

Placement on a Secure Unit by Surrogate Decision-Makers

by M. Carl Glatstein

In the context of an elder law practice, the issue of placement of an individual on a secure (locked) nursing home unit arises with a certain amount of regularity. Unfortunately, the responses to the problem by facilities, social workers, care managers, advocates, healthcare professionals, and attorneys vary considerably. When an individual lacks the cognitive ability to make appropriate decisions concerning his or her own safety and well being, it may be necessary to rely on the authority of a surrogate decision-maker to make these difficult placement decisions.

The term “surrogate decision-makers” refers to guardians, agents under medical powers of attorney, and proxy medical decision-makers. This article explores the authority and limitations imposed on surrogate decision-makers with respect to placement decisions on behalf of another individual.

Guardians

A guardianship is the most formal procedure for making decisions on behalf of an incapacitated individual. A guardian for an adult can be appointed only by a court of competent jurisdiction for an individual who is determined to be incapacitated, after notice and hearing.¹ For the purposes of guardianship, an “incapacitated person” is now defined as:

An individual, other than a minor, who is unable to effectively receive or evaluate information or both or make or communicate decisions to such an extent that the individual lacks the ability to satisfy essential requirements for physical health, safety, or self-care, even with appropriate and reasonably available technological assistance.²

The individual who is the subject of guardianship proceedings is referred to as the “respondent.”³ Once the respondent is adjudicated to be legally incapacitated and a guardian is appointed, the respon-

dent is then referred to as the guardian’s “ward.”⁴ A guardian has the duty to make decisions regarding the ward’s health, care, and welfare, unless specifically limited by the court. A guardian is required to exercise this authority only as necessitated by the ward’s limitations, and at all times must act in the ward’s best interests, exercising reasonable care, diligence, and prudence.⁵ In other words, the guardian should employ the least restrictive alternative whenever feasible.

The guardian has broad legal authority to make placement decisions, subject to certain statutory proscriptions against forced care and treatment for mental illness, alcoholism, and substance abuse.⁶ Unless specifically limited by the court in the order of appointment, the guardian has the power and legal authority to take custody of the ward and to determine the ward’s placement.⁷ The guardian also has the specific authority, unless limited by the court, to consent to medical or other care, treatment, or service for the ward.⁸

It is not uncommon to see restrictions on a guardian’s authority limiting removal of the ward from his or her home without further court order. If such a restriction is imposed, it is advisable to incorporate language allowing the guardian authority to arrange placement in the event of a medical emergency or on a physician’s authorization. Otherwise, it may be necessary to return to court for further clarification or expansion of the guardian’s authority. If a change in placement is contemplated when filing the guardianship petition, this should be disclosed to the court.⁹ Further, the guardian has an affirmative duty to inform the court of any change in the ward’s placement after appointment.¹⁰

The imposition of a guardianship results in the loss of certain civil liberties, among which may be the right of free association—the ability to choose where to live and with whom to interact. However,

the due process requirements of notice and hearing, and the right to counsel, help to assure that the ward’s rights are not removed lightly. As a consequence, unless specifically limited in the order of appointment, a guardian has the requisite legal power to authorize placement on a secure unit, even over the objections of the ward or others.

Agents Under Medical Durable Powers of Attorney

Appointment of an agent under a medical durable power of attorney often is viewed as an alternative to the formality, expense, and time involved to obtain a guardianship. As part of the Colorado Patient Autonomy Act,¹¹ Colorado law recognizes the right of an adult (the “principal”) to accept or reject medical treatment and to have medical treatment decisions made through an appointed agent (“agent” or “attorney-in-fact”) under a medical durable power of attorney.¹² The medical durable power of attorney is the document that is executed by the principal, delegating authority to the agent or attorney-in-fact. However, laypersons often confuse this term with that of the “agent,” as in: “I am the medical power of attorney and can make the decisions for my mother.”

A medical power of attorney is a form of an advance medical directive,¹³ a directive

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that also includes a living will.¹⁴ In Colorado, living wills typically do not designate an agent to make decisions, unless drafted by an attorney and incorporated into a medical durable power of attorney. Living wills address only end-of-life decisions regarding the withdrawal or continuation of life-sustaining procedures and artificial nourishment for an incapacitated individual.¹⁵ Consequently, a living will provides no authority for medical decision-making when it comes to placement on a secure unit.

