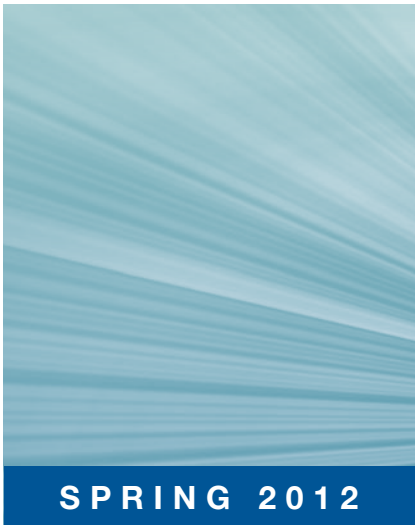
SPECIAL ISSUE

# brief




# Demystifying Advance Directives

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# DEMYSTIFYING ADVANCE DIRECTIVES

This *Special Issue Brief* provides an overview of advance directives and how to recognize and respond to them in a long term care setting. This *Brief* is intended to provide general information only and is not intended to constitute legal advice applicable to any particular situation, nor is it a substitute for obtaining individualized legal advice. Because state laws vary significantly with regard to their requirements for preparing effective advance directives, as well as the procedures for implementing their instructions, community policies and procedures regarding advance directives should be drafted and implemented in accordance with the specific state laws that apply to your community.[1]

## Introduction

Individual wishes about end-of life treatment may vary based on personal philosophy and attitudes towards life and death; they may also be affected by education, culture and religion. Educational and language barriers may be a significant impediment to expressing one's wishes verbally at the most critical moments, even for individuals who are still competent to make decisions.

For this reason, many states allow residents to express their wishes in writing, in legally enforceable documents called "advance directives," some of which are also referred to as "living wills." A "living will" is a document that an individual signs while he or she is still "competent," providing future direction to families and health care providers about the types of care the individual would like to receive (or not receive) when the individual no longer has the "capacity" to speak for him or herself.[2] According to data from the 2004 National Nursing Home Survey and the 2007 National Home and Hospice Care Survey, 65% of nursing home residents and 88% of discharged hospice care patients had at least one advance directive on record.

[1] This *Brief* does *not* cover the subject of physician assisted suicide, which is banned in all states except Washington and Oregon; nor does it address psychiatric advance directives (i.e., documents that direct psychiatric care in anticipation of a future state of incapacity) or a person's right to refuse psychiatric care.

[2] "Competency" is the mental ability to understand problems and make decisions. Black's Law Dictionary 322 (9th ed. 2009). A basic definition of the word "capacity" is the mental ability to understand the nature and effect of one's acts. Black's Law Dictionary 235 (9th ed. 2009).

Clearly, not all residents of seniors housing will have advance directives. Moreover, even when there is a living will, you must also be aware of other legally authorized potential sources of consent for a resident who lacks capacity:

1. Attorneys in fact (also called "agents") under durable powers of attorney ("DPOAs") for health care decisions;

2. Guardians (referred to as "conservators" in some states) appointed by the court; and

3. Persons authorized by state law to grant substitute consent on behalf of a resident (also referred to as "surrogates" or "proxies").[3]

Most states do not require any particular form for advance directives, although many states offer forms that can be used to demonstrate compliance with all the elements of that state's laws. Accordingly, there is a great deal of variation in the types of documents that residents or their families may present to you.

Like any legal document, advance directives may be subject to differing interpretations and conflicting opinions by family members faced with difficult health care or end-of-life decisions about their loved ones. In these situations, staff at the community level should be trained to spot issues and bring them to the attention of legal counsel for resolution, rather than attempt to interpret on their own.

## Advance Directives

"Advance directives" is an umbrella term that describes many types of documents and directives. They can generally be broken up into two types:

1. Those that are intended to *directly instruct* medical personnel and first responders in case the individual is incapacitated (these are the type of advance directives that are often referred to as "living wills"); and

2. Those that are intended to *empower another person to instruct* medical personnel and first responders in case the individual is incapacitated. These documents are often referred to as Powers of Attorney ("POAs") or Durable Powers of Attorney ("DPOAs"). Sometimes the person who is authorized under these types of documents is also called the "POA" or "DPOA."

[3] Some states include "state registered domestic partners" in the list of those authorized to give substitute consent. In Washington, for example, the persons authorized to provide informed consent to healthcare on behalf of an incapacitated patient are, in order of priority: "(i) [t]he appointed guardian of the patient, if any; (ii) [t]he individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions; (iii) [t]he patient's spouse or state registered domestic partner; (iv) [c]hildren of the patient who are at least eighteen years of age; (v) [p]arents of the patient; and (vi) [a]dult brothers and sisters of the patient." States often require that all available persons within a given class must agree with the decision to consent or refuse consent, and that if anyone of a "higher" class has refused consent, no one of a "lower" class may authorize it. Revised Code of Washington ("RCW") 7.70.065.

