

Protecting Rights or Waiving Them?

Why ‘Negotiated Risk’ Should Be Removed From Assisted Living Law

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ABSTRACT

Assisted living facilities claim that negotiated risk agreements give residents the freedom to act against facility advice. On the contrary, negotiated risk was proposed originally to waive a facility's liability for inadequate care, and liability waiver remains a significant component of negotiated risk.

This Article offers the first detailed legal analysis of state negotiated risk laws. Due to negotiated risk's dueling definitions – based either on the against-facility-advice scenario or the inadequate care scenario – state law is marked by ambiguity and inconsistency. Currently, fifteen states address negotiated risk in law, and an additional state has developed a standardized negotiated risk form. This Article places each of these states into one of eight categories, depending generally on the extent to which negotiated risk is used purportedly to resolve disputes, plan care, consent to inadequate care, or waive liability.

This Article recommends that negotiated risk be abandoned, and that all references to negotiated risk be eliminated from state law. Negotiated risk is in fact not necessary for a resident to act against facility advice. In nursing homes and other long-term care facilities, a resident undisputedly has the right to act against facility advice, with no need to negotiate an agreement with the facility. Also, any waiver of facility liability is unenforceable as a violation of public policy. In health care settings, courts uniformly refuse to enforce a consumers' waiver of a provider's liability. Finally, the term “negotiated risk” is too compromised to be of any further use. Negotiated risk has no settled definition, and state law definitions are generally vague enough to accommodate both the against-facility-advice scenario and the inadequate care scenario.

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PROTECTING RIGHTS OR WAIVING THEM?

WHY NEGOTIATED RISK SHOULD BE REMOVED FROM ASSISTED LIVING LAW

I. INTRODUCTION

Assisted living facilities care for approximately one million elderly Americans.² According to assisted living proponents, a key facet of assisted living is the value placed on residents' autonomy. The proponents praise "negotiated risk" in turn as an important tool for promoting and supporting that autonomy.³

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.⁴

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 staff of an assisted living facility. In the other shape, negotiated risk is an agreement in which a resident waives the facility's liability for certain inadequacies in the care provided.

In the first shape, for example, a negotiated risk agreement documents a resident's decision to eat sweets against medical advice. In the second shape, the negotiated risk agreement releases 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

² Assisted Living Federation of American, What is Assisted Living? (viewed on Internet on June 16, 2006), available at www.alfa.org/i4a/pages/index.cfm?pageid=3285.

³ See *infra* at 13-17.

⁴ See generally Robert Jenkins et al., A Study of Negotiated Risk Agreements in Assisted Living: Final Report, U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy (2006).

examines how negotiated risk proponents have attempted to move the debate away from the evaluation 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, 15 states have laws that refer to “negotiated risk” or a comparable term, and an additional state has developed a standard form for a “Negotiated Risk Contract.” In general, the relevant state laws refer ambiguously to disputes, agreements, and risk, without indicating whether negotiated risk involves inadequate facility care or (on 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 a facility's liability is likely unenforceable. Courts uniformly refuse to enforce consumer liability waivers in health care. 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 re-written across the country to eliminate any mention of negotiated risk. The term's vagueness and misuse allow it to be used to justify an inadequate quality of care. Negotiated risk endangers the health and safety of elderly assisted living residents across the country.

II. 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; living units may be private or

shared.⁵

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 care needs previously would have required residence in a nursing home.⁶ This change, along with the growing popularity of assisted living, has led to increases in the numbers of facilities and residents. The United States now has 20,000 to 36,000 assisted living facilities, with a total of approximately one million residents.⁷

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.⁸ Terminology varies from state to state – although the most common term is “assisted living facility,” other terms in use include “residential care facility for the elderly” (California), “home for the aged” (Michigan), “housing with services establishment” (Minnesota), and “personal care home” (Mississippi).⁹

⁵ See, e.g., Robert Mollica and Heather Johnson-Lamarche, Nat'l Academy for State Health Policy, *State Residential Care and Assisted Living Policy: 2004*, at 1-11, 1-15 through 1-17 (2005).

⁶ See, e.g., Robert Mollica and Heather Johnson-Lamarche, Nat'l Academy for State Health Policy, *State Residential Care and Assisted Living Policy: 2004*, at 1-24 (2005).

⁷ Assisted Living Federation of American, *What is Assisted Living?* (viewed on Internet on June 16, 2006), available at www.alfa.org/i4a/pages/index.cfm?pageid=3285 (20,000 facilities; over one million residents); Robert Mollica and Heather Johnson-Lamarche, Nat'l Academy for State Health Policy, *State Residential Care and Assisted Living Policy: 2004*, at 1-2 (2005) (36,451 facilities; approximately 937,000 units/beds). The large discrepancy in the number of facilities stems from the fact that assisted living is not easily defined, and state laws use different definitions and terminology.

⁸ See, e.g., Eric Carlson, *Long-Term Care Advocacy* §§ 5.101- 5.152 (Matthew Bender 2006) (summaries of 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).

⁹ See, e.g., Eric Carlson, National Senior Citizens Law Center, *Critical Issues in Assisted Living* 71-72 (2005).

III. “ASSISTED LIVING” IS LOOSELY DEFINED

A. Assisted Living Operators Advocate for Broad, Inclusive Definition

Surprisingly, the defining of “assisted living” can be difficult and contentious.¹⁰ One problem is the perhaps inevitable “big tent” philosophy among lobbyists for assisted living providers. No facility wants to be left out of the assisted living tent, so providers tend to push for broad assisted living definitions that will include (for example) both the 200-bed facility that provides extensive health care services, and the six-bed facility that provides only room, board and minimal assistance with activities of daily living.¹¹

In 2006, for example, 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.” In arguments that duplicate those made by other trade associations across the country, the report asserted that a nursing service requirement would “overmedicalize” assisted living and make it unaffordable.¹² The report recommended 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.”¹³

¹⁰ See, e.g., Assisted Living Workgroup, *Assuring Quality in Assisted Living: Guidelines for Federal and State Policy, State Regulation, and Operations 12-19* (2003) (inability to reach consensus on assisted living definition); Paula C. Carder, *The Social World of Assisted Living*, *J. Aging Studies*, vol. 16, at 1 (2002), *reprinted in* *Gray Areas: Ethnographic Encounters with Nursing Home Culture* 263, 264 (Phillip Stafford ed. 2003) (“both policy makers and researchers ... frustrated with the lack of a standard definition”).

¹¹ See, e.g. Ga. Comp. R. & Regs. r. 290-5-35-.04(o) (“‘Personal Care Home’ means 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 (“‘Assisted living center’ [means] 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.”).

¹² Empire State Ass’n of Assisted Living, *Assisted Living That Few Can Afford: An Examination of the Over-Medicalization of the Enhanced Assisted Living Residence and a Sensible Alternative* (May 2006).

¹³ Empire State Ass’n of Assisted Living, *Assisted Living That Few Can Afford: An Examination of the Over-Medicalization of the Enhanced Assisted Living Residence and a Sensible Alternative* 15 (May 2006).

B. Assisted Living Purportedly Is Based on Attractive But Ethereal Concepts

Another problem in defining “assisted living” is the ethereal nature of much of the literature on assisted living policy.¹⁴ 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 human principles, such as dignity, choice, and privacy, that are easily violated when individuals are dependent on others for care.... 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.¹⁵

Unfortunately, such worthy but elusive concepts as dignity, choice, and privacy are not put into practice easily. These appealing terms are mentioned commonly in state assisted living law, but in most cases the mentions occur in definitional sections that have little real-world

¹⁴ See, e.g., Rosalie A. Kane & Keren Brown Wilson, AARP, *Assisted Living in the United States: A New Paradigm for Residential Care for Frail Older Persons?* 8 (1993) (“assisted living “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*, 9 *J. Aging & Soc. Policy*, vol. 9, No. 2, at 51 (1997) (assisted living with an “underlying philosophical paradigm of homelike individual autonomy and self-determination”).

¹⁵ Keren Brown Wilson, *Assisted Living as a Model of Care Delivery*, in *Enhancing Autonomy in Long-Term Care*, at 145-46 (Lucia Gamroth et al., eds., Springer 1995).

significance.¹⁶ The most obvious example of the gap between theory and practice is in the presence of shared units in assisted living. Much of the initial enthusiasm for assisted living was based on the image of an individual receiving necessary care in his or her own home or apartment.¹⁷ Today, however, state assisted living laws routinely allow an assisted living unit to be shared-occupancy, sometimes by as many as four residents.¹⁸

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

C. 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 calls for specifics to be negotiated between the resident (or the

¹⁶ See, e.g., Ill. Adm. Code tit. 77, § 295.100(a) (a purpose of assisted living law “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 (assisted living services “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) (“Assisted living promotes resident self-direction and active participation in decision-making while emphasizing individuality, privacy and dignity.”).

¹⁷ See, e.g., Keren Brown Wilson, *Assisted Living as a Model of Care Delivery*, in *Enhancing Autonomy in Long-Term Care*, at 141 (Lucia Gamroth et al., eds., Springer 1995); Rosalie A. Kane, *Autonomy and Regulation in Long-Term Care: An Odd Couple, An Ambiguous Relationship*, in *Enhancing Autonomy in Long-Term Care*, at 80-81 (Lucia Gamroth et al., eds., Springer 1995) (“In my view, the minimum requirement in the U.S. cultural context includes a singly occupied room with a self-contained bath.”).

¹⁸ Robert Mollica and Heather Johnson-Lamarche, Nat’l Academy for State Health Policy, *State Residential Care and Assisted Living Policy: 2004*, at 1-16 (2005) (“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. r. 290-5-35-.07(11)(b) (“no more than four residents per bedroom”); Ind. Admin. Code tit. 410, § 16.2-5-1.6(g)(5) (no more than four beds per room when construction plans submitted for approval after July 1, 1984); Ohio Admin. Code § 3701-17-64(B)(3) (no more than four residents per unit).

resident’s representative) and the facility.¹⁹ As a result, state-law definitions are likely to gloss over difficult issues in defining assisted living, by explicitly or implicitly assuming 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, and the relevant statutes do little more than specify certain unremarkable requirements for a contract with a resident.²⁰ More commonly, negotiation-based models appear in state assisted living law through disclosure requirements. The premise is that consumers will be protected if facilities are required up front to disclose certain important aspects of the assisted living care to be provided.²¹

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 often is 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.

IV. DEFINITION OF “NEGOTIATED RISK” IS MURKY

Analysis of “negotiated risk” is hampered by confusion as to what negotiated risk is -- most importantly, whether or not negotiated risk includes a waiver of a facility’s legal liability.²²

¹⁹ See, e.g., Robert Mollica and Kimberly Snow, Nat’l Academy for State Health Policy, *State Assisted Living Policy* xi (1996) (states setting minimal standards, assuming that market forces will produce an adequate quality of care); see also Ill. Adm. Code tit. 77, 295.100(a) (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”).

²⁰ Mich. Comp. Laws Ann. § 333.26503. Michigan also licenses homes for the aged which, in comparison to housing-with-services establishments, are subject to more detailed regulatory requirements. See Mich. Comp. Laws Ann. § 333.20106(3).

²¹ See, e.g., Public Policy Platform of Assisted Living Federation of American (April 2004), available at 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”); Tex. Health & Safety Code § 247.026(b)(4)(B) (state-developed standardized disclosure form); 40 Tex. Admin. Code § 92.3(11) (same); Vt. Code R. 13-110-007, § 6.11 (required disclosure of services, rates, and admission/discharge criteria); see also Patrick A. Bruce, Note, *The Ascendancy of Assisted Living: The Case for Federal Regulation*, 14 Elder L. J. 61, 73-74 (2006) (disclosure requirements in state law).