A medical durable power of attorney must be executed at a time when the principal has capacity, in advance of the need for medical treatment in the event the principal lacks decisional capacity. "Decisional capacity" is defined as the ability to provide informed consent to or refusal of medical treatment.¹⁶ An interesting question often arises when the individual lacks decisional capacity to provide informed consent, but the doctor or health-care facility wants an agent appointed under a medical durable power of attorney. Execution of a medical durable power of attorney requires only "contractual" capacity, which arguably is a lower threshold than decisional capacity for making medical decisions.¹⁷ From the contractual perspective, all that the principal need understand is that the medical power of attorney grants to the agent the authority to act on his or her behalf.

For the purposes of this discussion, assume there is no issue as to the validity of the medical durable power of attorney, and assume the principal had contractual capacity to delegate medical decision-making authority to an agent. In such instances, the agent under a durable medical power of attorney generally has the requisite legal power to authorize placement of the principal on a secure unit.

As with any generalization, however, there are always exceptions. The agent's authority may be limited by the terms of the medical power of attorney document itself if it specifically prohibits or restricts the agent's authority in this regard. Further, neither the law nor the medical durable power of attorney may be construed to abrogate or limit any rights of the principal, including the right to revoke an agent's authority or the right to consent to or refuse any proposed medical treatment. Also, the agent may not consent to or refuse medical treatment over the principal's objection.¹⁸ Consequently, although the agent under a medical durable power of attorney has the authority to place the principal on a secure unit, such actions over the objection of the principal should not be taken lightly.

This is where conflict between legality and reality arises. Many individuals on a secure unit will state that they want to go home or, by their actions and behavior, will try to leave the locked unit. The question here is whether this conduct should be viewed as a revocation of the agent's authority to make such a medical decision. An agent is required to act in conformance with the principal's wishes. If the principal's wishes are not known to the agent and the medical durable power of attorney contains no directives, conditions, or limitations relating to the principal's condition, the agent should act in accordance with the best interests of the principal, as determined by the agent.¹⁹ In doing so, the agent is directed by statute to consult with the attending physician.²⁰

Although incapacity for guardianship is determined by the court, with certain due process protections, the lack of decisional capacity is generally determined by the physician in the context of the patient/doctor relationship. All too often, the prin-

icipal's objection to placement is overlooked. If a valid medical durable power of attorney is in effect, the agent's healthcare decisions take precedence over those of the guardian on medical matters.²¹ However, the guardian, or any other interested person, may for good cause ask the court to remove the agent or authorize the guardian to revoke the medical durable power of attorney.²²

Proxy Medical Decision-Makers

For many individuals, there is neither a guardian nor an agent under a medical durable power of attorney to act on their behalf. For such individuals, the appointment of a proxy medical decision-maker may be appropriate. The statute recognizes the fundamental right of all adults to make their own medical treatment decisions,²³ and that the lack of decisional capacity should not preclude having such decisions made on their behalf.²⁴

The appointment of a proxy²⁵ resembles the process that used to happen informally among a doctor, patient, and family prior to the involvement of the legislature and risk management professionals. When an individual lacked decisional capacity to provide informed consent to or refusal of medical treatment, the physician traditionally relied on family members to make decisions. There is no formal court process required to appoint a proxy and, thus, no due process protections. Further, there is no specific form or written instrument that appoints the proxy or evidences the proxy's authority. Even so, best practice by physicians and care facilities is to create a paper trail that documents who was contacted and compliance with the proxy appointment process.

The process is informal and is triggered by the physician on determining that the patient lacks decisional capacity to provide informed consent to or refusal of medical treatment. The doctor's specific findings regarding the cause, nature, and anticipated duration of the incapacity should be entered by the physician in the patient's medical record. The physician or his or her designee is to advise the patient of this determination. The physician is then required to make reasonable efforts to locate and notify as many "interested persons" as is practicable.²⁶

The term "interested persons" is narrowly construed for the purposes of the proxy statute and is limited to the spouse, either parent, any adult child, sibling, or