These two general types of documents complement each other and are not mutually exclusive. Most residents will have both a POA and a living will, because the POA identifies the person who is authorized to serve as a substitute or "surrogate" decision maker for the resident, while the "living will" is designed to describe an individual's preferences with regard to life sustaining treatment as he or she reaches the end of life.[4]

States vary in the type of directives they authorize, and the levels of incapacity that trigger them. All states with living will statutes (sometimes referred to as "Natural Death Acts") allow a competent person who is in a terminal condition to communicate preferences regarding life-sustaining treatment; some also allow this when the person is permanently unconscious, in a coma, or in a persistent vegetative state.[5]

## Learning Which of Your Residents Has an Advance Directive

Federal law and the laws of your state may require that you ask all of your residents whether they have advance directives, and that you add any such directives to the resident's medical record. In addition, pursuant to federal law, "hospitals, skilled nursing facilities, home health agencies, and hospice programs" that receive federal funding are required to comply with certain requirements relating to maintaining written policies and procedures regarding advance directives.[6] Clinics, public health agencies and rehabilitation agencies are also subject to these requirements. The federal law imposes on these facilities an obligation to maintain written policies and procedures with respect to all adult individuals receiving medical care by or through them to provide written information regarding rights and policies with respect to informed consent and substitute decision making. Facilities may not decline to provide services based on the existence or nonexistence of a DPOA.[7]

## Living Wills

Ideally, a living will contain both broad language to give a general idea of the resident's wishes, attitudes and beliefs, and specific references to concrete scenarios that the resident has thought about in advance and would like to provide precise instructions for. Some living wills may contain language about feelings. "Soft" language is used so that the resident's caregivers and substitute decision makers can understand the resident's general philosophy and wishes for his long term care, helping them to put themselves in his shoes and better answer the question: "*What*

[4] A third type of document is written by a doctor in consultation with the patient and is commonly referred to as a medical (or physician's) order for life sustaining treatment (MOLST or POLST). These physicians' orders are generally intended to provide medical guidance on implementation of an advance directive.

[5] *See, e.g.*, Ohio Rev. Code § 2133.02 (2011); Ga. Code § 31-32-2 (2011).

[6] 42 USC § 1395cc (a)(1)(Q) (2010).

*would the resident do if he were faced with this question now"?* Underscoring the usefulness of broad language in living wills and proxy documents, Oklahoma includes a requirement that life-sustaining treatment decisions made on behalf of an individual (called the "declarant" under Oklahoma law) must be:

> . . . based on the known intentions, personal views and best interests of the declarant. If evidence of the declarant's wishes is sufficient, those wishes shall control. If there is not sufficient evidence of the wishes of the declarant, the decisions shall be based on the reasonable judgment of the individual so deciding about the values of the declarant and what the wishes of the declarant would be based upon those values.[8]

Although that test is not included in all state laws, courts often use similar language to describe the duty of a guardian, attorney in fact or other substitute decision maker.

Scenario-based "instructional" directives that aim for specificity may not cover every situation. It is common to see specific directives in cases of patients that have already been diagnosed with a condition or disease and who know that they want or do not want a particular treatment to be administered should their condition worsen. For example, a patient that suffers from end-stage cancer may choose to refuse antibiotics to treat a secondary infection, seeing them as simply a way of prolonging the inevitable.

"General" directives that speak in broad, sweeping terms usually allow for a much greater degree of freedom of interpretation by medical staff. Directives such as "no extraordinary measures" and instructions not to "prolong life" fall within this category. The advantage for medical professionals is that such a document will give them a general idea of the resident's wishes, but will also give them the freedom to operate according to their professional judgment while staying true to those wishes. Some general directives will be fairly straightforward, such as "do not intubate" and "do not hospitalize" orders, or directives declining surgery or drugs. A disadvantage of general directives, however, is that they may sometimes be too general, and family or friends may attempt to substitute their own judgment for that of the resident.

It is important to keep in mind that directives will vary greatly, and that a directive does not need to *sound* "legal" to *be* legally enforceable. For example, a living will might say "If I'm sick, I don't want anyone to try to make me better." Although this language may sound too vague to be enforceable, it is possible that a court would decide that it constitutes a legally enforceable living will.[9]

[7] 42 USC § 1395cc (f) (2010).

[8] Okla. Stat. tit. 63, § 3101.16 (2011).

[9] Washington's Natural Death Act, for example, states that "[a]ny person or health facility may assume that a directive complies with this chapter and is valid." RCW 70.122.120 (2011).

## Requirements of a Valid Living Will

Advance directives must be in writing, signed by a resident who had capacity to do so at the time of signing, and dated. Several states allow a resident who is too weak to sign, but is still mentally competent to direct someone else to sign the document.[10]

A minority of states mandate that specific statutorily-prescribed[11] forms be used for advance directives to be valid; however, the majority of states require only that advance directives be in a form that is substantially similar to that prescribed by statute. Some states have no such requirements.

Most states require at least one person to serve as witness to the resident's signature, with a majority of states requiring two witnesses. An attending physician, employees of the attending physician, and employees of the health facility in which the resident resides generally cannot act as witnesses, though that may vary from state to state. Family members are able to act as witnesses only in some states,[12] and many states prohibit individuals from acting as witnesses if they stand to inherit from the resident's death or if they are financially responsible for the cost of the resident's care.[13]

There is a wide variation among states regarding specific requirements of a valid advance directive. For example, some states require advance directive documents to be notarized; others do not. Some states require that a resident give a copy of his living will to his attending physician before the document will become operative.[14] Some states may, or may not, recognize advance directives executed in a different state or country.[15]

## Do Not Resuscitate/DNR Orders

DNR orders are among the most common types of advance directives. Unlike most other advance directives, DNRs are very narrow in scope: their purpose is to allow a person to decline cardio-pulmonary resuscitation ("CPR"). CPR measures may include defibrillation, using medications to stimulate the heart, using a mechanical pump to drive circulation, endotracheal intubation and using a mechanical ventilator.

[10] For example, Rhode Island allows signature by either the declarant (the resident) "or another at the declarant's direction." R.I. Gen. Laws § 23-4.11.3(a) (2010).

[11] *See infra* Appendix 1 (identifying applicable state laws and regulations, believed to be current as of September 1, 2011).

[12] For example, Florida requires that "[a]t least one person who acts as a witness shall be neither the principal's spouse nor blood relative." Fla. Stat. § 765.202(2) (2010).

[13] *See, e.g.*, Wis. Stat § 154.03(1)(b) and (c) (2011).