²² See, e.g., Robert Jenkins et al., *A Study of Negotiated Risk Agreements in Assisted Living: Final Report*, U.S. Department of Health and Human Services, Assistant Secretary for

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.”²³ Also, 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 similarity in states’ negotiated risk laws. (*See infra* at 17-35.) By using terms such as “accepting responsibility,” the 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.²⁴

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.”²⁵ This argument, however, is contrary to the explanation earlier in the manual that “in a true negotiated risk 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 residents’ exercise of his free choice and autonomy.”²⁶ Also, one year after the manual’s release, its author wrote that a state’s prohibition of liability waivers had “fatally curtailed” negotiated risk.²⁷

As a result of this confusion, there now are two negotiated risks – the “true” negotiated

Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy 9-11, 14-15 (2006).

²³ Allen Lynch & Sarah Teachworth, *Risky Business: The Enforceability and Use of Negotiated Risk Agreements*, 1 *Seniors Housing & Care Journal* 5 (2002).

²⁴ *See, e.g.*, Ark. Code R. & Regs. 016 06 001, § 704 (“acceptance of responsibility” in Level I facilities), 016 06 002, § 704 (same in Level II facilities); Wis. Stat. Ann. § 50.034(3)(d) (“accepts responsibility”).

²⁵ Kenneth L. Burgess, *Negotiated Risk Agreements In Assisted Living Communities* 60 (ALFA 1999).

²⁶ Kenneth L. Burgess, *Negotiated Risk Agreements In Assisted Living Communities* 42 (ALFA 1999).

²⁷ Kenneth L. Burgess, *Negotiated Risk Agreements – One Year Later*, *Assisted Living Today*, Nov./Dec. 2001, at 36.

risk and a perverse doppelgänger.²⁸ 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.²⁹ In general, 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.³⁰

V. 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 a facility to retain a resident whose needs exceed the facility’s care-providing capabilities.³¹

²⁸ See generally Stephanie Edelstein, *Assisted Living: Recent Developments and Issues for Older Consumers*, Stan. L. & Pol’y Rev. 373, 379-80 (1998) (negotiated risk agreement likely to involve resident choosing to act against facility advice, but may waive 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*, *Generations*, Vol. 22, No. 3, at 76, 80 (1998) (negotiated risk sometimes used when “consumer’s preference counters that of the provider,” and at other times it “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 (negotiated risk agreement used to allow resident to return to assisted living facility despite inadequate care, but also used commonly when facility’s care is adequate).

²⁹ See, e.g., Robert Mollica and Heather Johnson-Lamarche, Nat’l Academy for State Health Policy, *State Residential Care and Assisted Living Policy: 2004*, at 1-14 through 1-15 (2005); but see Sandi Petersen, *Developing Risk-Management Protocols in Assisted Living*, *Nursing Homes Magazine*, December 8, 2005 (negotiated risk to 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”).

³⁰ See, e.g., Robert Jenkins et al., *A Study of Negotiated Risk Agreements in Assisted Living: Final Report*, U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy 8-13 (2006); Eric 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.

³¹ Bruce Vignery & Zita Dresner, *Troubling Assisted Living Facility Issues: Negotiated Risk Agreements*, *Elder Law Forum*, Nov./Dec. 1995, at 10.

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 more difficult to specify what type or level of service is required. 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.³² 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 light level of supervision.

Relatively early in the development of the assisted living model, one academic commenter suggested:

Explore the legal ramifications of waivers of liability. Although one cannot waive one's right to quality care, 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?³³

In a 1995 article, a provider attorney identified “negotiated risk” as “the first buzzword unique to assisted living.”³⁴ As the article described, some assisted living facilities were using negotiated risk to limit their responsibilities for resident care:

Some facilities are squeezing the concept into the blueprint of written admissions or resident contracts. Others think 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.³⁵

³² See, e.g., Keren Brown Wilson, *Assisted Living as a Model of Care Delivery*, in *Enhancing Autonomy in Long-Term Care*, at 143 (Lucia Gamroth et al., eds., Springer 1995).

³³ Rosalie A. Kane, *Autonomy and Regulation in Long-Term Care: An Odd Couple, An Ambiguous Relationship*, in *Enhancing Autonomy in Long-Term Care*, at 85 (Lucia Gamroth et al., eds., Springer 1995); see also Keren Brown Wilson, *Assisted Living: A Model of Supportive Housing*, in *Advances in Long-Term Care*, vol. 2, at 210 (Paul R. Katz et al., eds., Springer 1993) (“managed risk” proposed for assisted living).

³⁴ Joseph Bianculli, *Negotiated Risk – An Operational Issue*, Provider, Nov. 1995, at 32; see also Joseph Bianculli and Keren Brown Wilson, *Negotiated Risk in Assisted Living 1* (1996) (negotiated risk is “buzzword specific to assisted living”).

³⁵ Joseph Bianculli, *Negotiated Risk – An Operational Issue*, Provider, Nov. 1995, at 32.

Other provider attorneys have made similar observations. One attorney states: “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.”³⁶ Another provider attorney explains that “[a] negotiated risk contract is where the resident agrees to accept a certain setting and they assume the risk that that setting may or may not be appropriate for their care.”³⁷

Some assisted living providers have embraced the liability-waiver vision of negotiated risk. For example, 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.³⁸

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.”³⁹ 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

³⁶ Joel S. Goldman, *Potential Legal Roadblocks Ahead for Assisted Living* in ALFA Fall 2001 National Conference & Expo Conference Proceedings 299 (Oct. 21-23, 2001), as cited in Allen Lynch & Sarah Teachworth, *Risky Business: The Enforceability and Use of Negotiated Risk Agreements*, 1 Seniors Housing & Care Journal 5 n.11 (2002).

³⁷ John Durso, Testimony to Comm’n on Affordable Housing and Health Facility Needs for Seniors in the 21st Century (Nov. 7, 2001); see also N.H. Dep’t of Health & Human Servs., Final Report: H.B. 1319 – Negotiated Risk 2 (2000) (“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 not 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 “managed risk agreement” with liability waiver if resident remains in assisted living facility beyond point at which facility can meet care needs); Elisabeth Belmont et al., *A Guide to Legal Issues in Life-Limiting Conditions*, 38 J. Health L. 145, 188 (2005) (in negotiated risk, “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”).

³⁸ *Why Your Facility Should Have Negotiated Risk Agreements*, Briefings on Assisted Living, June 2000.

³⁹ Assisted Living Providers, on Internet site of TAGWEB, www.tagweb.com (viewed in January 2003).

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.⁴⁰

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 care. The matter is not that straightforward, however, as 19⁴¹ 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.⁴²

Consistent with these scenarios, 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, “For 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.”⁴³ The same article suggests negotiated risk agreements as a means of reducing a facility's exposure to liability claims.⁴⁴

⁴⁰ Kendra Case, *Shared Risk Starts With Resident Assessment*, Assisted Living Today, March 2002 at 27.

⁴¹ This Article concludes that 16, not 19, states utilize negotiated risk.

⁴² Sheryl Zimmerman et al., *How Good Is Assisted Living? Findings and Implications From an Outcomes Study*, J. of Gerontology, vol. 60B, No. 4, at S195, S195-S196 (2005).

⁴³ Allen Lynch & Sarah Teachworth, *Risky Business: The Enforceability and Use of Negotiated Risk Agreements*, 1 Seniors Housing & Care Journal 10 (2002).

⁴⁴ Allen Lynch & Sarah Teachworth, *Risky Business: The Enforceability and Use of Negotiated Risk Agreements*, 1 Seniors Housing & Care Journal 4 (2002) (“the legal exposure borne by long term care providers has been anything but limited, with the long term care

An insurance underwriting firm has recommended negotiated risk contracts as a way of protecting assisted living facilities that provide an inadequate level of care:

Because [assisted living facilities] do not provide 24/7 care (excluding locked units), shared-risk agreements can significantly reduce your exposure to litigation from falls. [Assisted living 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.⁴⁵

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 an assisted living facility to "avoid costly litigation."⁴⁶ The discussion of managed risk begins with the admonition to:

Be honest with the resident and the family that there may simply be *unavoidable* injuries during the resident's stay at your community. Do not promise that you can keep the resident safe.⁴⁷

The article recommends that a facility consider using contractual clauses that waive the facility's liability if the resident is injured after failing to wait an adequate period of time for staff assistance, and that state that the resident understands that the facility "cannot guarantee that [the resident] will not experience a fall or an injury from a fall."⁴⁸

VI. NEGOTIATED RISK IS CHARACTERIZED BY PROPONENTS AS RESIDENT'S DECISION TO ACT AGAINST FACILITY ADVICE

Presumably because the inadequate care scenario has proven unpopular, negotiated risk

litigation 'avalanche' having crippled some operators and impacted nearly all through less liability insurance coverage at a dramatically higher cost").

⁴⁵ Lighthouse Underwriters, ALFA Fall Conference Risk Management Seminar (Oct. 2001), as quoted in Allen Lynch & Sarah Teachworth, *Risky Business: The Enforceability and Use of Negotiated Risk Agreements*, 1 Seniors Housing & Care Journal 9 (2002). The same Lighthouse Underwriters material, as summarized by Lynch and Teachworth, "postulated 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.)

⁴⁶ Donna Fudge, *Staying Out of Court*, Assisted Living Today, Jan./Feb. 2004, at 18.

⁴⁷ Donna Fudge, *Staying Out of Court*, Assisted Living Today, Jan./Feb. 2004, at 20 (emphasis in original).

⁴⁸ Donna Fudge, *Staying Out of Court*, Assisted Living Today, Jan./Feb. 2004, at 20-21.

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. Proponents' common examples are residents who eat sweets despite diabetes,⁴⁹ refuse baths⁵⁰ or medication,⁵¹ smoke,⁵² or insist on self-care even though staff assistance is available.⁵³ In this scenario, the negotiated risk agreement "describes a process by

⁴⁹ See, e.g., Marshall B. Kapp & Keren Brown Wilson, *Assisted Living and Negotiated Risk: Reconciling Protection and Autonomy*, 1 J. Ethics, Law, and Aging 11 (1995) (insulin-dependent diabetic who wishes to eat sweets); Kenneth L. Burgess, *Negotiated Risk Agreements In Assisted Living Communities* 56 (ALFA 1999) (negotiated risk agreements used for "[d]ietary deviations beyond simply food preferences, such as where medical issues like diabetes are implicated); Allen Lynch & Sarah Teachworth, *Risky Business: The Enforceability and Use of Negotiated Risk Agreements*, 1 Seniors Housing & Care Journal 4 (2002) (negotiated risk agreement used for residents not following a prescribed diet); Paula C. Carder, *The Social World of Assisted Living*, J. Aging Studies, vol. 16, at 1 (2002), reprinted in *Gray Areas: Ethnographic Encounters with Nursing Home Culture* 263, 278-79 (Phillip Stafford ed. 2003); Paula C. Carder & Mauro Hernandez, *Consumer Discourse in Assisted Living*, The Journals of Gerontology, Vol. 59, No. 2, at S58 (2004); Janet O'Keefe 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); David Peete, "Risk Management": *Heeding the New Mantra*, Nursing Homes, Vol. 50 (May 1, 2001); Katherine Blanchette, AARP, *New Directions for State Long-Term Care Systems*, Vol. III: Supportive Housing, at 19 (1997).

⁵⁰ Kenneth L. Burgess, *Negotiated Risk Agreements In Assisted Living Communities* 56 (ALFA 1999); see also Allen Lynch & Sarah Teachworth, *Risky Business: The Enforceability and Use of Negotiated Risk Agreements*, 1 Seniors Housing & Care Journal 4 (2002) (negotiated risk agreement used when resident does not want to wait for bathing assistance).

⁵¹ Paula C. Carder & Mauro Hernandez, *Consumer Discourse in Assisted Living*, The Journals of Gerontology, Vol. 59, No. 2, at S58 (2004).