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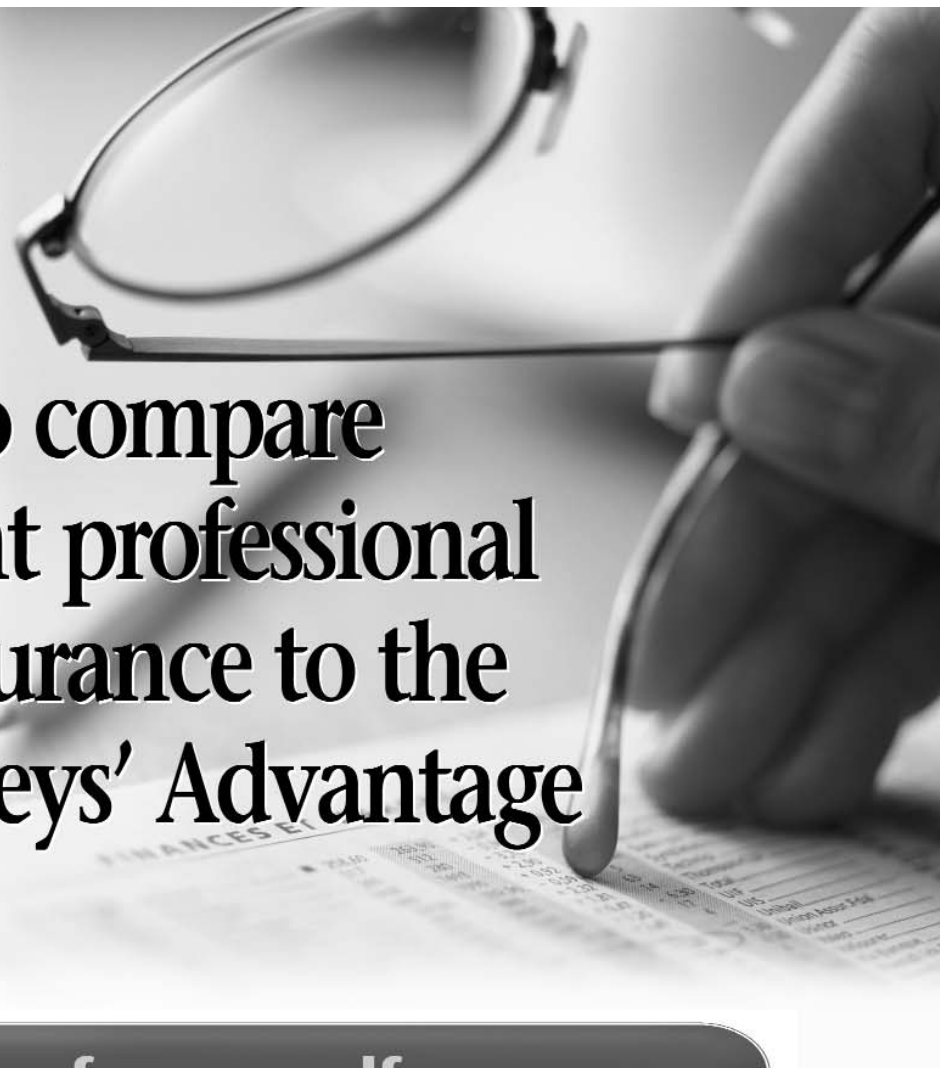
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grandchild, or any close friend of the patient.²⁷ Interested persons are to be advised of the patient's lack of decisional capacity and the need to select a proxy decision-maker. The proxy should be someone with a close relationship to the patient and the person who is most likely to be currently informed of the patient's desires.

If the interested persons reach a consensus as to who among them will serve as the proxy, the physician and healthcare facility are entitled to rely on the proxy's decision and authority.²⁸ The same immunities available to agents also apply to proxy decision-makers.²⁹ Therefore, healthcare providers who in good faith rely on the decision of the proxy are not subject to civil or criminal liability or regulatory sanction.³⁰

If there is no consensus, any of the interested persons may seek appointment of a guardian. A common misconception is that the proxy process requires unanimous consent from all the interested persons.³¹ It does not. The objector has the right to seek appointment of a guardian, but short of that, the objection does not automatically preclude the appointment of a proxy. Often, the dissenting party is unwilling to be proactive. However, in the absence of the filing of a guardianship petition, the issuance of a protective order, or an injunction, the proxy decision-maker may act on behalf of the patient. By contrast, an objection by the patient, either to the identity of the proxy selected or to the

decision made by the proxy, brings the process to a grinding halt. The proper recourse then is to initiate guardianship proceedings.

A proxy decision-maker has authority to withhold or withdraw artificial nourishment and hydration following a procedure similar to that outlined under living wills.³² Two physicians, one of whom must be trained in neurology or neurosurgery, must certify that the provision of artificial nourishment and hydration will merely prolong the act of dying and is unlikely to result in restoration of the patient to independent neurological functioning. The proxy may request the assistance of a medical ethics committee in making decisions to withhold or withdraw treatment.³³

Once a proxy, not always a proxy! If any interested person (including the patient) believes the patient has regained decisional capacity, the physician is required to reexamine and redetermine the need for a proxy decision-maker, and enter the findings in the medical record.³⁴ However, it is not necessary to repeat this process for every decision. Bear in mind that capacity is not black and white; for example, the patient may lack decisional capacity to consent to chemotherapy, but possess sufficient capacity to object to amputation of a limb. In such instances, the cautious approach is to seek guardianship.