[14] At least three states impose special requirements when advance directives are executed in long term care facilities. California and Delaware require that one of the witnesses be a patient advocate or ombudsman, *see* Cal. Prob. Code § 4675; Del. Code tit. 16 § 2511(b) (2010); and Vermont requires that an ombudsman, a recognized member of the clergy, an attorney licensed to practice in Vermont, or a designee sign a statement affirming that he or she has explained the nature and effect of the advance directive to the resident, *see* Vt. Stat. tit. 18 § 9703(d) (2009).

[15] For example, Connecticut will respect "[h]ealth care instructions or appointment of a health care proxy executed under the laws of another state in compliance with the laws of that state or the state of Connecticut, and which are not contrary to the public policy of this state." Similar but not identical rules apply in the case of a directive executed in a foreign country. Conn. Gen. Stat. § 19a-580g (2011).

Because community staff will likely be trained in CPR and have automated defibrillators on site, it is important to be aware of state law regarding any DNR orders. California, for example, allows residential care facilities for seniors to keep automated defibrillators on site only if DNRs are observed.[16] Therefore, communities should create and train all appropriate staff regarding legally required protocols.

Most states authorize DNRs, whether as part of living wills or as separate documents. Some states allow doctors to issue DNRs as well.[17] DNRs are often subject to similar execution requirements as other advance directives, including signature by the individual, witness requirements, and sometimes signature by the resident's doctor.

While in most states DNRs go into effect as soon as they are executed, other states require a finding that CPR would be futile, would place an extraordinary burden on the resident, or that the resident is in a terminal condition before the DNR becomes effective.[18]

Revocation requirements for DNRs are similar to those for other advance directives, including destruction, oral or written revocation, and manifesting a general intent to revoke, depending on the state. Some states also allow guardians or other substitute decision makers to revoke a DNR.[19]

A person's DNR will usually be noted in the resident's medical record (several states require this), but it is also not uncommon for people with DNRs to carry "DNR identifiers," such as wallet cards, necklaces or bracelets to inform first responders of their DNR status.[20] However, respect for resident rights will limit a community's ability to require (rather than suggest) that a resident carry or wear an identifier.

Some states excuse doctors who refuse to comply with DNRs, as long as they make a reasonable effort to transfer the patient to another facility that will comply with the order;[21] however, many state laws require healthcare facilities, emergency medical staff, and healthcare providers other than doctors to comply with DNRs.[22] Many states protect facilities and staff from liability for complying with a DNR; state laws also exist that protect those who resuscitate a resident who had a DNR, if there was a good faith belief that the resident did not have a standing DNR.

There are, of course, many reasons why a person may choose not to execute a DNR. For example, a resident may know that she is likely to die in six months, but still wants CPR to prevent choking to death on a chicken bone. Once a person has been resuscitated, a DNR has no effect on further treatment. For example, if paramedics resuscitate a person with a DNR because they are not made aware of the DNR, doctors will attend to that patient as they normally would, unless other advance directives are in place.

[16] Cal. Code Regs. tit. 22 § 87607 (2011).

[17] *See, e.g.*, W. Va. Code § 16-30C-6 (2010).

[18] *See, e.g.*, N.Y. Pub. Health Law § 2965(3)(c) (2011).

[19] *See, e.g.*, Colo. Rev. Stat. § 15-18.6-107 (2010).

[20] *See, e.g.*, Kan. Admin. Regs. § 109-14-1 (2011) (setting forth specific requirements for organizations that distribute DNR identifiers).

[21] *See, e.g.*, Miss. Code § 41-41-215 (2011).

[22] *See, e.g.*, Ark. Code § 20-13-904(a) (2011); Colo. Rev. Stat. § 15-18.6-104 (2010).

## Some Other Common Subjects of Advance Directives

In addition to DNR Orders, as described above, the following are some of the other situations commonly covered by advance directives. This list is not exhaustive, but it provides an idea of the potential complexity of some advance directive documents. It is important to note that advance directives are just as important to determine what a resident *wants* as they are to determine what a resident *does not want*. Directives may include:

- General restrictions on treatment, such as refusing medical treatment altogether, refusing hospitalization, claiming the right to die at home, orders to withdraw all treatment under certain circumstances (such as specific types of injuries, or upon a catastrophic injury), refusing medicine or drugs generally (or refusing specific drugs), refusing surgery (or certain specific procedures);

- Measures to prolong life (or to prolong the moment of death when a physician has determined that death is imminent), such as life support, use of artificial or radical means, and taking extraordinary, heroic or extreme measures;

- Measures to take when there is no reasonable expectation of recovery, when the resident is in a coma or persistent vegetative state, has suffered irreversible substantial brain damage or brain death, or a loss of cognitive function, disability or incapacitation that the resident considers unacceptable;[23] and

- Measures to take with regard to residents whose treatment extends for a more prolonged period than immediate emergency treatment, such as the resident's wishes with regards to pain management,[24] merciful treatment and comfort, dependency and deterioration, wishes of a resident with an incurable or terminal disease or condition, acceptable quality of life, refusing hospice or palliative care, refusing sustenance,[25] and refusing to be connected to a ventilator or artificial lung, or to receive any sort of respiratory support.

More uncommon directives may require that a resident's cardiac implantable electrical device (pacemaker) be disabled upon certain events, refuse dialysis, and refuse chemotherapy. Many advance directives will also provide instructions for organ and tissue donation.

[23] An advance directive may say something like "if I am in a state where I will never regain the ability to make decisions and express my wishes, or if I will never be restored to a conscious, sapient state, then I want the following…"

[24] A directive may say things like "I want to be lucid, even if it means I may be in pain" or "I want to not be in pain, even if it means I will be less lucid."

