expects that the treatment will be rendered in accordance with the applicable standard of care. This is so regardless of how risky or dangerous the procedure or treatment modality might be.<sup>263</sup>

The Delaware court concluded that “[p]ermittting a primary assumption of the risk defense under these circumstances would simply be unconscionable.”<sup>264</sup> As further support for its ruling, the court cited the statutory and regulatory duties of health care providers generally and of assisted living providers specifically. Given the state’s interest in establishing and protecting an adequate quality of care, the court reasoned that it was improper for quality of care to be compromised by individual agreements between a facility and resident.<sup>265</sup> The court noted, as discussed

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257. See *infra* notes 274-281 and accompanying text for discussion of assumption of risk in extreme and recreational sports.

258. *Storm*, 898 A.2d at 883.

259. *Id.*

260. *Id.*

261. *Id.*

262. *Id.* at 877.

263. *Id.* at 884.

264. *Id.*

265. *Id.* at 885.

previously in this article, that a Delaware regulation explicitly prohibits liability waivers in negotiated risk agreements.<sup>266</sup>

*b. Addressing Proponents' Arguments*

Even facility attorneys and negotiated risk proponents recognize that negotiated risk agreements may not be enforceable.<sup>267</sup> One facility attorney, in an informational resource developed for the American Association of Homes and Services for the Aging, goes further and suggests that a negotiated risk agreement would be rejected by a court:

While it is important for a provider to detail the full scope of provided and excluded services, and it is important to involve the resident and his or her family in the planning of care, it may be a mistake to assume that the facility can absolve itself of responsibility for the resident by negotiating and having the resident execute a waiver, release of liability, or other form of "negotiated risk agreement." No matter what an assisted living provider recites in the contract, it may be liable if avoidable harm to a resident in its facility is foreseeable and the provider stands by and makes no reasonable effort to intervene. Any written contract that purports to exonerate a facility from such a fundamental civil duty is likely to be deemed by the courts to be unconscionable and against public policy, particularly when a waiver or release pertains to future unknown events. Moreover, an elderly person signing such an agreement probably will be considered disadvantaged and unable to engage in an enforceable, arm's-length transaction.<sup>268</sup>

Only one negotiated risk defense cites case law in any depth.<sup>269</sup> Ultimately, this defense makes only the limited claim that negotiated risk agreements "are not inherently unenforceable."<sup>270</sup> Even this modest claim cannot withstand scrutiny, however. For one, the defense argues that privately-owned assisted living facilities

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266. *Id.* at 885-86.; *see supra* Part VI.H.2. The court mistakenly cited to 40-700-007 DEL. CODE REGS. § 63.611, rather than citing correctly to Section 63.612. *Storm*, 898 A.2d at 885. These regulations became effective in 2002, the same year in which the resident entered the facility and suffered the fall. *Id.* These regulations have since been renumbered, although the text of the negotiated risk regulation remains substantially similar. *See* 40-300-005 DEL. CODE REGS. § 63.229 (Weil 2007).

267. *See, e.g.*, BURGESS, *supra* note 31, at 61 ("In reality, even should a provider enter one of these agreements primarily for the purpose of avoiding legal responsibility, they [sic] could be sorely disappointed. Liability determinations depend on many factors and the presence of a negotiated risk agreement may or may not control a court's ultimate determination."); Lynch & Teachworth, *supra* note 28, at 23 ("[A]t best, it's a close call as to whether a [negotiated risk agreement] might violate public policy.").

268. PAUL GORDON, AM. ASS'N OF HOMES AND SERVS. FOR THE AGING, ASSISTED LIVING ADMISSION AGREEMENTS: PROVISIONS ESSENTIAL TO SOUND MGMT. 3 (1999).

269. Lynch & Teachworth, *supra* note 28, at 3-29.

270. *Id.* at 24.

do not owe a duty to the public at large.<sup>271</sup> This claim is refuted by the many cases that have struck down liability waivers used by private enterprises.<sup>272</sup> Also, the defense argues that negotiated risk “may or may not” involve a service of public importance.<sup>273</sup> As a practical matter, however, a negotiated risk agreement will be written only when a resident faces some non-trivial risk of injury. Given an assisted living facility’s general obligation to provide for residents’ well-being, a real-life waiver of facility liability always will involve a service of public importance, even in the “against-facility-advice” scenario. For example, a service of public importance would be involved if a facility acted negligently in relation to an insulin-dependent resident’s desire to eat sweets, or a resident’s self-administration of medication.