⁵² Michael Anderson, *Contract Negotiations*, *Assisted Living Today*, July/Aug. 2004, at 71; Paula C. Carder & Mauro Hernandez, *Consumer Discourse in Assisted Living*, The Journals of Gerontology, Vol. 59, No. 2, at S58 (2004); Natalie M. Duval, *Negotiated Risk Agreements in Long-Term Care Support Services* 3 (2001).

⁵³ Robert Mollica, *State Policy and Regulations*, in *Assisted Living: Needs, Practices, and Policies in Residential Care for the Elderly* (Sheryl Zimmerman et al., ed., Johns Hopkins Univ. Press 2001) (undressing and bathing); Robert Mollica and Kimberly Snow, *Nat'l Academy for State Health Policy*, *State Assisted Living Policy* 24 (1996) (same); Kenneth L. Burgess, *Negotiated Risk Agreements In Assisted Living Communities* 56 (ALFA 1999) (medication administration).

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.”⁵⁴

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.⁵⁵ The relevant section is entitled “Implementing Resident Autonomy Through Risk Agreements,” and it includes elements of both the against-facility-advice and inadequate care scenarios. The against-facility-advice scenario is invoked 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.”⁵⁶

On the other hand, the inadequate care scenario is suggested, confusingly, by requiring a resident “to engage in a risk agreement and to 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.”⁵⁷ In a similar vein, the report lists 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.”⁵⁸

⁵⁴ Paula C. Carder, *The Social World of Assisted Living*, J. Aging Studies, vol. 16, at 1 (2002), reprinted in *Gray Areas: Ethnographic Encounters with Nursing Home Culture* 263, 278 (Phillip Stafford ed. 2003) (internal quotations omitted).

⁵⁵ The Assisted Living Quality Coalition consisted of the Alzheimer’s Association, the American Association of Homes and Services for the Aging, the American Association of Retired Persons, the American Health Care Association, the American Seniors Housing Association, and the Assisted Living Federation of America.

⁵⁶ Assisted Living Quality Coalition, *Assisted Living Quality Initiative: Building a Structure that Promotes Quality*, Appendix B, Guidelines to States on Setting Minimum Standards for Providers of Assisted Living § VI(I) (1998). Earlier in the same report, negotiated risk agreements are described as a means of “govern[ing] behaviors that residents choose against a provider’s advice.” *Id.* at 30.

⁵⁷ Assisted Living Quality Coalition, *Assisted Living Quality Initiative: Building a Structure that Promotes Quality*, Appendix B, Guidelines to States on Setting Minimum Standards for Providers of Assisted Living § VI(I) (1998).

⁵⁸ Assisted Living Quality Coalition, *Assisted Living Quality Initiative: Building a Structure that Promotes Quality*, Appendix B, Guidelines to States on Setting Minimum Standards for Providers of Assisted Living § VI(B) (1998).

In arguments based on the against-facility-advice scenario, negotiated risk generally is justified by a withering portrayal of life in a nursing home.⁵⁹ Allegedly, nursing homes follow a prescriptive medical model whereas assisted living facilities follow a more humanistic social model of care.⁶⁰ In the medical model, allegedly, decisions are made by the health care professionals, and the resident/patient has no choice but to comply. One article flatly states: “In a nursing facility, [a diabetic resident] would not be given the option of eating cake.”⁶¹

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 has proceeded beyond beneficence to manifestations of intrusive and restrictive forms of paternalism.”⁶²

One critique of traditional nursing home care, in a paper prepared initially for an ALFA-convened conference, bemoans 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

⁵⁹ One observer notes a “distancing” process in which assisted living proponents define assisted living facilities in large part through the 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.

Paula C. Carder, *The Social World of Assisted Living*, J. Aging Studies, vol. 16, at 1 (2002), reprinted in *Gray Areas: Ethnographic Encounters with Nursing Home Culture* 263, 271 (Phillip Stafford ed. 2003) (internal quotations omitted).

⁶⁰ Kenneth L. Burgess, *Negotiated Risk Agreements In Assisted Living Communities* 14-15 (ALFA 1999); Paula C. Carder, *The Social World of Assisted Living*, J. Aging Studies, vol. 16, at 1 (2002), reprinted in *Gray Areas: Ethnographic Encounters with Nursing Home Culture* 263, 265-66 (Phillip Stafford ed. 2003).

⁶¹ Paula C. Carder, *The Social World of Assisted Living*, J. Aging Studies, vol. 16, at 1 (2002), reprinted in *Gray Areas: Ethnographic Encounters with Nursing Home Culture* 263, 278 (Phillip Stafford ed. 2003).

⁶² Marshall B. Kapp & Keren Brown Wilson, *Assisted Living and Negotiated Risk: Reconciling Protection and Autonomy*, 1 J. Ethics, Law, and Aging 7 (1995).

environments.”⁶³ The same paper criticizes “the current trend for guidelines and standardized care protocols,” suggesting that facilities follow “[a] protocol for when people should get in and out of bed and how they should spend their waking hours.”⁶⁴

VII. 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 15 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 agreement that in some way discusses risk.⁶⁵

⁶³ Rosalie A. Kane & Keren Brown Wilson, *Assisted Living at the Crossroads: Principles for Its Future* 19 (2001), *available at* www.ilru.org/html/training/webcasts/handouts/2002/10-09-JK/crossroads.html.

⁶⁴ Rosalie A. Kane & Keren Brown Wilson, *Assisted Living at the Crossroads: Principles for Its Future* 29 (2001), *available at* www.ilru.org/html/training/webcasts/handouts/2002/10-09-JK/crossroads.html.

⁶⁵ 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, e.g.*, Kenneth Burgess, *Negotiated Risk Agreements In Assisted Living Communities* 51 (ALFA 1999). As discussed subsequently in this Article, 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.

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 the 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 to risk. Also, risk is likely to be the sole topic of a negotiated risk agreement whereas, in a care planning document, risk will be only one of the topics discussed.

For example, Alaska’s “assisted living plan” is not recognized in this Article as a negotiated risk agreement, even though the relevant law discusses the resident’s right to evaluate risks and make choices, along with the facility’s right to accept or reject the resident’s choices regarding risks. Alaska Stat. § 47.33.230(a)(2), (3). The assisted living plan appears to be a care planning document rather than a contract because Alaska law refers to an assisted living “plan”

Beyond this common denominator, generalizing about negotiated risk is a precarious proposition. Negotiated risk differs greatly from state to state and, within a state, often presses together two or more inconsistent concepts. The following eight categories demonstrate the muddled status quo of state negotiated risk law:

- A. Resolving Disputes with Emphasis on Resident's Acceptance of Risk
District of Columbia & Kansas
- B. Care Planning with Emphasis on Resident's Acceptance of Risk
Florida, Illinois, & Utah
- C. Care Planning with Limited References to Acceptance of Risk
Oregon
- D. Care Planning to Reduce Probability of Negative Outcome
Hawaii & Oklahoma
- E. Consenting to Inadequate or Insufficient Care
Ohio
- F. Ambiguity as to Whether Agreements Are Used to Resolve Disputes, or to Consent to Inadequate or Insufficient Care
Wisconsin & Arkansas
- G. Signed Statement of Facility's Risk Policy
Iowa
- H. Waiver of Liability Forbidden or Disclaimed
Washington, Delaware, New Jersey & Vermont

Each of these categories and states is discussed below.

(rather than a contract or agreement). The law does not mention signatures or agreements – the plan is to be developed by the resident or resident's representative with participation from facility staff. Alaska Stat. § 47.33.220; *see also* Alaska Stat. § 47.22.230(d) (assisted living plan must be in writing). Finally, the assisted living plan must “identify and describe” a myriad of issues with little relationship to risk, for example “the resident's preference in roommates, living environment, food, recreational activities, religious affiliation, and relationships and visitation with friends, family members, and others.” Alaska Stat. § 47.22.230(b)(3); *but see* Robert Jenkins et al., A Study of Negotiated Risk Agreements in Assisted Living: Final Report, U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy 5 (2006) (including Alaska law as addressing negotiated risk).

A. Resolving Disputes With Emphasis on Resident’s Acceptance of Risk

1. General Features

In the District of Columbia and Kansas, the relevant law refers 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. (*See supra* at 13-17.)

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

- 1) The resident and the facility disagree;
- 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 their 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, states’ laws frequently use terms such as “shared responsibility” that bring to mind images of fairness, but also could cover an agreement that shifts liability to the resident.

2. 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.”⁶⁶ 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.”⁶⁷ In turn, a “shared responsibility agreement” is defined as an agreement that outlines the parties’ responsibilities.⁶⁸

The 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

⁶⁶ D.C. Code Ann. § 44-106.05(a).

⁶⁷ D.C. Code Ann. § 44-102.01(21). In language not included here, the statute recognizes that the resident’s interests may be represented by a representative.

⁶⁸ D.C. Code Ann. § 44-102.01(22).

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 [service plans].”⁶⁹ The following sentence, however, suggests that the purpose of a shared responsibility agreement is to shift risk from facility to resident: “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 [facility] concerning such decisions or actions.”⁷⁰

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.”⁷¹ The facility must explain to the resident the issues subject to negotiation, and then “[n]egotiate a shared responsibility agreement, with the resident as a full partner.”⁷²

The law gives a resident the right to enter into a shared responsibility agreement;⁷³ 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.⁷⁴

3. Kansas

In most respects, the Kansas “negotiated service agreement” is nothing more than a

⁶⁹ D.C. Code Ann. § 44-106.05(b). The statute refers to ISPs, which are defined as “Individualized Service Plans.” D.C. Code Ann. § 44-102.01(14); *see also* D.C. Code Ann. § 44-103.04 (development and use of ISPs).

⁷⁰ D.C. Code Ann. § 44-106.05(b).

⁷¹ D.C. Code Ann. § 44-106.05(c).

⁷² D.C. Code Ann. § 44-106.05(c)(1).

⁷³ D.C. Code Ann. § 44-105.04(4).

⁷⁴ D.C. Code Ann. § 44-105.04(5). The requirement of a shared responsibility agreement is qualified by need: the resident has the right to refuse a 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].” D.C. Code Ann. § 44-105.04(5) (emphasis added); *see also* D.C. Code Ann. § 44-106.04(a)(6) (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 likely is made by a facility – a shared responsibility agreement will be “needed” when a facility demands that such an agreement be signed.

written care plan that arguably is not negotiated at all.⁷⁵ The “agreement” is developed by the facility “in collaboration” with the resident or resident’s representative.⁷⁶ The agreement describes needed services, and identifies who will be providing and paying for those services.⁷⁷

The concept of risk enters the negotiated service agreement when the resident or resident’s representative refuses a services that is necessary for the resident’s health or safety, in the opinion of the facility operator or nurse, or of the resident’s physician or case manager. In that case, the negotiated service agreement must identify the refused service along with the negative consequences of refusing that service, and “acceptance by the resident or the resident’s legal representative of the potential risk.”⁷⁸

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”⁷⁹

The 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”⁸⁰ The second half of the definition,

⁷⁵ See also Robert Jenkins et al., A Study of Negotiated Risk Agreements in Assisted Living: Final Report, U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy 45 n.14 (2006) (not including Kansas law in 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)).

⁷⁶ Kan. Stat. Ann. § 28-39-244(a). The statute provides that “[e]ach individual involved in the development of the negotiated service agreement shall sign the agreement.” Kan. Stat. Ann. § 28-39-244(h). In most cases, evidently, the resident or resident’s representative would not sign, because the agreement would have been developed by facility staff.

⁷⁷ Kan. Stat. Ann. § 28-39-244(a).

⁷⁸ Kan. Stat. Ann. § 28-39-244(f).

⁷⁹ Fla. Stat. Ann. § 400.402(15).