[25] "Sustenance" usually refers to artificially-administered feeding and fluids, which may include refusal of food, hydration or nutrition generally, as well as specific mentions to feeding tubes or serum. Assisted feeding is not the same as a feeding tube, but may fall within the definition of "sustenance."

## Durable Powers of Attorney ("DPOAs")

DPOAs give a third party the authority to make healthcare decisions on behalf of an incapacitated resident. The person with authority may be referred to as a healthcare proxy or agent, patient advocate, attorney-in-fact, or surrogate.[26] It is very important to note that not every "power of attorney" is a *healthcare* power of attorney. Indeed, a DPOA may cover only financial or business affairs, while providing no authority at all with regard to medical or care decisions. All states have laws authorizing healthcare powers of attorney. In some cases, the person with authority may not even be aware that he has been appointed as such. There is generally no legal duty to accept the appointment; however, once a person assumes the role of proxy, he may have several duties, which may include acting in good faith, acting in accordance with the resident's wishes, and acting in the resident's best interest.[27]

A proxy's powers will generally include the authority to speak for and make decisions on behalf of the resident, but these powers can generally be as broad or as limited as the resident makes them, subject to the applicable law in each state.[28] A DPOA may, or may not, authorize the agent to place an individual in a facility against his or her will, depending on applicable state law. Some healthcare proxy documents will designate more than one healthcare agent, in case the first choice is unavailable or unwilling to act as agent. Medical powers of attorney may include a provision giving the proxy access to the resident's medical records.[29] Most states place restrictions on the appointment of a healthcare agent.[30] By presidential order, healthcare agents have the same visitation privileges as family members.[31]

## Triggering the Effectiveness of a DPOA

Most DPOAs become effective when the resident loses his or her capacity to make his or her own decisions, though a few states require that the resident be in a state of permanent unconsciousness or in a terminal condition in order to activate a DPOA. Some states allow the determination to be made by the resident's primary or attend-

[26] Some of these terms may also have alternate legal meanings or significance; your staff should be trained to consult with counsel if there is any concern or ambiguity about a DPOA document.

[27] *See e.g.*, Ariz. Rev. Stat. § 36-3203(c) (2011).

[28] For example, Wisconsin places restrictions on a healthcare agent's authority to admit the resident into a nursing home, see Wis. Stat. § 155.20(2)(c) (2011), and some states do not allow the healthcare agent to make the decision to withdraw nutrition or hydration unless it is specifically provided for in the power of attorney document or certain other conditions are met, see, e.g., S.D. Codified Laws § 59-7-2.7 (2011) (where the power of attorney does not specifically grant an agent the power to authorize removal of artificial hydration and nutrition, the agent may authorize it if one of the following exist: if the patient's death is imminent and it is not needed for comfort care or the relief of pain, if it cannot be physically assimilated by the resident, if the burden of providing it outweighs its benefit, or if there is clear and convincing evidence that the resident expressed the desire that artificial nutrition or hydration be withheld, or refused artificial nutrition or hydration prior to the loss of decisional capacity).

[29] *See, e.g.*, Ind. Code § 30-5-7-5 (2011).

[30] For example, most states do not permit healthcare agents to act as witnesses to the documents on which they are appointed, and several states specifically prohibit physicians or healthcare providers directly involved in the resident's care, see, e.g., Ga. Code § 31-32-5 (2011); or employees of the facility where the resident is being treated to be appointed as healthcare agents, see, e.g., Haw. Rev. Stat. § 327E-3(b) (2010); though some states make exceptions where the employee is also a relative of the resident, see, e.g., N.D. Cent. Code § 23-06.5-04 (2011).

[31] Memorandum on Respecting the Rights of Hospital Patients to Receive Visitors and to Designate Surrogate Decision Makers for Medical Emergencies, 75 Fed. Reg. 20511 (Apr. 15, 2010).

ing physician,[32] while others require that the decision be made by two doctors or in concert with a specialist[33] or a psychiatrist or psychologist[34]. Some states have the same capacity requirements for triggering healthcare proxies and living wills, while others have separate statutes and requirements for each.

In Delaware, as well as several other states, "[a] decree of annulment, divorce, dissolution of marriage or a filing of a petition for divorce revokes a previous designation of a spouse as an agent unless otherwise specified in the decree or in a power of attorney for health care."[35]

A court appointed guardian "of the person" generally has priority over the decisions of an agent under a DPOA, but that is not always the case. Again, when faced with a conflict between potential decision makers, or if it is unclear whether a particular person is authorized to make healthcare decisions, consult your attorney.

## Declining to Participate in the Directions Contained in an Advance Directive

The laws of an individual state may protect your community (or any individual member of your staff) if participation in following a resident's advance directive would violate religious or ideological beliefs.[36] For example, if your community's policy is *not* to participate in compliance with certain advance directives, federal law and the laws of your state may require that you disclose this fact to all residents of your community, as well as to potential residents before providing any services.[37]

## Revocation of an Advance Directive

In many states, the requirements for *executing* an effective advance directive *are different than* the requirements for *revoking* an advance directive. This might mean that a resident with diminished capacity can nonetheless effectively revoke an advance directive, even if he would not have the power to execute an advance directive in his current condition.[38] While the word "revoke" appears to denote a very formal, structured process, in reality most states' statutes

[32] *See, e.g.*, Cal. Prob. Code § 4658 (2010).

[33] *See, e.g.*, Mass. Gen. Laws ch. 201D, § 6 (2011).

[34] *See, e.g.*, Mich. Comp, Laws § 700.5508 (2011).

[35] Del. Code tit 16 § 2504(d) (2011).