Finally, the defense’s case authority is drawn exclusively, and incongruously, from cases involving extreme and recreational sports.<sup>274</sup> These cases concern “scuba diving, race tracks (including spectators in the race track pit), motorcycle riding tracks, skiing (including lessons and equipment rental), health club memberships, horseback riding and beach club memberships,”<sup>275</sup> none of which bear any relationship to assisted living. The defense observes, accurately, that sports-related liability waivers have been both upheld and struck down.<sup>276</sup> The next step of the argument is unsupported: the defense concludes from the sports-related cases that liability waivers are potentially viable in assisted living.<sup>277</sup>

The defense’s obvious flaw is its unwarranted focus on extreme and recreational sports, and the consequent failure to examine negotiated risk in the context of health care. The defense claims that sports-related liability waivers “are the distant cousins that [negotiated risk agreements] never knew they had,” but nothing in the defense supports this claim.<sup>278</sup> Presumably, the reliance on sports cases by the defense, and by the assisted living facility in the Delaware case,

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271. *Id.*

272. *See, e.g.,* Eelbode v. Chec Med. Ctrs, Inc., 984 P.2d 436 (Wash. Ct. App. 1999) (invalidating a private physical therapist’s liability waiver); Cudnik v. William Beaumont Hosp., 525 N.W.2d 891, 895 n.5 (Mich. Ct. App. 1994) (“We are not persuaded by defendant’s argument that the provision of medical care should be considered a ‘private affair.’ The courts have long recognized that the provision of medical care involves issues of public interest.” (internal citations omitted)); Olson v. Molzen, 558 S.W.2d 429 (Tenn. 1977) (invalidating a private osteopath’s liability waiver).

273. *Id.* at 23.

274. Lynch & Teachworth, *supra* note 28, at 19-20. The defense’s authors report that they drew their cases from the annotations of two *American Law Reports* (A.L.R.) articles. *Id.* at 28 nn.133 & 138; *see* Michele Meyer McCarthy, Annotation, *Tort Liability Arising From Skydiving, Parachuting, or Parasailing Accident*, 92 A.L.R.5th 473 (2001); Randy J. Sutton, Annotation, *Validity, Construction, and Effect of Agreement Exempting Operator of Amusement Facility From Liability for Personal Injury or Death of Patron*, 54 A.L.R.5th 513 (1997).

275. Lynch & Teachworth, *supra* note 28, at 21.

276. *Id.*

277. *Id.* at 23-24.

278. *Id.* at 19.



reflects a results-driven analysis. The sports cases have been put forward not because they are analogous to assisted living, but because sport is virtually the only consumer context in which liability waivers are potentially enforceable.<sup>279</sup>

The defense also claims that negotiated risk agreements are *more* likely than sports-related liability waivers to be enforced, because negotiated risk agreements “are themselves an expression of an *established* public policy in the law and in society—that of accommodating and maximizing choice—for residents in particular and disabled persons in general.”<sup>280</sup> Again, the defense’s claim is not supportable. The defense’s “established public policy” is societal disapproval of disability-based discrimination,<sup>281</sup> which is hardly equivalent to approval of negotiated risk. True maximization of resident choice would allow resident choices to be made without liability waivers.

### C. The Term “Negotiated Risk” is Not Useful

This article’s recurring theme is the slipperiness of the term “negotiated risk.” The words “negotiated” and “risk” themselves are reasonably evocative of the original meaning—the “inadequate care” scenario. Over the years, however, the “inadequate care” scenario and the “against-facility-advice” scenario have become hopelessly confused.<sup>282</sup> The best example of this confusion is state negotiated risk laws. As previously discussed, state law is both ambiguous and inconsistent in its treatment of negotiated risk.<sup>283</sup> Depending on the state, a negotiated risk agreement may be used to resolve disputes or to plan care. The agreement may be designed to reduce the resident’s risk or consent to inadequate care. In some states, negotiated risk laws leave open the possibility of a liability waiver, whereas, in other states, the laws explicitly bar any liability waivers.