⁸⁰ Fla. Stat. Ann. § 400.402(23).

however, gives no hint of risk or compromise: 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.”⁸¹

Florida statutory law is much more verbose in defining these terms than in using them. The Florida Statutes mention the terms only once, in requiring that “the concept of managed risk” be implemented in those facilities licensed to provide nursing services.⁸² The corresponding 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.⁸³

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, independence, autonomy, and decision-making ability.”⁸⁴ A discussion of principles posits “that there is an acceptable balance between consumer protection and resident willingness to accept risk and that most consumers are competent to make their own judgments about the services they are obtaining.”⁸⁵

“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.”⁸⁶ The provider is responsible for informing the resident of risks

⁸¹ Fla. Stat. Ann. § 400.402(23).

⁸² Fla. Stat. Ann. § 400.402(23). Specifically, this requirement applies only to those facilities licensed to provide “extended congregate care.” 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.” Fla. Stat. Ann. § 400.407(3)(b).

⁸³ Fla. Admin. Code Ann. r. 58A-5.030(7)(c).

⁸⁴ 210 Ill. Comp. Stat. Ann. 9/5; *see also* Ill. Adm. Code tit. 77, § 295.100(a) (same language in regulations).

⁸⁵ 210 Ill. Comp. Stat. Ann. 9/5; *see also* Ill. Adm. Code tit. 77, § 295.100(a) (same language in regulations).

⁸⁶ 210 Ill. Comp. Stat. Ann. 9/10; *see also* Ill. Adm. Code tit. 77, § 295.200 (same language in regulations).

and the consequences of assuming those risks.⁸⁷ A resident has the right to refuse services, provided that she has received clear information regarding refusal's risks and benefits.⁸⁸

The definition of a “negotiated risk *agreement*” sharpens focus onto the agreement’s enforceability and the possibility of harm. The relevant regulation describes the agreement as “binding” and specifies that the agreement “describ[es] conditions or situations that could put the resident at risk of harm or injury.”⁸⁹

A negotiated risk agreement may not waive any assisted living regulation, and this limitation would appear to prevent a facility from using a negotiated risk agreement to authorize an inadequate level of care.⁹⁰ Among the nonwaivable regulations is a prohibition against a facility’s admission or retention of a person if the facility cannot provide adequate care.⁹¹

3. Utah

Of all the states, Utah is the one that most directly links negotiated risk to waiver of a facility’s liability. Although Utah law does not address negotiated risk or any related concept, the Utah Bureau of Health Facility Licensing, Certification and Resident Assessment has created a form for a Negotiated Risk Contract. In the contract, a resident’s “responsible party” recognizes that the resident has had “difficulty” in certain specified ways, authorizes the facility to allow the resident to continue the behavior in question, and releases the facility from liability in regard to such behavior. The contract is signed by the responsible party and a facility representative.⁹²

⁸⁷ 210 Ill. Comp. Stat. Ann. 9/10; *see also* Ill. Adm. Code tit. 77, § 295.200 (same language in regulations).

⁸⁸ Ill. Adm. Code tit. 77, § 295.4010(i).

⁸⁹ Ill. Adm. Code tit. 77, § 295.200.

⁹⁰ Ill. Adm. Code tit. 77, § 295.2070(e).

⁹¹ Ill. Adm. Code tit. 77, § 295.2000(a).

⁹² Utah Bureau of Health Facility Licensing, Certification and Resident Assessment, Negotiated Risk Contract form, *available at* health.utah.gov/hflcra/forms/risk.PDF (Internet site visited on June 21, 2006); *see also* Mary Jane Ciccarello & Joanne Wetzler, *Assisted Living in Utah: A Brief Overview for Consumers*, 19 Utah Bar J. 24, 26 (2006) (negotiated risk agreements “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.”⁹³ Options and consequences are explained to the resident, and the managed risk plan documents the resident’s decision either to accept the consequences of current behavior or change behavior.⁹⁴ Specifically, the plan must include an explanation of the “cause of concern,” possible negative consequences, a description of the resident’s preference, 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.⁹⁵

D. Care Planning to Reduce Probability of Negative Outcome

1. Hawaii

In Hawaii, negotiated risk is best summarized as a mechanism reducing a resident’s risk. As is typical in negotiated risk law, however, summarization is a treacherous process, and any summary must be qualified by the recognition that relevant Hawaii law is both vague and internally inconsistent.

The relevant term is “managed risk.” Hawaii statutory law makes no mention of the term, but it receives a prominent position in Hawaii assisted living regulations. The initial paragraph of the assisted living regulations lists three principles that are to be applied to the regulations: aging in place, negotiated plan of care, and managed risk.⁹⁶ The subsequent regulations, however, do little to distinguish “managed risk” from the “negotiated plan of care”: the

⁹³ Or. Admin. R. 411-055-0000(24) (residential care facility); 411-056-0005(20) (assisted living facility). Managed risk applies both in residential care facilities and assisted living facilities, through identical and parallel regulatory language. Assisted living facilities are required to offer private living units, but residential care facilities may have shared occupancy. Or. Rev. Stat. § 443.400(5) (residential care facility); Or. Admin. R. 411-056-0005(5) (assisted living facility).

⁹⁴ Or. Admin. R. 411-055-0000(24) (residential care facility); 411-056-0005(20) (assisted living facility).

⁹⁵ Or. Admin. R. 411-055-0180(j) (residential care facility); 411-056-0015(j) (assisted living facility).

⁹⁶ Haw. Admin. r. 11-90-1(1)-(3).

definition explains that “‘managed risk’ means 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.*”⁹⁷

Perhaps this definition’s most noteworthy aspect 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.

2. Oklahoma

Oklahoma law is comparatively succinct. The regulations’ 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.”⁹⁸ The assisted living facility is instructed to discuss the matter with the resident or resident’s representative, and “attempt to negotiate a written agreement that minimizes risk and adverse consequences and offers alternatives while respecting resident preferences.”⁹⁹

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. In general, liability is not addressed directly – instead, the laws speak with less precision of, for example, “consequences” or “sharing responsibility.” The laws are similarly ambiguous as to whether the refused service otherwise would be available.

As categorized in this Article, Ohio is the only state in which consent to inadequate care is presented as the primary purpose of (to use Ohio terminology) a “risk agreement.” In Wisconsin and Arkansas, such consent is one purpose of negotiated risk; the other purpose is the resolution of disputes. (*See infra* at 27-30.)

⁹⁷ Haw. Admin. r. 11-90-2 (emphasis added). The same regulation explains that “‘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.”

⁹⁸ Okla. Admin. Code § 310:663-3-6(a).

⁹⁹ Okla. Admin. Code § 310:663-3-6(b).

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.”¹⁰⁰ By requiring that the facility “identify the risks inherent in a decision ... not to receive a service *provided by the facility*,”¹⁰¹ 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. This provision 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.¹⁰²

A formal policy of this type could make little sense 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 necessarily would say that the resident has a right to refuse services unless the refusal threatens the health and safety of others.¹⁰³ Beyond that, the policy could say little, 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 governing personal care services contemplates that a risk agreement might pertain either to a resident refusing available services, or acknowledging the unavailability of needed services. Refusal of available services is evoked in the subsection that requires a facility to provide necessary personal care services, with an exception when the resident and

¹⁰⁰ Ohio Rev. Code Ann. § 3721.012; *see also* Ohio Admin. Code § 3701-17-57(E) (similar provision in Ohio regulations).

¹⁰¹ Ohio Rev. Code Ann. § 3721.012 (emphasis added).

¹⁰² Ohio Rev. Code Ann. § 3721.19(B); *see also* Ohio Admin. Code § 3701-17-57(F) (similar provision in Ohio regulations).

¹⁰³ *See, e.g.*, Ohio Rev. Code Ann. § 3716.19(A)(1)(c), (d) (involuntary transfer or discharge authorized when “emergency arises” in which safety or health of other individuals in the facility is endangered).

facility have entered into a risk agreement.¹⁰⁴ If a resident requires personal care services that the facility does not provide, the regulation presents three options: the facility or resident can arrange for the services to be provided, the resident can be transferred, or the facility and resident can enter into a risk agreement.¹⁰⁵

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

1. Wisconsin

Wisconsin law requires a facility 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.”¹⁰⁶ The risk agreement indeed is mandatory – a resident’s refusal to sign or revise a risk agreement can justify her involuntary transfer or discharge.¹⁰⁷

“Risk agreement” is defined in the 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.”¹⁰⁸ Neither resident nor facility is to “refuse to accept reasonable risk or insist that the other party accept unreasonable risk.”¹⁰⁹

¹⁰⁴ Ohio Admin. Code § 3701-17-59(B)(2).

¹⁰⁵ Ohio Admin. Code § 3701-17-59(c). The risk agreement option is only open to those facilities with a policy of using such agreements. Ohio Admin. Code § 3701-17-59(c)(2).

Ohio regulations are inconsistent as to whether a facility can admit or retain a resident for whom it cannot provide adequate care. As discussed here, such admission or retention is allowed through the mechanism of risk agreements. On the other hand, 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.” Ohio Admin. Code § 3701-17-57(A).

¹⁰⁶ Wis. Stat. Ann. § 50.034(3)(d); *see also* Wis. Admin. Code HFS § 89.23(3)(e) (Services must “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)).

¹⁰⁷ Wis. Admin. Code HFS § 89.29(3)(a)(8).

¹⁰⁸ Wis. Admin. Code HFS § 89.13(27).

¹⁰⁹ Wis. Admin. Code HFS § 89.28(4).

A regulation refers 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.”¹¹⁰ 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.”¹¹¹

Under either scenario, “[a] risk agreement may not waive any [assisted living regulation] or any other right of the [resident].”¹¹² This no-waiver rule may be less restrictive than it appears 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.¹¹³ Thus to a certain extent, the 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: it both provides for the enforceability of risk agreements, and requires that care be adequate to meet resident needs. The 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.”¹¹⁴

2. Arkansas

Arkansas law likewise is evasive as to whether negotiated risk applies to the against-facility-advice scenario, the inadequate care scenario, or both. The term used 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.”¹¹⁵ Neither “shared responsibility” nor “assisted living values” is

¹¹⁰ Wis. Admin. Code HFS § 89.28(2)(a)(1).

¹¹¹ Wis. Admin. Code HFS § 89.28(2)(b).

¹¹² Wis. Admin. Code HFS § 89.28(3).

¹¹³ *See, e.g.*, Wis. Admin. Code HFS § 89.23(1), (2)(a)(3), (3)(b).

¹¹⁴ Wis. Admin. Code HFS § 89.23(2)(a)(1), (2)(a)(5).

¹¹⁵ Ark. Code R. & Regs. 016 06 001, § 300 (Level I facilities), 016 06 002, § 300 (Level II facilities). The primary difference between a Level I facility and a Level II facility is that a

defined or even mentioned again in the regulations; “choice” is defined in a way roughly consistent with its dictionary definition, but with references to resident options, care planning, and other assisted living concepts.¹¹⁶

The “compliance agreement” regulation alternates confusingly from discussing a facility’s limitations in admitting or retaining residents, to explaining compliance agreements as a mechanism to honoring resident choice. The pivotal sentence sets limits on a resident’s free choice:

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.¹¹⁷

A compliance agreement is intended to “minimize the possible risk and adverse consequences while still respecting the resident’s preferences.”¹¹⁸ Involuntary transfer or discharge is authorized for failure to comply with a risk agreement or (again, as in Wisconsin) refusal to negotiate or revise such an agreement.¹¹⁹

The compliance agreement provisions are flanked in the law by two provisions related to a facility’s level of care: a listing of the health care conditions that cannot be accommodated in that level of assisted living, and the admonition that an individual is prohibited from residing in assisted living if she needs around-the-clock nursing care or requires services that by law cannot be provided in an assisted living facility.¹²⁰ Significantly, this prohibition applies even if the

Level II facility is allowed to admit and retain residents who need a nursing home level of care. Ark. Code R. & Regs. 016 06 001, § 400.2, 016 06 002, § 400.2. Regarding compliance agreements, the law for Level I facilities and Level II facilities is almost identical.

¹¹⁶ Ark. Code R. & Regs. 016 06 001, § 300, 016 06 002, § 300.