[36] *See, e.g.*, RCW 70.122.060(4) (2011) (certain healthcare professionals may not be required to participate in withholding life sustaining treatment if they object to so doing); Mo. Rev. Stat. § 404.830 (2010) ("1. No physician, nurse, or other individual who is a health care provider or an employee of a health care facility shall be required to honor a health care decision of an attorney in fact if that decision is contrary to the individual's religious beliefs, or sincerely held moral convictions. 2. No hospital, nursing facility, residential care facility, or other health care facility shall be required to honor a health care decision of an attorney in fact if that decision is contrary to the hospital's or facility's institutional policy based on religious beliefs or sincerely held moral convictions unless the hospital or facility received a copy of the durable power of attorney for health care prior to commencing the current series of treatments or current confinement…").

[37] *See, e.g.*, Alaska Admin. Code tit. 7, §§ 12.320 (2010).

[38] *Compare* Mont. Code Ann. § 50-9-104(1) (2009) (a declarant may revoke a declaration at any time and in any manner), *with* Mont. Code Ann. § 50-9-103(1) (2009) (an individual must be of sound mind to execute advance directives).

are very liberal in allowing revocation of standing advance directives. For example, Colorado law provides that "[a] declaration may be revoked by the declarant orally, in writing, or by burning, tearing, cancelling, obliterating, or destroying said declaration."[39] Once revoked, a directive is not generally effective unless a new directive is executed.

Some states' laws are silent on the subject of capacity requirements for revoking standing directives, which likely means that in those states, directives can be revoked without regard for capacity. Other states specifically provide that directives may be withdrawn without regard to the resident's mental or physical condition.[40] A terminal resident with dementia who explicitly refused hydration in his living will may ask for water, and in many states this would be considered a valid revocation of that particular directive.

## Good Faith Compliance

Many states provide that a facility that follows a resident's advance directives in good faith and without acting negligently will not be liable if that document turns out to have been invalid. "Good faith" can often mean that, to the best of the employee's or the facility's knowledge, the document was valid and in force at the time that it was followed, and had not been superseded, revoked or modified. Using a "reasonable basis" standard, the good faith protection from liability would not exist if the employee or facility had reason to believe, or *should have known,* that a document is not valid or had been revoked or superseded.

## Recommended Best Practices

1. Communities should have clear policies in place regarding advance directives, particularly with regard to living wills or other directives that address emergency or end-of-life treatment and care. All appropriate staff should be trained with regard to the community's policies and the policies should be communicated to all current and prospective residents, particularly if your community has a policy of *not* following certain kinds of directives.[41] Make sure your policies address applicable confidentiality requirements and comply with all other statutory requirements.[42]

[39] Colo. Rev. Stat. § 15-18-109 (2010).

[40] *See, e.g.*, Neb. Rev. Stat. § 20-406 (2011); RCW 70.122.040(1) ("A directive may be revoked at any time by the declarer, without regard to the declarer's physical or mental state or competency, . . . .")

[41] Your state may also require that your community keep written policies and procedures regarding advance directives and provide copies of both your policies and of applicable state laws to your residents, *see, e.g.*, Ala. Admin. Code r. 420-5-10-.05 and 560-X-37.01 (2011); Arizona requires that assisted living facilities provide residents with the current phone number of an entity that provides information about healthcare directives, *see* Ariz. Admin. Code § R9-10-710(A)(3)(g) (2011); New York publishes a pamphlet that contains information and forms regarding the appointment of a healthcare agent and requires that it be distributed to hospital patients, *see* N.Y. Comp. Codes R. & Regs. tit. 10, § 700.5 (2011).

[42] For example, notwithstanding any directives to the contrary, it is illegal in most states to withhold treatment from a resident who is pregnant. Ohio law, for example, says that "[a]n attorney in fact under a durable power of attorney for health care does not have authority to refuse or withdraw informed consent to health care for a principal who is pregnant if the refusal or withdrawal of the health care would terminate the pregnancy, unless the pregnancy or the health care would pose a substantial risk to the life of the principal, or unless the principal's attending physician and at least one other physician who has examined the principal determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive." Ohio Rev. Code §§ 1337.13(D) (2011).

2. Prior to move-in, staff should determine whether the resident has advance directives, and of what type. Copies of the resident's most current directives, such as Powers of Attorney, DNRs or living wills, should be placed in the resident's record and available to the appropriate staff. Please be aware that some state laws expressly prohibit you from requiring residents to execute advance directives as a condition for admission to your community,[43] and even encouraging residents to execute advance directives may be considered a violation of state law. Some states also prohibit you from requiring residents who *do* have advance directives to execute new directives in a different form as a requirement for admission.

3. Be familiar with your state's records retention laws regarding advance directives.[44]

4. Train your employees to know where advance directives are filed and how to access them in case of emergency. Develop and follow a policy regarding posting of DNR directives.

5. Follow up on concerns that a particular directive was not validly executed, is not a current expression of the resident's intentions, or has been revoked. Failure to do so may result in losing a defense of "good faith" if there is a later dispute.

6. As appropriate, community staff should consult legal counsel in cases where questions arise regarding the meaning or effectiveness of a particular living will or Power of Attorney, or whether a particular family member or other individual is authorized to make decisions for a resident.[45]

[43] *See, e.g.*, Fla. Admin. Code r. 59A-12.013 (2010).

[44] For example, Alabama mandates that "[f]or each resident an assisted living facility shall maintain on its premises [...] any Advance Directive that has been executed by the resident. [...] The resident records shall be retained for a period of not less than three years after the resident is discharged or dies." Ala. Admin. Code r. 420-5-4.05 (2011).

[45] New York law, for example, states that "[n]otwithstanding a determination […] that the principal lacks capacity to make health care decisions, where a principal objects to the determination of incapacity or to a health care decision made by an agent, the principal's objection or decision shall prevail unless the principal is determined by a court of competent jurisdiction to lack capacity to make health care decisions." N.Y. Pub. Health Law § 2983(5) (2011).