The ultimate question is whether a proxy has the requisite legal authority to arrange placement of the patient on a se-

cure unit. The short answer should be yes; however, as with the limitation of authority on agents under medical durable powers of attorney, the authority of a proxy also is limited by the right of the patient to object.³⁵

Administrative Regulatory Safeguards and Constraints

Residents in nursing homes that receive federal funding (essentially any care center accepting Medicare or Medicaid dollars) are guaranteed certain rights, including "... the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility."³⁶ Residents' rights also are protected by state regulations, promulgated by the Colorado Department of Public Health and Environment ("CDPHE"), which make clear that the civil liberties of the individual must be protected.³⁷

However, even in the context of protecting civil liberties, the physician and professional staff have tremendous authority. For instance, a resident has the right to be adequately informed of his or her medical condition and proposed treatment and the right to refuse medication and treatment, unless otherwise indicated by his or her physician.³⁸ The resident also has the enumerated right to be free from physical and chemical restraints, except those restraints initiated through the judgment of professional staff for a specified and limited period of time or on the written authorization of a physician.³⁹

How then does an individual, who by statute has the right to object to the actions of the agent or proxy, exercise such rights? Acknowledging that personal liberty is a fundamental and constitutionally protected right, can it be compromised without due process, notice and hearing, and the right to counsel? Does placement on the secure unit of a skilled nursing facility not constitute some form of false imprisonment? These are valid questions that may be raised in the context of zealous advocacy for the rights of the individual. However, in practice, if each individual requiring placement on a secure unit were given this form of full due process, the courts would be overwhelmed.

An analogous model exists under Colorado's statutes for care and treatment of the mentally ill,⁴⁰ which provides that a seventy-two-hour mental health hold may be initiated by a physician, psychologist, social worker, or law enforcement officer.

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At the conclusion of the mental health hold, if the respondent is still gravely disabled or a danger to himself or herself or others, it is converted to a short-term certification. If the respondent continues to be held under a short-term certification, due process is assured by the mandatory appointment of counsel to represent the respondent. The respondent has the right to judicial review of the certification within ten days. The vast majority of these cases do not undergo judicial review. However, for those that do, unless another contradicting professional opinion is introduced at hearing, the court typically confirms the certification. Nevertheless, this process assures the right to counsel, notice and hearing, and judicial review.

The CDPHE has attempted, by regulation, to provide a rational and reasoned alternative to judicial determination of each and every case requiring placement on a secure unit.⁴¹ Every facility that has a secure unit must use a pre-admission screening process by an evaluation team. This team includes the facility's Director of Nursing, a social services staff member, a member of the utilization control committee, and another outside individual who has either mental health or social work training.⁴²

Moreover, written findings and their factual bases must be documented in the facility's health records. The evaluation team must find, based on available evidence, that:

- 1) the resident is a serious danger to self or others; or
- 2) the resident habitually wanders or is a wander risk and is unable to find the way back; or
- 3) the resident has a significant behavior problem that seriously disrupts the rights of other residents; and in all cases
- 4) less restrictive alternatives have been unsuccessful in preventing harm to self or others; and
- 5) legal authority for such restrictive authority has been established.⁴³

Finally, the need for the placement must be authenticated by a physician,⁴⁴ demonstrating once again the extraordinary power of the physician to significantly limit an individual's civil liberties. The legal authority for the restrictive placement is based on the informed, written consent of the resident or the resident's "legally responsible and authorized representative."⁴⁵

If the resident has been "adjudicated incompetent," in other words is legally determined to be incapacitated, the rights of

the resident devolve to the resident's guardian.⁴⁶ Consequently, unless restricted by the court, the guardian may authorize the placement of the ward on a secure unit in compliance with CDPHE regulations, even over the objections of the ward.

In the event a guardian has not been appointed, the CDPHE will accept either an agent under a medical durable power of attorney or a proxy as the legally responsible and authorized representative having the requisite legal authority to con-

sent to secure placement.⁴⁷ If the resident does not object to placement, the agent or proxy has the requisite legal authority to authorize placement. However, if the resident objects, or by his or her behavior continues to try to elope or exit the unit, such behavior—from a legal perspective—could certainly be perceived as revocation of the authority of the agent or proxy.