¹¹⁷ Ark. Code R. & Regs. 016 06 001, § 704, 016 06 002, § 704.

¹¹⁸ Ark. Code R. & Regs. 016 06 001, § 704, 016 06 002, § 704. For example, the regulations suggest use of a compliance agreement when a facility feels that a resident might be at risk if given a key, code, or other exit device for leaving the facility. Ark. Code R. & Regs. 016 06 001, § 904(b)(1), 016 06 002, § 904(b)(1).

¹¹⁹ Ark. Code R. & Regs. 016 06 001, §§ 602.1(g), 704(7), 016 06 002, §§ 602.1(g), 704(7); *see* Wis. Admin. Code HFS § 89.29(3)(a)(8).

¹²⁰ Ark. Code R. & Regs. 016 06 001, § 704, 016 06 002, § 704.

resident is willing to waive the facility's liability."¹²¹ Overall, the law's structure – the flanking of the negotiated risk provisions with provisions relating to facility's admission and retention limitations – suggests that negotiated risk also relates to a facility's ability (or inability) to care for residents with particular care needs.

G. Signed Statement of Facility's Risk Policy

1. Iowa

Iowa law is particularly ambiguous on the purpose of what in Iowa is called “shared risk,” even though this concept is purportedly a central feature of assisted living. The definition of assisted living includes the encouragement of resident decision-making, and indicates that those decisions should emphasize shared risk along with choice, dignity, privacy, individuality, and independence.¹²²

In Iowa law, shared risk's most tangible manifestation is a requirement that an incoming resident sign the facility's “managed risk policy disclosure statement.”¹²³ 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.”¹²⁴

H. Waiver of Liability Explicitly Forbidden or Disclaimed

1. General Features

Yet again, generalization is difficult. Although Washington, Delaware, New Jersey and Vermont each do not allow negotiated risk to waive a facility's liability, the states' laws differ in many ways. In Washington, the negotiated risk process looks much like care planning. In Delaware and New Jersey, negotiated risk (“managed risk” in New Jersey) is an internally inconsistent combination of dispute resolution and risk assumption. Vermont is an exception in a positive way – the relevant law succinctly sets out a dispute-resolution focus, and specifies that

¹²¹ Ark. Code R. & Regs. 016 06 001, §§ 601.4, 704, 016 06 002, §§ 601.4, 704; *see also* Ark. Code Ann. § 20-10-1704(c)(2) (almost identical provision in state statute).

¹²² Iowa Code Ann. § 231C.2(2); Iowa Admin. Code r. 321-25.1.

¹²³ Iowa Admin. Code r. 321-25.22(1).

¹²⁴ Iowa Admin. Code r. 321-25.36; *see also* Iowa Admin. Code r. 321-25.4(11) (in certification application, facility required to submit “current policy and procedure for managing risk and upholding tenant autonomy when tenant decision making may result in poor outcomes for the tenant or others”).

negotiated risk does not include waiver of a facility's liability.

2. Washington

In Washington, 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 the possible involvement of the resident or resident's representative in the agreement's development.¹²⁵

The negotiated service agreement determines the care to be provided in virtually every context, whether the issue is (for example) basic services, activities, medication, nutrition, nursing services, tube feeding, staffing, and safety measures.¹²⁶ Allusions to risk are limited and oblique¹²⁷ and, in contrast, a regulation explicitly states that a negotiated service agreement 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.”¹²⁸

3. Delaware

Delaware's 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.”¹²⁹ “Shared responsibility” is defined

¹²⁵ Wash. Rev. Code Ann. § 18.20.370(1); *see also* Wash. Admin. Code §§ 388-78A-2130 (corresponding regulation), 388-78A-2170(1), (2) (facility providing services as specified in negotiated service agreement). The negotiated service agreement must be signed by the resident or resident's representative, but the signature requirement appears designed not to create an agreement enforceable in court, but to develop consensus among persons involved in the resident's care. The signature requirement applies not only to the facility and the resident, but also to any public or private case manager for the resident. Wash. Admin. Code § 388-78A-2150.

¹²⁶ Wash. Admin. Code § 388-78A-2170 (basic services), -2180 (activities), -2210 (medication), -2300 (nutrition), -2320 (nursing services), -2330 (tube feeding), -2450 (staffing), -2700 (safety measures).

¹²⁷ *See, e.g.*, Wash. Admin. Code § 388-78A-2380(4) (unsafe for resident to leave facility unescorted, but can leave consistent with terms of negotiated service agreement).

¹²⁸ Wash. Admin. Code § 388-78A-2140(8).

¹²⁹ Del. Regs. § 40-300-005, 63.218. The regulations generally refer to a “managed/negotiated risk agreement,” but for simplicity this Article condenses the term to

benignly as “[t]he concept that residents and assisted living facilities share responsibility for planning and decision-making affecting the resident.”¹³⁰ 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.¹³¹

Negotiated risk agreements seem designed for dispute resolution. 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.¹³²

Significantly, a negotiated risk agreement cannot waive a facility’s liability¹³³ 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.”¹³⁴

4. New Jersey

New Jersey law is roughly comparable to Delaware’s. In each state, the relevant law is an ambiguous stew of dispute resolution concepts and risk references, clarified by a prohibition against any waiver of facility liability.

New Jersey law begins by suggesting that a resident’s autonomy and health may be in conflict: “managed risk” is defined as a “process of balancing resident choice and independence with the health and safety of the resident and other persons in the facility or program.”¹³⁵ In the

“negotiated risk agreement.”

¹³⁰ Del. Regs. § 40-300-005, 63.229.

¹³¹ Del. Regs. § 40-300-005, 63.1208.

¹³² Del. Regs. § 40-300-005, 63.1209; *see also* Del. Regs. § 40-800-124, 25.5.1.2.1 (state obligated to participate as appropriate in development of negotiated risk agreement, when payment for assisted living care is provided at least in part through state’s Assisted Living Medicaid Waiver Program).

¹³³ Del. Regs. § 40-300-005, 63.1212.

¹³⁴ Del. Regs. § 40-300-005, 63.1211. This same regulation goes on to state: “A managed/negotiated risk agreement shall not be used to supersede any requirements of these regulations.”

¹³⁵ N.J. Admin. Code tit. 8, § 8:36-1.3.

very next sentence, however, the definition abandons the 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”¹³⁶ Similarly, the defined purpose of a “managed risk agreement” is “to avoid or reduce the risk of adverse outcomes.”¹³⁷

The definition of “managed risk agreement” includes the explanation that such an agreement is “developed in consideration of shared responsibility, bounded choice and assisted living values.”¹³⁸ In turn, these terms’ definitions are in part innocuous, but with the intimation that a resident is accepting risk. “Assisted living values” include “each resident’s choice, dignity, independence, individuality and privacy in a home-life environment,” along with “aging in place” and – from a resident’s point of view, the only discordant note – “shared responsibility.”¹³⁹ “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.”¹⁴⁰

The 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.”¹⁴¹ This broad principle is unobjectionable from a resident’s point of view, but its suggestion of communitarianism is reversed by the following sentence’s risk-evoking instruction that “[t]o participate fully in shared responsibility, residents shall be provided with clear and understandable information about the possible consequences of their decision-making.”¹⁴²

A separate 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 -- specifically, “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

¹³⁶ N.J. Admin. Code tit. 8, § 8:36-1.3.

¹³⁷ N.J. Admin. Code tit. 8, § 8:36-1.3.

¹³⁸ N.J. Admin. Code tit. 8, § 8:36-1.3.

¹³⁹ N.J. Admin. Code tit. 8, § 8:36-1.3.

¹⁴⁰ N.J. Admin. Code tit. 8, § 8:36-1.3.

¹⁴¹ N.J. Admin. Code tit. 8, § 8:36-1.3.

¹⁴² N.J. Admin. Code tit. 8, § 8:36-1.3.

norms of the facility or program or the majority of the residents.”¹⁴³ 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.¹⁴⁴

Although the regulations leave open the possibility that a managed risk agreement could waive or reduce a facility’s liability, that possibility is foreclosed by New Jersey statute. In a provision applicable both to assisted living facilities and nursing homes, New Jersey law voids “[a]ny provision or clause waiving or limiting the right to sue for negligence or malpractice in any admission agreement or contract.”¹⁴⁵

5. Vermont

In comparison with other state laws discussed in this Article, Vermont’s definition of negotiated risk is notably lucid. The waiver of liability issue is addressed explicitly: “Negotiated risk does not constitute a waiver of liability.”¹⁴⁶ Also, “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.”¹⁴⁷

If a resident has entered into an applicable negotiated risk agreement, she cannot be discharged involuntarily for being a danger to herself.¹⁴⁸ It is unclear how meaningful this protection might be in practice. A diabetic would be allowed to eat candy (for example) but, as discussed subsequently (*see infra* at 38-41), such individual choices are allowed routinely in long-term care without need of negotiated risk. 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.¹⁴⁹

Even less likely is the probability (as suggested by the regulations) that a negotiated risk agreement might eliminate the need for an involuntary discharge predicated on “a serious threat

¹⁴³ N.J. Admin. Code tit. 8, § 8:36-4.17(a).

¹⁴⁴ N.J. Admin. Code tit. 8, § 8:36-4.17(a)(3), (4).

¹⁴⁵ N.J. State Ann. § 30:13-8.1.

¹⁴⁶ Vt. Code R. 13-110-007, § 3.4.

¹⁴⁷ Vt. Code R. 13-110-007, § 3.4.

¹⁴⁸ Vt. Code R. 13-110-007, § 6.5(a).

¹⁴⁹ Vt. Code R. 13-110-007, § 6.5(f).

to residents or staff.”¹⁵⁰ Obviously, the resident signing the negotiated risk agreement has no ability to consent to risk on others’ behalf.

I. State Law Overall

As shown by this analysis, state negotiated risk law is generally ambiguous and inconsistent, whether viewed solely within a single state, or viewed across several or all of the 16 states that explicitly have recognized negotiated risk. Ambiguity is demonstrated, for example, by the ubiquitous but vague references to risk in virtually every state’s laws, and by the states’ failure to distinguish between the against-facility-advice scenario and the inadequate care scenario.

Inconsistency is shown by Wisconsin and Arkansas (for example) referring both to dispute resolution and a resident’s consent to inadequate care. Iowa law is similarly inconsistent in mandating disclosure of risk policies but never defining a risk policy in a meaningful way. The law is not consistent even in the four states that prohibit liability waivers, because the prohibition conflicts with the laws’ discussion of risk and risk agreements.

Interstate ambiguity and inconsistency are demonstrated most succinctly by this Article’s need to create eight separate categories to describe sixteen states. Based on state law, negotiated risk can differ greatly from one state to another. 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.

VIII. EMPIRICAL EVIDENCE IS SCANT

With two exceptions, negotiated risk literature is theoretical rather than empirical. In one of these exceptions, a survey of facility administrators found 82 instances in which negotiated risk agreements had been used. “Falling” and “wandering” – each from the inadequate-care scenario – were identified as the most common issues addressed in negotiated risk agreements.¹⁵¹ The survey report, however, does not indicate the terms of the agreements or the types of situation involved – for example, whether an agreement arose from the inadequate care

¹⁵⁰ Vt. Code R. 13-110-007, § 6.5(b).