# Appendix 1:
# Relevant Advance Directive Statutes and Regulations

The following table is provided solely as a reference and is believed to be current as of September 1, 2011. You should always "double check" to ensure that any policy or form complies with the most current laws of your state, since this table may be incomplete for the particular needs of your community, staff and residents, or may not reflect the most current statutory or regulatory requirements.

| State | Statutes | Regulations |
|---|---|---|
| **Alabama** | Ala. Code ch. 22-8A and § 26-1-2 (2011). | Ala. Admin. Code r. 420-2-1-.02, 420-2-1-.31, 420-2-1 Appendix A, 420-5-4-.04 to .05, 420-5-10-.05, 420-5-19-.01, 420-5-20-.04 to .05, 560-X-28-.01 to .02 and 560-X-37-.01 (2011). |
| **Alaska** | Alaska Stat. ch. 13.52 (2010). | Alaska Admin. Code tit. 7, §§ 12.320, 12.339, 12.349, and ch. 16 (2011). |
| **Arizona** | Ariz. Rev. Stat. §§ 36-859 and 36-3201 to 3297 (2011). | Ariz. Admin. Code §§ R6-6-806, R9-10-703, R9-10-710, R9-10-714, R9-10-901, R9-10-904, R9-10-907, R9-10-908, R9-10-913 and R9-10-919 (2011). |
| **Arkansas** | Ark. Code §§ 20-13-104, 20-13-904, 20-17-201 to 218 and 20-17-1221 (2011). | Ark Code R. §§ 007.28.6 (2011). |
| **California** | Cal. Prob. Code §§ 4600 to 4806 (2010). | Cal. Code Regs. tit. 22, §§ 74743, 85001, 87101, 87469, 87607, 87633, 87801, 87822, 87870 (2011). |
| **Colorado** | Colo. Rev. Stat. §§ 12-34-121, 15-14-500.3 to 509, and 15-18-101 to 15-18.7-110 (2010). | 6 Colo. Code Regs. §§ 1015-2, 9 Colo. Code Regs. § 2503-1:3.734, and 10 Colo. Code Regs. §§ 2505-10:8.130, 2505-10:8.487 and 2505-10:8.491 (2011). |
| **Connecticut** | Conn. Gen. Stat. §§ 1-56r, 1-56h, 19a-570 to 580g and 45a-562 (2011). | Conn. Agencies Regs. §§ 19-13-D105, 19a-580d-1 to 9 (2011). |
| **Delaware** | Del. Code tit. 16, ch. 25 (2011). | 16 Del. Admin. Code §§ 3201-2.0, 3201-9.0, 3225-5.0, 4304 and 4304-1.0 to 12.0 (2011). |
| **District of Columbia** | D.C. Code §§ 7-621 to 630 and 21-2201 to 2213 (2011). | D.C. Mun. Regs. tit. 22-A, §§ 102, 105, 199 and 3909 (2011). |
| **Florida** | Fla. Stat. § 744.3115 and ch. 765 (2010). | Fla. Admin. Code r. 58A-2.0232, 59A-12.013, 59A-3.254, 59A-4.106, 59A-8.0245, 64B8-9.016, 64E-2.031, 65E-5.130, 65E-5.170 and 65E-5.2301 (2010). |
| **Georgia** | Ga. Code §§ 29-4-18, 31-32-1 to 14 and 31-39-1 to 9 (2011). | Ga. Comp. R. & Regs. 290-9-7-.10, 290-9-7-.19, 290-9-9-.07, 290-9-37-.18 and 290-9-43-.16 (2011). |

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| **Hawaii** | Haw. Rev. Stat. ch. 327E and 551D (2010). | Haw. Code R. § 17-1736-16 (2010). |
| **Idaho** | Idaho Code §§ 39-3422 and 39-4501 to 4515 (2011). | Idaho Admin. Code r. 15.01.01.040, 16.02.03.400, 16.03.07.020, 16.03.09.235 and 16.03.22.220 (2011). |
| **Illinois** | 755 Ill. Comp. Stat. 35 / 1 to 10 and 45 / 1-1 to 4-12, and (2011). | Ill. Admin. Code tit. 77, §§ 280.4040, 295.7000, 300.1035, 330.1125, 340.1540, 350.1235, 385.1500, 390.1025 and 515.380, and tit. 89, § 146.215 (2011). |
| **Indiana** | Ind. Code §§ 16-36-4-1 to 21, 30-5-5-16 to 17, 30-5-6-5 and 30-5-7-1 to 4 (2011). | 410 Ind. Admin. Code 16.2-1.1-6, 16.2-3.1-4, 16.2-5-1.2, 16.2-5-8.1, 17-9-3 and 17-12-3 (2011). |
| **Iowa** | Iowa Code § 142C.12B, and ch. 144A and 144B (2011). | Iowa Admin. Code r. 441-79.12(249A), 441-81.13(249A), 641-85.1(135), 641-142.1(144A), 641-142.2(144A), 641-142.3(144A,147A), 641-142.4(144A,147A), 641-142.5(144A), 641-142.6(144A), 641-142.7(144A), 641-142.8(144A) and 641-142.9(144A) (2011). |
| **Kansas** | Kan. Stat. §§ 58-625 to 665 and 65-28,101 to 109 (2011). | Kan. Admin. Regs. §§ 26-39-103, 26-41-101, 26-42-101, 26-43-101 and 109-14-1 (2011). |
| **Kentucky** | Ky. Rev. Stat. §§ 311.621 to 641 (2011). | 907 Ky. Admin. Regs. 1:672 (2011). |
| **Louisiana** | La. Rev. Stat. §§ 40:1299.58 to 58.10 and 40:1299.64 to 64.6 (2011). | La. Admin. Code tit. 19, § V.101 (2010). |
| **Maine** | Me. Rev. Stat. tit. 18-A, §§ 5-702 to 923 (2010). | 10-144 Me. Code R. ch. 110, ch. 10, 10-144 Me. Code R. ch. 120, ch. 2, and 14-191 Me. Code R. ch. 3 (2011). |
| **Maryland** | Md. Code, Health-Gen. §§ 5-601 to 626 and Md. Code, Est. & Trusts §§ 17-101 to 116 (2011). | Md. Code Regs. 10.07.09.04, 10.07.09.05, 10.07.09.09, 10.07.09.11 and 10.07.21.21 (2011). |
| **Massachusetts** | Mass. Gen. Laws ch. 201D (2011). | 104 Mass. Code Regs. 27.17, 109 Mass. Code Regs. 11.12, 130 Mass. Code Regs. 450.112 and 651 Mass. Code Regs. 12.05 (2011). |
| **Michigan** | Mich. Comp. Laws §§ 330.1716, 333.1051 to 1067, 333.20192, 333.20919 and 700.5501 to 5520 (2011). | Mich. Admin. Code r. 325.22207 (2011). |
| **Minnesota** | Minn. Stat. ch. 145B and 145C (2010). | Minn. R. 4658.0445, 4668.0810 and 9525.3055 (2010). |
| **Mississippi** | Miss. Code §§ 41-41-201 to 229 (2011). | 25-1 Miss. Code R. § 2:III-4, and 23-1 Miss. Code R. §§ 9:6 and 9 Attachment X (2011). |