Despite, or perhaps because of, state laws’ confusing treatment of negotiated risk, negotiated risk proponents often cite state law as evidence that negotiated risk

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279. See, e.g., *Vodopost v. MacGregor*, 913 P.2d 779, 783 (Wash. 1996) (“Outside of these voluntary high-risk sports situations, our courts have often found preinjury releases for negligence to violate public policy.”); *Storm v. NSL Rockland Place, LLC*, 898 A.2d 874, 883 (Del. Super. Ct. 2005) (finding that the assumption of risk defense “most frequently surfaces in cases of sports-related activities that involve physical skill and challenges posing significant risk of injury to participants . . . .” (quotations omitted)).

280. Lynch & Teachworth, *supra* note 28, at 23 (emphasis in original).

281. In the Lynch & Teachworth article defending negotiated risk, the endnote for the asserted “established public policy” cites only one case—the Supreme Court’s opinion in *Olmstead v. L.C.*, 527 U.S. 581, 607 (1999), holding that the Americans with Disabilities Act requires that state programs develop adequate non-institutional placements for individuals with disabilities. Lynch & Teachworth, *supra* note 28, at 23 n.147.

282. See, e.g., Robert G. Schwemm & Michael Allen, *For the Rest of Their Lives: Seniors and the Fair Housing Act*, 90 IOWA L. REV. 121, 190-91 n.362 (2004) (discussing negotiated risk without distinguishing between the “inadequate care” scenario and the “against-facility-advice” scenario).

283. See *supra* Part VI.

is becoming well-established.<sup>284</sup> For instance, one facility attorney has stated that “[a]dding support to the prediction that negotiated risk agreements, when properly used, will be supported by the courts, is the fact that a number of states expressly refer to negotiated risk agreements in their licensing regulations for assisted living.”<sup>285</sup> Other facility attorneys cite the use of negotiated risk in state law as “a telling sign that [negotiated risk agreements] are coming of age.”<sup>286</sup> In a 2004 health care newsletter, a law firm reported that a negotiated risk agreement is “[o]ne method of addressing [an] increased liability exposure,” noting that negotiated risk “is provided for by regulation in some states.”<sup>287</sup> A related argument relies on the fact that negotiated risk agreements have not been banned. In the words of one article, “[w]hile only 12 states specifically address [negotiated risk agreements], they have not been prohibited by any state. This is noteworthy in that regulatory actions tend to be reactive responses designed to address concerns.”<sup>288</sup>

These arguments illustrate the fundamental problem with the term “negotiated risk”: it no longer has any settled meaning. The presence of “negotiated risk” in state law is in fact *not* evidence of negotiated risk’s viability. Negotiated risk in state law differs widely from one state to another. Furthermore, the pervasive ambiguity of negotiated risk laws means that negotiated risk agreements within a state may also differ widely.<sup>289</sup>

This article recommends abandoning the terms “negotiated risk,” “shared responsibility,” and “managed risk.” If assisted living facilities or regulators wish to advocate for the “inadequate care” scenario, those arguments should be made explicitly, without euphemism. The “inadequate care” scenario is too important to be glossed over by ambiguous language.

Abandoning negotiated risk will have a positive impact on the “against-facility-advice” scenario. As discussed earlier, a nursing home resident already has the right to act against facility advice, and to do so without waiving any rights.<sup>290</sup> By relying on the “against-facility-advice” scenario, however, negotiated risk proponents have weakened the decision-making rights of assisted living residents.

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284. See, e.g., Robert L. Kane & Rosalie A. Kane, *What Older People Want From Long-Term Care, and How They Can Get It*, 20 HEALTH AFF. 114, 125 (2001).