¹⁵¹ Keren Brown Wilson et al., *Negotiated Risk Agreements: Opportunity or Exploitation?*, *Ethics, L., and Aging Rev.*, vol. 7, at 59, 76 (2001). “Falling” was addressed in 21.95% of the admission agreements; while “wandering” was addressed in 13.41% of the agreements.

scenario or the against-facility-advice scenario.¹⁵²

A recent study reviewed 31 negotiated risk agreements in three states – Florida, Oregon, and Washington. The majority of the reviewed agreements evidently would be classified under the against-facility-advice scenario; these agreements 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-managing medications, refusing housekeeping, and assisting another resident who uses a wheelchair.”¹⁵³

Several of the negotiated risk agreements focused on the resident’s condition rather than her decisions. For a resident who was blind and another with spinal stenosis,¹⁵⁴ a negotiated risk agreement identified a risk of falling. For a morbidly obese resident who could not wear shoes, an agreement identified risks of falls, skin breakdown, and foot infection. “Possible alternatives” were listed as weight reduction programs, foot protection, weight-loss medication, surgery, and transfer to a nursing home.¹⁵⁵ In one Wisconsin facility, all residents at high risk of falls were required at admission to sign a negotiated risk agreement pertaining to falls.¹⁵⁶

In Oregon, several of the negotiated risk agreements involved smoking in non-smoking areas, even though smoking can be a risk to persons other than the smoker. Most of the other Oregon agreements involved behaviors that were offensive to others but not dangerous – yelling,

¹⁵² Keren Brown Wilson et al., *Negotiated Risk Agreements: Opportunity or Exploitation?*, *Ethics, L., and Aging Rev.*, vol. 7, at 59, 71-77 (2001).

¹⁵³ Robert Jenkins et al., *A Study of Negotiated Risk Agreements in Assisted Living: Final Report*, U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy 31 (2006).

¹⁵⁴ “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), *available at* www.niams.nih.gov/hi/topics/spinalstenosis/spinal_sten.htm#spine_a.

¹⁵⁵ Robert Jenkins et al., *A Study of Negotiated Risk Agreements in Assisted Living: Final Report*, U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy 31 (2006).

¹⁵⁶ Robert Jenkins et al., *A Study of Negotiated Risk Agreements in Assisted Living: Final Report*, U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy 31 (2006).

playing loud music, being intoxicated, and watching pornography in the presence of housekeeping staff.¹⁵⁷

In examining the content of the Oregon negotiated risk agreements, the study found that a good number followed the against-facility-advice scenario – a resident’s behavior or choice presenting a potential risk, and the agreement being written to “protect the resident’s autonomy” in an unspecified way.¹⁵⁸

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 Oregonians revealed that negotiated risk agreements were used commonly to support an eviction, by demonstrating a facility’s pre-eviction efforts to warn a resident.¹⁵⁹

In Wisconsin, the study found 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, the negotiated risk agreement specified that the facility could not supervise dietary intake on a 24-hour basis, prevent purchases at the facility’s store, or remove candy from the resident’s living quarters. Another negotiated risk agreement, this one pertaining to a resident who took walks, stated that the facility could not provide escorts for walks, and did not offer 24-hour monitoring of residents’ whereabouts.¹⁶⁰

¹⁵⁷ Robert Jenkins et al., A Study of Negotiated Risk Agreements in Assisted Living: Final Report, U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy 32 (2006).

¹⁵⁸ Robert Jenkins et al., A Study of Negotiated Risk Agreements in Assisted Living: Final Report, U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy 32 (2006).

¹⁵⁹ Robert Jenkins et al., A Study of Negotiated Risk Agreements in Assisted Living: Final Report, U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy 32 (2006).

¹⁶⁰ Robert Jenkins et al., A Study of Negotiated Risk Agreements in Assisted Living: Final Report, U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy 32 (2006).

IX. 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."¹⁶¹ Actually, restraints can be used in a nursing home only with a physician's order and the consent of the resident or resident's surrogate.¹⁶² Use of restraints must be "to treat the resident's medical symptoms" and never for the staff's convenience.¹⁶³ Likewise, activities must be offered¹⁶⁴ but "resident choice" is a recognized reason for a resident to forego participation.¹⁶⁵

In the words of one health policy specialist, "regulations are often blamed unfairly for autonomy incursions that are not regulatorily mandated."¹⁶⁶ Providers and their representatives not infrequently exaggerate the stringency of regulatory requirements, due to a general risk aversion and a "law-related anxiety"¹⁶⁷ that often is not well founded:

¹⁶¹ Marshall B. Kapp & Keren Brown Wilson, *Assisted Living and Negotiated Risk: Reconciling Protection and Autonomy*, 1 J. Ethics, Law, and Aging 7 (1995).

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

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

¹⁶⁴ 42 C.F.R. § 483.15(f)(1).

¹⁶⁵ Surveyor's Guideline to 42 C.F.R. § 483.15(f)(1), Appendix PP to CMS State Operations Manual. 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).

¹⁶⁶ Rosalie A. Kane, *Autonomy and Regulation in Long-Term Care: An Odd Couple, An Ambiguous Relationship*, in *Enhancing Autonomy in Long-Term Care*, at 83 (Lucia Gamroth et al., eds., Springer 1995).

¹⁶⁷ Marshall B. Kapp & Keren Brown Wilson, *Assisted Living and Negotiated Risk: Reconciling Protection and Autonomy*, 1 J. Ethics, Law, and Aging 8 (1995); Marshall B. Kapp,

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.¹⁶⁸

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 14 hours elapse between the evening meal and the following day's breakfast.¹⁶⁹ In one case study,¹⁷⁰ 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.¹⁷¹ The author found that it was

difficult 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

Who Is Responsible For This? Assigning Rights and Consequences in Elder Care, 9 J. Aging & Soc. Policy, vol. 9, No. 2, at 58 (1997).

¹⁶⁸ Rosalie A. Kane, *Autonomy and Regulation in Long-Term Care: An Odd Couple, An Ambiguous Relationship*, in *Enhancing Autonomy in Long-Term Care*, at 78 (Lucia Gamroth et al., eds., Springer 1995).

¹⁶⁹ 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.").

¹⁷⁰ The case is one of 18 cases derived from study data. Each of these 18 cases "may illustrate the predicament of more than one resident and perhaps of several staff members as well." Rosalie A. Kane & Arthur Caplan, Preface to *Everyday Ethics: Resolving Dilemmas in Nursing Home Life*, at xii (Springer 1990).

¹⁷¹ James Childress, *If You Let Them, They'd Stay in Bed: Case Commentary*, in *Everyday Ethics: Resolving Dilemmas in Nursing Home Life*, at 85 (Rosalie A. Kane & Arthur Caplan, eds., Springer 1990).

another reason to suspect that the institution is displaying bad faith in its conflict with [the resident].¹⁷²

Under the federal Nursing Home Reform Law¹⁷³ and constitutional and common law pertaining to health care decision-making,¹⁷⁴ nursing home residents generally have the right to make decisions regarding their health care and their day-to-day life, 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."¹⁷⁵ 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."¹⁷⁶ A regulation specifies that a resident may "[c]hoose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care."¹⁷⁷

In fact, a diabetic nursing home resident could choose to eat cake.¹⁷⁸ A resident also could self-administer medication, as long as the facility's interdisciplinary team determined that

¹⁷² James Childress, *If You Let Them, They'd Stay in Bed: Case Commentary*, in *Everyday Ethics: Resolving Dilemmas in Nursing Home Life*, at 86-88 (Rosalie A. Kane & Arthur Caplan, eds., Springer 1990) (emphasis in original).

¹⁷³ The Nursing Home Reform Law applies to every nursing home certified to accept reimbursement from the Medicare program, the Medicaid program, or both. 42 U.S.C. §§ 1395i-3 (Medicare-certified facilities), 1396r (Medicaid-certified facilities); 42 C.F.R. § 483.5-483.75 (regulations for facilities certified for Medicare, Medicaid, or both). Because of the ubiquity of Medicare and Medicaid reimbursement in nursing home care, over 97 percent of the nation's nursing homes are subject to the Reform Law. HHS, *The National Nursing Home Survey: 1999 Summary* at 7, available at www.cdc.gov/nchs/data/series/sr_13/sr13_152.pdf.

¹⁷⁴ See, e.g., *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 269 (1990).

¹⁷⁵ 42 C.F.R. § 483.15(a).

¹⁷⁶ 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) (corresponding regulation).

¹⁷⁷ 42 C.F.R. § 483.15(b)(1).

¹⁷⁸ 42 C.F.R. § 483.10(b)(4) (right to refuse medical treatment). The federal nursing home regulations do not address directly the issue of whether a diabetic resident could choose to eat sweets. It is presumed here that the right to refuse medical treatment encompasses the right to eat food that is medically contraindicated – specifically, the right of a diabetic to eat sweets.

self-administration would be safe.¹⁷⁹ Regarding baths, the federal Surveyor's Guidelines to the federal nursing home regulations go into great detail on 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.¹⁸⁰

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. All the necessary arrangements could take place in the care plan meetings that nursing homes conduct for each resident.¹⁸¹

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).¹⁸²

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, assisted living rules frequently contain similar limitations on the ability of residents to

¹⁷⁹ 42 C.F.R. § 483.10(n) (“An individual resident may self-administer drugs if the interdisciplinary team . . . has determined that this practice is safe.”).

¹⁸⁰ Surveyor's Guideline to 42 C.F.R. § 483.15(e), Appendix PP to State Operations Manual.

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

¹⁸² 42 C.F.R. § 483.20(k)(2)(ii).

self-administer medication¹⁸³ and, in a similar fashion, negotiated risk laws often specify that other residents are not to be put at risk.¹⁸⁴

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 others' health or safety.¹⁸⁵ 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.

B. Negotiated Risk Agreements Violate Public Policy

1. Assumption of Risk

As discussed above (*see supra* at 17-35), state negotiated risk laws frequently speak of a resident accepting risk. In Oregon, a resident can decide to "accept the consequences" of his behavior.¹⁸⁶ Florida law refers to a resident's right to "assume risks."¹⁸⁷ A resident "accepts responsibility" in Wisconsin,¹⁸⁸ and in Arkansas acknowledges "acceptance of responsibility for the outcome from the agreed-upon course of action."¹⁸⁹

¹⁸³ *See, e.g.*, Kan. Admin. Regs. § 28-39-147(p) ("In assisted living . . . , a resident may self-administer drugs unless a registered professional nurse or a physician has determined that this practice is unsafe.").

¹⁸⁴ *See, e.g.*, Haw. Admin. r. 11-90-2 ("managed risk" means a formal process . . . to reduce the probability of a poor outcome for the resident or *of putting others at risk for adverse consequences*" (emphasis added)); Ark. Code R. & Regs. 016 06 001, § 704, 016 06 002, § 704 ("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)).

¹⁸⁵ 42 U.S.C. §§ 1395i-3(c)(2)(A)(iii), (iv), 1396r(c)(2)(A)(iii), (iv) (involuntary transfer or discharge from nursing home justified by endangering health or safety of others); 42 C.F.R. § 483.12(a)(2)(iii), (iv) (same).

¹⁸⁶ Or. Admin. R. 411-055-0000(24) (residential care facility), 411-056-0005(20) (assisted living facility).

¹⁸⁷ Fla. Admin. Code Ann. r. 58A-5.030(7)(c).

¹⁸⁸ Wis. Stat. Ann. § 50.034(3)(d).

¹⁸⁹ Ark. Code R. & Regs. 016 06 001, § 704 (Level I facilities), 016 06 002, § 704 (Level II facilities).

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.¹⁹⁰ 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.¹⁹¹

In fact, to a significant extent the doctrine of assumption of risk is a relic. The Supreme Court states:

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 general purpose behind this development in the common law seems to have been to give maximum freedom to expanding

¹⁹⁰ See, e.g., Kenneth Burgess, Negotiated Risk Agreements In Assisted Living Communities 21 (ALFA 1999); Allen Lynch & Sarah Teachworth, *Risky Business: The Enforceability and Use of Negotiated Risk Agreements*, 1 Seniors Housing & Care Journal 14-15 (2002); Marshall B. Kapp & Keren Brown Wilson, *Assisted Living and Negotiated Risk: Reconciling Protection and Autonomy*, 1 J. Ethics, Law, and Aging 9-10 (1995).