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| **Missouri** | Mo. Rev. Stat. §§ 404.800 to 872 and ch. 459 (2010). | Mo. Code Regs. tit. 9, § 10-5.180, and tit. 19, §§ 30-35.010, 30-40.303, 30-40.333, 30-40.600, 30-86.042, 30-88.010 and 50-10.020 (2011). |
| **Montana** | Mont. Code Ann. § 72-17-216 and tit. 50, ch. 9 (2009). | Mont. Admin. R. 37.10.101 to 108, 37.106.2805 and 37.106.2828 (2011). |
| **Nebraska** | Neb. Rev. Stat. §§ 20-401 to 416 and 30-3401 to 3432 (2011). | 175 Neb. Admin. Code ch. 4, § 006, ch. 7, § 006, ch. 9, § 006, ch. 14, § 006, ch. 15, § 006 and ch. 16, § 006, and 471 Neb. Admin. Code ch. 2, § 2-005 (2011). |
| **Nevada** | Nev. Rev. Stat. §§ 162A.200 to 400, 449.600 to 690 and 449.900 to 965 (2009). | Nev. Admin. Code §§ 449.5405, 449.74457, 449.797, 450B.950, 450B.955, 450B.960 and 630.230 (2011). |
| **New Hampshire** | N.H. Rev. Stat. ch. 137-J (2010). | NH ADC HE-W 559.01 to .08 and SAF-C 5922.03 (2011). |
| **New Jersey** | N.J. Stat. §§ 26:2H-53 to 79 (2011). | N.J. Admin. Code §§ 8:36-6.1, 8:39-9.6, 8:39-35.2, 8:43-4.15, 8:43-4.16, 8:43F-3.6, 8:43G-5.2, 8:43G-15.2, 8:85-1.2 and 8:85-1.17, tit. 10, ch. 8, 32 and 48B, §§ 10:49-9.15, 10:52-1.18, 10:53A-2.9, 10:60-1.6, 10:74-5.2, and 15A:3-2.1 to 15A:3 App. A (2011). |
| **New Mexico** | N.M. Stat. §§ 24-6B-21 and 24-7A-1 to 18 (2011). | N.M. Code R. §§ 7.8.2, 7.27.6, 7.28.2 and 8.302.1 (2011). |
| **New York** | N.Y. Mental Hyg. Law § 33.03 and N.Y. Pub. Health Law §§ 2980 to 2994 (2011). | N.Y. Comp. Codes R. & Regs. tit. 10, §§ 400.21, 405.7, 405.43, 415.3, 700.5, 800.90 and 1001.12, and tit. 14, §§ 512.8, 527.6, 527.7, 633.18, 633.20 and 633.99 (2011). |
| **North Carolina** | N.C. Gen. Stat. §§ 32A-15 to 27 and 90-320 to 323 (2010). | 10A N.C. Admin. Code 6R.0501, 6R.0504 and 28E.0103 (2011). |
| **North Dakota** | N.D. Cent. Code ch. 23-06.5 and 23-06.6 (2011). | None |
| **Ohio** | Ohio Rev. Code §§ 1337.11 to 17 and ch. 2133 (2011). | Ohio Admin. Code 3701-17-57, 3701-83-07, and ch. 3701-62 (2011). |
| **Oklahoma** | Okla. Stat. tit. 58, §§ 1071 to 1077, and tit. 63, §§ 3080.1 to 5, 3101.1 to 16 and 3102.1 to 3 (2011). | Okla. Admin. Code §§ 310:661-5-4, 310:667-3-2 and 317:30-3-13 (2011). |
| **Oregon** | Or. Rev. Stat. §§ 127.505 to 127.684 (2009). | Or. Admin. R. 309-040-0410, 333-027-0080, 411-050-0400, 411-050-0444, 411-050-0447 and 411-086-0400 (2011). |
| **Pennsylvania** | 20 Pa. Con. Stat. ch. 54 (2011). | 28 Pa. Code ch. 1051 (2011). |
| **Rhode Island** | R.I. Gen. Laws ch. 23-4.10 (2010). | 31-4 R.I. Code R. § 18:15.0 and 31-5 R.I. Code R. § 12:16.0 (2011). |