285. BURGESS, *supra* note 31, at 22-23.

286. Lynch & Teachworth, *supra* note 28, at 9.

287. *Limiting Liability in Assisted Living Residences*, HEALTHCARE REV. (Duane Morris LLP, Philadelphia, Pa.), Spring 2004, at 4; see also Michael Anderson, *Inside the Residency Agreement*, ASSISTED LIVING TODAY, July-Aug. 2003, at 56 (claiming, although without authority, that negotiated risk agreements are “increasingly popular”); Anderson, *supra* note 60, at 71 (claiming, again without authority, that negotiated risk agreements are “increasingly popular”); Burgess, *supra* note 33, at 35-37 (finding that states increasingly embrace negotiated risk concepts in their regulations).

288. Wilson et al., *supra* note 164, at 71.

289. See JENKENS ET AL., *supra* note 3, at 25-40 (presenting the “limited” and thus “not generalizable” empirical knowledge available regarding negotiated risk agreements).

290. See *supra* Part VIII.A.

As the word “negotiated” indicates, a resident has no *right* to act against facility advice within the negotiated risk framework. Instead, the resident must negotiate with the facility to act against facility advice, with no limitation on the concessions that the facility might seek. The term “care planning,” already widely used in both nursing homes and assisted living facilities, does a much better job of describing how a facility should approach a resident’s inclination to refuse facility advice. Care planning meetings generally involve both the facility staff and the resident; issues are discussed, and decisions are documented.<sup>291</sup>

#### CONCLUSION

Negotiated risk is hopelessly flawed. Although the term was introduced to describe the “inadequate care” scenario, the proponents of negotiated risk now are likely to defend it under the “against-facility-advice” scenario. This change has caused confusion at many levels. Public policy articles generally fail to acknowledge the different versions of negotiated risk. State laws are consistent only in being ambiguous as to what negotiated risk means. Great uncertainty surrounds the use of negotiated risk in practice, because no one knows what type of agreements are in use, or how frequently the agreements are used.

Negotiated risk should be abandoned. First, in the “against-facility-advice” scenario, negotiated risk agreements are unnecessary. Residents should be able to refuse facility advice without negotiating away rights or signing a legal document. Second, negotiated risk agreements are unenforceable if they waive a facility’s liability. Courts consistently have refused to enforce consumer liability waivers in health care. Proponents’ reliance on sports-related cases only highlights the weakness of their arguments. Finally, the term “negotiated risk” is no longer meaningful, regardless of the validity or invalidity of the various concepts described now as “negotiated risk.” Even if it were necessary for a resident to negotiate and sign a legal document in the “against-facility-advice” scenario, or to waive an assisted living facility’s liability, the term “negotiated risk” is now too confusing to be useful in either situation. New terminology must be used, and that terminology must be specific enough to distinguish between the different assisted living scenarios.

The abandonment of “negotiated risk” is important for the development of assisted living. In many ways, assisted living is a work in progress. State assisted living laws vary greatly, and the variations include such important matters as the type of residents, the level of health care provided, and the qualifications of staff

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291. See, e.g., 42 U.S.C. §§ 1395i-3(b)(2); 1396r(b)(2) (2001) (establishing care planning in nursing homes); 42 C.F.R. § 483.20(k)(2) (2006) (establishing the same); ALA. ADMIN. CODE r. 420-5-4-.05(3)(g)(24) (2004) (establishing care planning in assisted living facilities); S.C. CODE ANN. REGS. 61-84 (2001) (establishing the same).

members.<sup>292</sup> Future assisted living policy development will require careful examination of state policies and their consequences. This careful examination, however, cannot take place if policies are obscured by ambiguous terms with multiple meanings.

Specifically, assisted living policy development will be hampered unless negotiated risk is dropped. Careful policy analysis requires an honest evaluation of the types of residents appropriate for assisted living, and a facility's obligation to meet a resident's increasing needs. Those important issues cannot be addressed as long as negotiated risk continues to obscure residents' rights and facilities' obligations.

Most importantly, negotiated risk should be abandoned because it endangers vulnerable assisted living residents. Residents rely on facility staff in a multitude of ways, so residents' health and safety is at risk if facilities can limit care simply by obtaining residents' signatures on negotiated risk agreements.

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292. CARLSON, *supra* note 11, at 13-16, 25-32, 53-61.