As discussed in this Article (*see supra* at 25), the language of assumption/acceptance is troubling because it often straddles the fence as to whether a facility's liability actually is waived. Likewise the articles cited in this footnote, in relying on assumption of risk to defend negotiated risk, refuse to be pinned down as to whether negotiated risk involves a waiver of liability. See, e.g., Burgess at 60 (agreements "may operate to limit provider liability" (emphasis in original)); Lynch & Teachworth at 5 ("perhaps in exchange for a release from liability for that behavior's consequences;" "usually with a liability release or waiver").

¹⁹¹ *Tiller v. Atlantic Coast Line R. Co.*, 318 U.S. 54, 68 (1943) (Frankfurter, J., concurring).

industry.¹⁹²

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.”¹⁹³ The attitude is well represented by Justice Cardozo’s oft-quoted but outdated admonition: “The timorous may stay at home.”¹⁹⁴

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.¹⁹⁵ 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.¹⁹⁶ That 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.”¹⁹⁷

Freedom of contract must be weighed against another important value: responsibility for

¹⁹² *Tiller v. Atlantic Coast Line R. Co.*, 318 U.S. 54, 58-59 (1943).

¹⁹³ 4 F. Harper, F. James, & O. Gray, *The Law of Torts* § 21.3, at 225 (2d ed. 1986).

¹⁹⁴ *Murphy v. Steeplechase Amusement Co., Inc.*, 166 N.E. 173, 174 (N.Y. 1929).

¹⁹⁵ *See, e.g.*, W. Page Keeton et al., *Prosser and Keeton on the Law of Torts* § 68, at 482 (5th ed. 1984); *Knight v. Jewett*, 834 P.2d 696, 703 n.4 (Cal. 1992); *Schmidt v. United States*, 912 P.2d 871, 874 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)).

¹⁹⁶ *See, e.g.*, 4 F. Harper, F. James, & O. Gray, *The Law of Torts* § 21.6, at 248 (2d ed. 1986) *Ransburg v. Richards*, 770 N.E.2d 393, 395 (Ind. Ct. App. 2002); *White v. Village of Homewood*, 628 N.E.2d 616, 618 (Ill. App. Ct. 1993).

¹⁹⁷ *Cudnik v. William Beaumont Hospital*, 525 N.W.2d 891, 894 (Mich. Ct. App. 1994); *see also* 4 F. Harper, F. James, & O. Gray, *The Law of Torts* § 21.6, at 248-50 (2d ed. 1986).

one's negligent acts.¹⁹⁸ Denying recovery to an injured plaintiff is a harsh result, and liability waivers thus are subject to a jaundiced judicial eye.¹⁹⁹

At one end of the extreme is Virginia which, pursuant to an 1890 decision of the Virginia Supreme Court, declines enforcement of any liability waiver relating to personal injury.²⁰⁰ At the other extreme is Missouri, in which liability waivers are not deemed to be contrary to public policy, but nonetheless are strictly construed against the party claiming waiver of liability.²⁰¹

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.²⁰² Other courts reverse the emphasis, stating that liability waivers are suspect or generally unenforceable.²⁰³

Liability for intentional torts or gross negligence is not waivable.²⁰⁴ Also nonwaivable are any obligations imposed by statute or regulation.²⁰⁵

¹⁹⁸ Heil Valley Ranch, Inc. v. Simkin, 784 P.2d 781, 784 (Colo. 1989).

¹⁹⁹ Cornell v. Council of Unit Owners Hawaiian Village Condominiums, Inc., 983 F.Supp. 640, 643 (D.Md.1997); Heil Valley Ranch, Inc. v. Simkin, 784 P.2d 781, 783-84 (Colo. 1989).

²⁰⁰ Johnson's Adm'x v. Richmond & Danville R. R. Co., 11 S.E. 829, 829-30 (Va. 1890); see Hiatt v. Lake Barcroft Community Ass'n, Inc., 418 S.E.2d 894, 895 (Va. 1992) (affirming continuing validity of *Johnson's Adm'x*).

²⁰¹ Alack v. Vic Tanny Int'l of Mo., Inc., 923 S.W.2d 330, 334 (Mo. 1996).

²⁰² 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) ("general validity of exculpatory clauses," unless parties have unequal bargaining power, contract is unconscionable, or transaction affects public interest).

²⁰³ See, e.g., Barnes v. New Hampshire Karting Ass'n, Inc., 509 A.2d 151, 154 (N.H. 1986) ("In New Hampshire, exculpatory contracts are generally prohibited.").

²⁰⁴ See, e.g., Sommer v. Federal Signal Corp., 593 N.E.2d 1365, 1370-71 (N.Y. 1992); Vodopost v. MacGregor, 913 P.2d 779, 785 (Wash. 1996); Alack v. Vic Tanny Int'l of Mo., Inc., 923 S.W.2d 330, 337 (Mo. 1996); Lamp v. Reynolds, 645 N.W.2d 311, 314 (Mich. Ct. App. 2002).

²⁰⁵ See, e.g., 4 F. Harper, F. James, & O. Gray, *The Law of Torts* § 21.6, at 252 (2d ed. 1986).

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.²⁰⁶

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 service performed; 3) fairness of contracting process, and 4) clarity of exculpatory language.²⁰⁷ 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-a-vis personal safety or private property as to violate public policy.”²⁰⁸

The most frequently cited test is that articulated by the California Supreme Court in *Tunkl v. Regents of Univ. of Cal.*, 383 P.2d 441 (Cal. 1963).²⁰⁹ As might be expected, the test is a list of factors, rather than an algorithm. The 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.”²¹⁰

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”:

- Business of a type generally thought suitable for public regulation;
- Service of great public importance, which is often a matter of practical necessity for some members of the public;
- Seller holds itself out as willing to perform service for any member of public who seeks it;
- Seller possesses decisive advantage of bargaining strength;
- Seller confronts public with standardized adhesion contract of exculpation, with no opportunity for buyer to pay a higher price to obtain protection against negligence; and
- Buyer’s person or property is placed under control of seller, subject to risk of seller’s

²⁰⁶ See, e.g., *Perez v. McConkey*, 872 S.W.2d 897, 904 (Tenn. 1994).

²⁰⁷ *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) (same four factors used by Wyoming).

²⁰⁸ *Schmidt v. United States*, 912 P.2d 871, 874 (Okla. 1996) (emphasis omitted).

²⁰⁹ See *Dalury v. S-K-I, Ltd.*, 670 A.2d 795, 797 (Vt. 1995) (*Tunkl* sets forth “leading judicial formula for determining whether an exculpatory agreement violates public policy”).

²¹⁰ *Tunkl v. Regents of Univ. of Cal.*, 383 P.2d 441, 444 (Cal. 1963).

carelessness.²¹¹

Many states explicitly follow the factors set forth in *Tunkl*.²¹² 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.²¹³ Some states apply an intuitive “totality of the circumstances” test.²¹⁴

Overall, there is significant overlap between states’ tests for determining the enforceability of liability waivers. The *Tunkl* test itself was an amalgam of factors used by other states²¹⁵ and, as discussed, the *Tunkl* test has been used and modified by other states.

3. Liability Waivers In Health Care

Because 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”²¹⁶ but the opposite is true. Virtually 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

²¹¹ *Tunkl v. Regents of Univ. of Cal.*, 383 P.2d 441, 445-46 (Cal. 1963).

²¹² *See, e.g., Olson v. Molzen*, 558 S.W.2d 429, 431 (Tenn. 1977) (“We think these criteria are sound and we adopt them.”); *Wagenblast v. Odessa School Dist.*, 758 P.2d 968, 971 (Wash. 1988).

²¹³ *See, e.g., Milligan v. Big Valley Corp.*, 754 P.2d 1063, 1066 (Wyo. 1988) (discussing certain *Tunkl* factors to determine whether duty to public existed, for application in four-part test drawn from Colorado law); *Jones v. Dressel*, 623 P.2d 370, 376 (Colo. 1981) (same).

²¹⁴ *Wolf v. Ford*, 644 A.2d 522, 527 (Md. 1994) (applying test based on “the totality of the circumstances of any given case against the backdrop of current societal expectations”); *Dalury v. S-K-I, Ltd.*, 670 A.2d 795, 798 (Vt. 1995) (same, quoting from *Wolf*).

²¹⁵ *Tunkl v. Regents of Univ. of Cal.*, 383 P.2d 441, 445-46 (Cal. 1963); *see also Belshaw v. Feinstein*, 65 Cal. Rptr. 788, 798 (Cal. Ct. App. 1968) (citing *Tunkl*; invalidating liability waiver used by neurosurgeons).

²¹⁶ Kenneth Burgess, *Negotiated Risk Agreements In Assisted Living Communities* 44 (ALFA 1999).

shift the risk of negligence to patients.”²¹⁷

Tunkl concerns surgery conducted at the UCLA Medical Center. The surgery’s consent form recognized that the hospital was a research and education center, and waived any liability claim that the patient otherwise might have had against the hospital.

The hospital asserted the liability waiver in a lawsuit brought subsequently by the patient, but the California Supreme Court found the waiver unenforceable. The court noted that unenforceability did not require that each factor be present but, in this case, each factor was in fact present: the hospital was subject to public regulation, surgery was a necessary and important service, the hospital held itself out to provide services to the general public, the hospital had a decisive advantage of bargaining strength, the hospital used a standardized adhesion contract of exculpation, and the patient had put himself under the hospital’s control.²¹⁸

Using similar reasoning – each of the *Tunkl* factors was found to be present – the Michigan Court of Appeals refused to enforce a liability waiver in a case stemming from a postradiation ulcer burn.²¹⁹ The Court noted an “overwhelming majority of other jurisdictions” that previously had refused to enforce liability waivers signed by hospital patients, based on the reasoning that “medical treatment involves a particularly sensitive area of public interest.”²²⁰

Courts indeed have had little difficulty finding a violation of public policy in a liability waiver involving a patient’s health care. In a case concerning a failed abortion (the woman remained pregnant), the Tennessee Supreme Court reasoned 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 necessary.”²²¹ 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.”²²² Overall, the Court had little patience for liability waivers in health care:

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

²¹⁷ Glen Robinson, *Rethinking the Allocation of Medical Malpractice Risks Between Patients and Providers*, 49 *Law & Contemp. Probs.* 173, 184 (1986).

²¹⁸ *Tunkl v. Regents of Univ. of Cal.*, 383 P.2d 441, 446-447 (Cal. 1963).

²¹⁹ *Cudnik v. William Beaumont Hosp.*, 525 N.W.2d 891, 895-96 (Mich. Ct. App. 1994).

²²⁰ *Cudnik v. William Beaumont Hosp.*, 525 N.W.2d 891, 895 (Mich. Ct. App. 1994).

²²¹ *Olson v. Molzen*, 558 S.W.2d 429, 431 (Tenn. 1977).

²²² *Olson v. Molzen*, 558 S.W.2d 429, 431 (Tenn. 1977).

own negligence. We do not approve the procurement of a license to commit negligence in professional practice.²²³

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 already has explained why negotiated risk is unnecessary in the against-facility-advice scenario (*see supra* at 38-42), and subsequently will discuss why the confusion caused by the two scenarios is independent reason for removing negotiated risk from law (*see infra* at 54-56).

This Article's analysis assumes that the 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.²²⁴ In real life, 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. The Article makes its assumptions 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; 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 (#1), assisted living services are of public importance (#2), assisted living facilities offer their services to the general public (#3), and a resident is under the facility's control (#6).

²²³ *Olson v. Molzen*, 558 S.W.2d 429, 432 (Tenn. 1977); *see also* *Porubiansky v. Emory Univ.*, 275 S.E.2d 163, 167-69 (Ga. Ct. App. 1980) (invalidating liability waiver used by dental clinic); *Ash v. New York Univ. Dental Ctr.*, 564 N.Y.S.2d 308, 310 (N.Y. App. Div. 1990) (same); *Smith v. Hosp. Authority of Walker, Dade and Catoosa Counties*, 287 S.E.2d 99, 101-102 (Ga. Ct. App. 1981) (invalidating liability waiver signed by blood donor); *Meiman v. Rehabilitation Ctr., Inc.*, 444 S.W.2d 78, 80 (Ky. Ct. App. 1969) (invalidating liability waiver related to broken leg suffered during physical therapy).