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| **South Carolina** | S.C. Code §§ 44-77-10 to 160 and 62-5-501 to 505 (2010). | S.C. Code Regs. 61-7, 61-17, 61-77 and 61-84 (2010). |
| **South Dakota** | S.D. Codified Laws ch. 59-7 and 34-12D, and § 34-26-68 (2011). | S.D. Admin. R. 44:04:17:02, and ch. 44:05:06 (2011). |
| **Tennessee** | Tenn. Code §§ 32-11-101 to 113, 34-6-201 to 218 and 68-30-117 (2011). | Tenn. Comp. R. & Regs. 1200-08-01-.01, 1200-08-01-.07, 1200-08-01-.12, 1200-08-01-.13, 1200-08-01-.15 App. I, 1200-08-06-.01, 1200-08-06-.13,1200-08-06-.16 App. I, 1200-08-11-.01, 1200-08-11-.11, 1200-08-11-.12, 1200-08-11-.14 App. I, 1200-08-15-.01, 1200-08-15-.12, 1200-08-15-.13, 1200-08-15-.15 App. I, 1200-08-25-.02, 1200-08-25-.08, 1200-08-25-.12, 1200-08-25-.14, 1200-08-25-.15, 1200-08-25-.17 App. I, 1200-08-26-.01, 1200-08-26-.12, 1200-08-26-.13, 1200-08-26-.15 App. I, 1200-08-27-.01, 1200-08-27-.12, 1200-08-27-.13, 1200-08-27-.15 App. I, 1200-08-36-.01, 1200-08-36-.09, 1200-08-36-.15, 1200-08-36-.16, and 1200-08-36-.18 App. I (2011). |
| **Texas** | Tex. Health & Safety Code ch. 166 (2009). | 22 Tex. Admin. Code § 193.9, 25 Tex. Admin. Code §§ 125.33, 133.42, 157.25, 405.51 to 63, and 412.175, and 40 Tex. Admin. Code §§ 16.1 to 4, 19.403, 19.419, 19.420, 19.1911, 92.41, 97.283, 97.292, 97.301 and 98.61 (2011). |
| **Utah** | Utah Code §§ 26-28-121 and 75-2a-101 to 125 (2011). | Utah Admin. Code r. R432-31, R432-100, R432-150, R432-270, R432-300 and R539-3 (2011). |
| **Vermont** | Vt. Stat. tit. 18, ch. 231 (2009). | 12-4 Vt. Code R. §§ 200:3, 202:5, 202:6, 203:5, 203:6, and 12-5 Vt. Code R. §§ 15:1 to 15: App. G (2011). |
| **Virginia** | Va. Code §§ 32.1-291.21 and 54.1-2981 to 2996 (2011). | 12 Va. Admin. Code §§ 5-66-10 to 80, 5-381-180, 5-381-230, 5-391-190, 5-391-240, 30-10-130, 30-20-240, 30-50-335, 35-105-750, and 22 Va. Admin. Code §§ 40-60-590, 40-72-380 and 40-72-970 (2011). |
| **Washington** | Wash. Rev. Code ("RCW") ch. 11.94 and 70.122 (2011). | Wash. Admin. Code §§ 182-501-0125, 246-337-075, 246-337-095, 388-71-0744, and 388-97-0220 to 0280 (2011). |
| **West Virginia** | W. Va. Code ch. 16, art. 30 to 30C (2010). | W. Va. Code R. §§ 64-12-4.4.c.3, 64-12-7.2.j.4, 64-13-2.2 and 64-13-4.6 (2011). |
| **Wisconsin** | Wis. Stat. ch. 154 and 155 (2011). | Wis. Admin. Code DHS §§ 83.28, 83.33, 85.15, 125.01 to .05, 131.13, 131.17, 131.19, 131.24 and 131.33 (2011). |
| **Wyoming** | Wyo. Stat. §§ 35-22-201 to 208 and 35-22-401 to 416 (2010). | Wyo. Admin. Code Health CRD ch. 1 to 4, and Wyo. Admin. Code Health EMS ch. 5, § 15 and ch. 10, § 12 (West 2011). |
| **United States** | 10 U.S.C. § 1044c, and 42 U.S.C. §§ 1395i-3, 1395cc, 1396a and 14406 (2010); P.L. 111-148 Patient Protection And Affordable Care Act. | 38 C.F.R. §§ 17.32, 51.70 and 52.70, and 42 C.F.R. §§ 403.730, 417.436, 417.472, 417.801, 422.128, 430.12, 431.20, 431.107, 438.6, 460.112, 482.13, 483.10, 484.10, 489.10, 489.100 to 104, 494.70 and 494.170 (2011). |

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Gail Mautner advises and litigates in the dual areas of labor and employment law and probate, trust and guardianship disputes. Ms. Mautner is a member of the Lane Powell Trust and Estates Practice Group and chairs the firm's Labor and Employment Practice Group. She advises clients regarding all aspects of compliance with federal, state and local employment law, representing clients in disputed employment matters in the courts, before administrative agencies and in mediations. She regularly conducts on-site training for clients' supervisors and line staff on preventing workplace harassment, ADA/FMLA requirements, religious and disability accommodation, wage and hour compliance, employee discipline and termination, and layoffs. Ms. Mautner also works closely with her colleagues in the business transactions group, negotiating, drafting and litigating executive, noncompetition, and other employment related agreements.

Ms. Mautner is a graduate of the University of California, Hastings College of Law and is admitted to practice in Washington and California. She was named as a "Washington Super Lawyer," *Super Lawyers Magazine*, Labor & Employment (2003, 2005-2011) and selected "Local Litigation Star" by *Benchmark Litigation*, Labor and Employment Litigation (2012).

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