In a purely legal context, such revocation would deprive the agent or proxy of legal authority to act in contravention of the

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resident's wishes. This results in a dilemma. Neither the agent under a medical power of attorney nor a proxy determined in accordance with statute is authorized to act until there is a medical determination that the individual lacks the cognitive ability to provide informed consent. Nevertheless, the relevant statutes attempt to safeguard the rights of the presumptively incapacitated individual to revoke the authority of the agent or the proxy, making a determination that theoretically should require a certain degree of capacity.

The resident has recourse through the courts to protect his or her rights and liberty interests, although such recourse may be an expensive and time-consuming process and is likely to result in guardianship proceedings and a court determination of incapacity. However, from a regulatory perspective, the rights of the individual are safeguarded through the placement evaluation process outlined above and grievance procedures⁴⁸ established to redress violations of residents' rights.

The placement on a secure unit is to terminate: (1) whenever the condition or behavior justifying the placement diminishes to the extent that it no longer satisfies the criteria above; (2) if consent to the

placement is withdrawn; or (3) if the facility and physician determine that continued placement would adversely affect the resident's health or safety.⁴⁹ In any event, the placement is to be reevaluated after thirty days, and at least once every 180 days thereafter.⁵⁰

At any time, the resident, resident's legal representative, or member of the resident's family may present a grievance to the full-time staff member designated by the care facility for such purposes.⁵¹ After conferring with the persons involved in the matter, the staff designee must provide a written explanation of findings and proposed remedies within three days. If the findings and remedies are not satisfactory, within ten days, the resident may submit the grievance to the facility's grievance committee, orally or in writing. The grievance committee, within ten days, then shall provide a written explanation of its findings and proposed remedies.

If this resolution is still unsatisfactory, the resident may file the grievance in writing with the Executive Director of the CDPHE. The CDPHE will investigate the facts and circumstances and issue written findings, conclusions, and recommendations. Within thirty days of the CDPHE's

findings and recommendations, the resident may seek a full administrative review hearing by the CDPHE.⁵² Thus, a parallel administrative review process is available to any resident, which may result in a speedier resolution than recourse through the court process.

An individual capable of complying with the grievance procedures established by regulation to protect residents' rights is not, in all likelihood, going to suffer such cognitive impairment as to justify placement on a secure unit. Bear in mind that use of the grievance procedure and recourse through the courts are not mutually exclusive. Although it could be argued that placement on a secure unit by an agent or proxy over the objection of the resident is a violation of the individual's right to due process, nothing in the regulations prohibits the individual from seeking judicial intervention. Instead, the regulatory protections afforded are designed to enhance the rights of the individual.

Conclusion

When the time for placement of an individual on a secure unit becomes necessary due to dementia, wandering, or other unsafe behavior, facilities often urge



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families to seek appointment of a guardian. Unfortunately, this can be a lengthy and expensive process, which often is unwarranted. A court-appointed guardian generally has the statutory power to authorize placement of the ward on a secure unit, unless otherwise restricted by the court. However, agents under medical powers of attorney and proxy medical decision-makers also have the ability to authorize placement of an individual on a secure unit, provided the facility has complied with CDPHE regulations controlling secure units.⁵³

The liberty interests of the individual are afforded due process protections through the formality of court proceedings for guardianships. Although court review and guardianship always remain available, resorting to the courts often is not practical, timely, or cost effective. Fortunately, administrative review of secure placements is available in addition to judicial review, so that the individual placed on a secure unit over his or her objections may have easier and faster access to review by trained professionals.

The rights of the individual are not lost by placement on a secure unit. In fact, the safeguard of the informal grievance process and formal administrative review of the placement decision are available and complement due process and judicial review. In practice, for most individuals, this review is sufficient without requiring families to resort to the court for the formality of guardianship.

Physicians and care facilities, acting in good faith, should be able to rely on the authority of the agent or proxy without being subject to civil or criminal liability or regulatory sanction.⁵⁴ However, for those individuals who continue to protest their placement on a secure unit, the safest and most conservative approach is to seek court-ordered guardianship. This is the only avenue available that formally requires judicial review and protection afforded by due process.