²²⁴ 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.").

If a negotiated risk agreement waives a facility's liability for the facility's potential inability to meet a resident's needs – the inadequate-care scenario – the remaining factors (#4 and #5) are also likely met. Most probably, the resident would have little real ability to negotiate different or better terms. As discussed above, courts recognize that health care professionals have the upper hand when negotiating with patients.²²⁵ A court likely would recognize that an assisted living resident could not be expected to refuse a facility's request (or demand) that a negotiated risk agreement be signed.

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 were to sign a liability waiver in return for the facility allowing her to eat chocolate desserts. Factors 1, 2, 3 and 6 are met because the waiver is signed in the context of assisted living care; factors 4 and 5 are met because again the resident will have little real ability to refuse to sign the waiver.²²⁶

In regard to overreaching business practices, assisted living residents are at least as vulnerable as – in fact, likely *more* vulnerable than -- the surgery patients, job applicants, abortion patients, and dental patients whose liability waivers were invalidated in the cases cited above.²²⁷ Assisted living residents rely on the facility for assistance with simple daily necessities such as dressing, eating, and bathing. Once a resident has been admitted, moving to another facility is especially difficult and traumatic.

Stepping back from the six *Tunkl* factors leads to a slightly different perspective but the same result. As discussed, *Tunkl* recognizes that the concept of “public interest” cannot be captured completely in a formula,²²⁸ and some states accordingly follow a “totality of the

²²⁵ See *Olson v. Molzen*, 558 S.W.2d 429, 431 (Tenn. 1977) (“begs the question” to say patient could have gone to another provider); *Porubiansky v. Emory Univ.*, 275 S.E.2d 163, 167-69 (Ga. Ct. App. 1980) (laypersons with little leverage to negotiate with health care professionals).

²²⁶ 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.

²²⁷ See *Tunkl v. Regents of Univ. of Cal.*, 383 P.2d 441 (Cal. 1963) (surgery); *Eelbode v. Chec Medical Centers, Inc.*, 984 P.2d 436 (Wash. Ct. App. 1999) (lifting test for job applicant); *Olson v. Molzen*, 558 S.W.2d 429 (Tenn. 1977) (abortion); *Porubiansky v. Emory Univ.*, 275 S.E.2d 163 (Ga. Ct. App. 1980) (dental care).

²²⁸ See *Tunkl v. Regents of Univ. of Cal.*, 383 P.2d 441, 444 (Cal. 1963).

circumstances” test to determine a violation of public policy.²²⁹ Under such a test, the relevant question can 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 finds, is clearly 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.

b. Addressing Proponents’ Arguments

Even provider attorneys and negotiated risk proponents recognize that negotiated risk agreements may not be enforceable.²³⁰ One provider 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.²³¹

²²⁹ 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).

²³⁰ See, e.g., Kenneth Burgess, *Negotiated Risk Agreements In Assisted Living Communities* 61 (ALFA 1999) (“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.”); Allen Lynch & Sarah Teachworth, *Risky Business: The Enforceability and Use of Negotiated Risk Agreements*, 1 *Seniors Housing & Care Journal* 23 (2002) (“at best, it’s a close call as to whether a [negotiated risk agreement] might violate public policy.”).

²³¹ Paul Gordon, *Assisted Living Admission Agreements: Provisions Essential to Sound Management* 3 (American Ass’n of Homes and Services for the Aging 1999).

Only one negotiated risk defense cites case law in any depth.²³² Ultimately, this defense makes only the limited claim that negotiated risk agreements “are not inherently unenforceable.”²³³ Even this modest claim cannot withstand scrutiny.

For one, the defense argues that negotiated risk “may or may not” involve a service of public importance.²³⁴ 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.

Another portion of the negotiated risk defense is the claim that privately-owned assisted living facilities do not owe a duty to the public at large.²³⁵ This claim is refuted by the many cases that have struck down liability waivers used by a private enterprise.²³⁶

Finally, the defense’s case authority is drawn exclusively – and incongruously – from cases involving extreme and recreational sports.²³⁷ The recreational sports cases concern “scuba

²³² Allen Lynch & Sarah Teachworth, *Risky Business: The Enforceability and Use of Negotiated Risk Agreements*, 1 *Seniors Housing & Care Journal* 3-29 (2002).

²³³ Allen Lynch & Sarah Teachworth, *Risky Business: The Enforceability and Use of Negotiated Risk Agreements*, 1 *Seniors Housing & Care Journal* 24 (2002).

²³⁴ Allen Lynch & Sarah Teachworth, *Risky Business: The Enforceability and Use of Negotiated Risk Agreements*, 1 *Seniors Housing & Care Journal* 23 (2002).

²³⁵ Allen Lynch & Sarah Teachworth, *Risky Business: The Enforceability and Use of Negotiated Risk Agreements*, 1 *Seniors Housing & Care Journal* 23 (2002).

²³⁶ See, e.g., *Cudnik v. William Beaumont Hosp.*, 525 N.W.2d 891, 896 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.” (citation omitted)); *Eelbode v. Chec Medical Centers, Inc.*, 984 P.2d 436 (Wash. Ct. App. 1999) (private physical therapist); *Olson v. Molzen*, 558 S.W.2d 429 (Tenn. 1977) (private osteopath).

²³⁷ The defense’s authors report that they drew their cases from the annotations of two A.L.R. articles. Allen Lynch & Sarah Teachworth, *Risky Business: The Enforceability and Use of Negotiated Risk Agreements*, 1 *Seniors Housing & Care Journal* 19 n.133, 138 (2002); see Michele Meyer McCarthy, *Tort Liability Arising From Skydiving, Parachuting, or Parasailing Accident*, 92 A.L.R.5th 473 (2001); Randy Sutton, *Validity, Construction, and Effect of*

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,²³⁸ 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.²³⁹ 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.²⁴⁰

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.²⁴¹ Presumably the article’s reliance on the sports cases reflects a results-driven analysis – the sports cases are discussed because sports is virtually the only consumer context in which liability waivers are potentially enforceable.²⁴²

At one point, the defense 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.”²⁴³ Again, the defense’s claim is not supportable. The defense’s “established public

Agreement Exempting Operator of Amusement Facility from Liability for Personal Injury or Death of Patron, 54 A.L.R.5th 513 (1997).

²³⁸ Allen Lynch & Sarah Teachworth, *Risky Business: The Enforceability and Use of Negotiated Risk Agreements*, 1 Seniors Housing & Care Journal 21 (2002).

²³⁹ Allen Lynch & Sarah Teachworth, *Risky Business: The Enforceability and Use of Negotiated Risk Agreements*, 1 Seniors Housing & Care Journal 21 (2002).

²⁴⁰ Allen Lynch & Sarah Teachworth, *Risky Business: The Enforceability and Use of Negotiated Risk Agreements*, 1 Seniors Housing & Care Journal 23-24 (2002).

²⁴¹ Allen Lynch & Sarah Teachworth, *Risky Business: The Enforceability and Use of Negotiated Risk Agreements*, 1 Seniors Housing & Care Journal 19 (2002).

²⁴² 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.”).

²⁴³ Allen Lynch & Sarah Teachworth, *Risky Business: The Enforceability and Use of Negotiated Risk Agreements*, 1 Seniors Housing & Care Journal 23 (2002) (emphasis in original).

policy” is societal disapproval of disability-based discrimination,²⁴⁴ which is not equivalent to approval of negotiated risk. True maximization of resident choice would allow resident choices to be made without any 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.²⁴⁵

The best example of this confusion is state negotiated risk laws. As discussed above (*see supra* at 17-35), state law is both ambiguous and inconsistent in its treatment of negotiated risk. Depending on the state, a negotiated risk agreement may be used to resolve disputes or instead to plan care. The agreement may be designed to reduce the resident’s risk or, on the other hand, to consent to inadequate care. In some states, negotiated risk law leaves open the possibility of a liability waiver, whereas in other states the law explicitly bars 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 is becoming well-established.²⁴⁶ A provider attorney states: “Adding 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.”²⁴⁷ Other provider attorneys cite the use of negotiated risk in state law as “a telling sign that [negotiated risk agreements] are coming of age.”²⁴⁸ In a health care newsletter, a law firm

²⁴⁴ In the article defending negotiated risk, the endnote for the asserted “established public policy” contains one citation – *Olmstead v. L.C.*, 527 U.S. 581 (1999), the Supreme Court case holding that the Americans with Disabilities Act requires state programs to develop adequate non-institutional placements for individuals with disabilities.

²⁴⁵ *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 n.362 (2004) (discussing negotiated risk without distinguishing between inadequate care scenario and against-facility-advice scenario).

²⁴⁶ *See, e.g.*, Robert L. Kane & Rosalie A. Kane, *What Older People Want from Long-Term Care, and How They Can Get It*, Health Affairs, Nov.- Dec. 2001, at 114, 125.

²⁴⁷ Kenneth Burgess, *Negotiated Risk Agreements In Assisted Living Communities* 22-23 (ALFA 1999).

²⁴⁸ Allen Lynch & Sarah Teachworth, *Risky Business: The Enforceability and Use of Negotiated Risk Agreements*, 1 Seniors Housing & Care Journal 9 (2002).

reports 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.”²⁴⁹

A related argument points out that negotiated risk agreements have not been banned. In the words of one article:

While 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.²⁵⁰

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.²⁵¹

This Article recommends abandoning the terms “negotiated risk,” “shared responsibility,” and “managed risk.” If assisted living providers 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 (*see supra* at 38-41), a nursing home resident already has the right to act against facility advice, and to do so without waiving any rights. By relying on the against-facility-advice scenario, however, negotiated risk proponents have weakened the decision-

²⁴⁹ Duane Morris LLP, *Limiting Liability in Assisted Living Residences*, Healthcare Review, Spring 2004, at 4, available at www.duanemorris.com/newsletters/static/HCnewsletter_4.04.pdf (viewed on June 21, 2006); *see also* Michael Anderson, *Inside the Residency Agreement*, Assisted Living Today, July/Aug. 2003, at 56 (claiming without authority that negotiated risk agreements are “increasingly popular”); Michael Anderson, *Contract Negotiations*, Assisted Living Today, July/Aug. 2004, at 71 (again, claiming without authority that negotiated risk agreements are “increasingly popular”); Kenneth L. Burgess, *Negotiated Risk Agreements – One Year Later*, Assisted Living Today, Nov./Dec. 2001, at 35 (“States increasingly embrace negotiated risk concepts in regulations.”).

²⁵⁰ Keren Brown Wilson et al., *Negotiated Risk Agreements: Opportunity or Exploitation?*, Ethics, L., and Aging Rev., vol. 7, at 59, 71 (2001).

²⁵¹ *See* Robert Jenkins et al., A Study of Negotiated Risk Agreements in Assisted Living: Final Report, U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy 25-40 (2006) (limited empirical knowledge regarding negotiated risk agreements).

making rights of assisted living residents. 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 in order 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.²⁵²

X. 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 of course 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 – 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

²⁵² See, e.g., 42 U.S.C. §§ 1395i-3(b)(2), 1396r(b)(2) (care planning in nursing homes); 42 C.F.R. § 483.20(k)(2) (same); Ala. Admin. Code r. 420-5-4-.05(3)(g)(24) (care planning in assisted living facilities); S.C. Code Regs. § 61-84-703 (same).

the variations include such important matters as the type of residents, the level of health care provided, and the qualifications of staff members.²⁵³ In coming years, assisted living policy development will require careful examination of state policies and their consequences. That 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.

²⁵³ Eric Carlson, National Senior Citizens Law Center, *Critical Issues in Assisted Living* 13-16, 25-32, 53-61 (2005).