NOTES

1. CRS §§ 15-14-301 through -318.
2. CRS § 15-14-102(5).

3. CRS § 15-14-102(12).
4. CRS § 15-14-102(15).
5. CRS § 15-14-314(1).
6. Pursuant to CRS § 15-14-316(4), a guardian does not have authority to obtain treatment over the ward's objection for mental illness (CRS §§ 27-10-101 *et seq.*); developmental disabilities (CRS §§ 27-10.5-101 *et seq.*); or alcoholism or substance abuse (CRS §§ 25-1-201 *et seq.*), without complying with these specific statutes.
7. CRS § 15-14-315(1)(b). However, a guardian may not move the ward's dwelling out of state without the express authorization of the court.
8. CRS § 15-14-315(1)(d).
9. Colo. Prob. Code Form 32.
10. CRS § 15-14-314(2)(f).
11. CRS §§ 15-14-503 to -509.
12. CRS § 15-14-504.
13. CRS § 15-14-505(2).
14. "Living wills" or "declarations as to medical or surgical treatment" are provided for under the Colorado Medical Treatment Decision Act, CRS §§ 15-18-101 to -113.
15. For a thorough discussion of living wills and other forms of advance directives, *see, e.g.*, Frank, "Surrogate Decision-Making for 'Friendless' Patients," 34 *The Colorado Lawyer* 71 (April 2005).
16. CRS § 15-14-505(4).
17. The standard for contractual capacity was set forth in *Hanks v. McNeil Coal Corp.*, 114 Colo. 578, 168 P.2d 256 (1946), finding that to execute a contract, an individual must be capable of understanding and appreciating the extent and effect of the business transactions to be undertaken. *See also Davis v. Colorado Kenworth Corp.*, 396 P.2d 958, 961 (Colo. 1964), *citing Hanks* for the proposition that one may be insane on some subjects and still have the capacity to contract.
18. CRS § 15-14-506(4)(a).
19. CRS § 15-14-506(2).
20. CRS § 15-14-506(3).
21. CRS § 15-14-316(3).
22. CRS § 15-14-609(1).
23. CRS § 15-18.5-101(1)(a).
24. CRS § 15-18.5-101(1)(b).
25. CRS §§ 15-18.5-101 through -103.
26. CRS § 15-18.5-103(3).
27. *Id.*
28. CRS § 15-18.5-103(1).
29. CRS § 15-18.5-102(2).
30. CRS § 15-14-508(2).
31. Consensus should not be confused with unanimity. *See Frank, supra*, note 15.
32. CRS § 15-18.5-103(6).
33. CRS § 15.18.5-103(6.5).
34. CRS § 15-18.5-103(7).
35. CRS §§ 15-18.5-103(5) and 15-14-506(4)(a).

36. 42 CFR § 483.10.
37. 6 CCR 1011-1, Ch. 5, Pt. 12.
38. 6 CCR 1011-1, Ch. 5, Pt. 12.1.6.
39. 6 CCR 1011-1, Ch. 5, Pt. 12.1.8.
40. An analogous model exists under Colorado's statutes for care and treatment of the mentally ill, CRS §§ 27-10-101 through -129, which provide that a seventy-two-hour mental health hold may be initiated by a physician, psychologist, social worker, or law enforcement officer. If the respondent continues to be held under a short-term certification, counsel must be appointed. The respondent has the right to judicial review of the certification within ten days.
41. 6 CCR 1011-1, Ch. 5, Pt. 19.
42. 6 CCR 1011-1, Ch. 5, Pt. 19.4.2.
43. 6 CCR 1011-1, Ch. 5, Pt. 19.4.1.
44. 6 CCR 1011-1, Ch. 5, Pt. 19.4.5.
45. 6 CCR 1011-1, Ch. 5, Pt. 19.4.4.
46. 6 CCR 1011-1, Ch. 5, Pt. 12.2.
47. Telephone interview with Shelley Hitt, Colorado Department of Public Health and Environment (June 2005); *see also* CDPHE, *Health Facilities Newsletter* (Spring 1994).
48. Set forth in the Standards for Hospitals and Health Facilities, Long Term Care Facilities, 6 CCR 1011-1, Ch. 5, Pt. 12.4.
49. 6 CCR 1011-1, Ch. 5, Pt. 19.5.
50. 6 CCR 1011-1, Ch. 5, Pt. 19.5.2.
51. 6 CCR 1011-1, Ch. 5, Pt. 12.4.3.
52. CRS § 24-4-105.
53. 6 CCR 1011-1, Ch. 5, Pt. 19.
54. CRS § 15-14-508(2). ■

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