STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Olympia, Washington 98504

RE: Joel O. Diven
Docket No.: 06-10-A-1023DE
Document: Findings of Fact and Final Order

Regarding your request for information about the above-named practitioner, certain information may have been withheld pursuant to Washington state laws. While those laws require that most records be disclosed on request, they also state that certain information should not be disclosed.

The following information has been withheld: **NONE**

If you have any questions or need additional information regarding the information that was withheld, please contact:

Customer Service Center
P.O. Box 47865
Olympia, WA 98504-7865
Phone: (360) 236-4700
Fax: (360) 586-2171

You may appeal the decision to withhold any information by writing to the Deputy Secretary, Department of Health, P.O. Box 47890, Olympia, WA 98504-7890.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
DENTAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Dentist of:	)	Docket No. 06-10-A-1023DE
JOEL O. DIVEN, D.D.S., Credential No. DE00003155,	)	FINDINGS OF FACT, CONCLUSIONS OF LAW AND FINAL ORDER
Respondent.	)	

APPEARANCES:

Respondent, Joel O. Diven, D.D.S., by
Bennett Bigelow & Leedom, P.S., per
Carol Sue Janes, Attorney at Law

Department of Health Dental Program, by
Office of the Attorney General, per
Stephen Carpenter, Assistant Attorney General

COMMISSION PANEL: John Davis, D.D.S., J.D., Panel Chair
Larry Knutson, D.D.S.
James Vento, D.D.S.
Bernard Nelson, Public Member

PRESIDING OFFICER: John F. Kuntz, Health Law Judge

The Dental Quality Assurance Commission (the Commission) convened a prompt hearing on November 20, 2006. The Department of Health issued a Statement of Charges alleging that the Respondent engaged in unprofessional conduct in violation of the Uniform Discipline Act. License revoked.

ISSUES

A. Whether the Respondent's conduct regarding Patient A constitutes unprofessional conduct under RCW 18.130.180(4), (7) (incorporating

WAC 246-817-310, WAC 246-817-320, and WAC 246-817-380), and (24)?

B. If the Department proves unprofessional conduct, what are the appropriate sanctions under RCW 18.130.160?

SUMMARY OF THE PROCEEDINGS

The Department presented the testimony of Amy Booth, Barton Scott Johnson D.D.S., Melissa Farrell, and A.N. Morton. The Respondent testified on his own behalf and presented the testimony of Charles R. Weber, D.D.S., Hollis Elliot, and Robert C. Webster, D.M.D. There were 13 exhibits admitted at the hearing:

Department Exhibits:

Exhibit D-1: Not admitted.

Exhibit D-2: Not admitted.

Exhibit D-3: Not admitted.

Exhibit D-4: Department of Corrections Incident Report of Kelly Remy, P.A., dated May 23, 2006.

Exhibit D-5: Department of Corrections Incident Report of Robert Webster dated May 24, 2006.

Exhibit D-6: Not admitted.

Exhibit D-7: Not admitted.

Exhibit D-8: Not admitted.

Exhibit D-9: Respondent's Self Report dated June 29, 2006.

Exhibit D-10: Department of Health Complaint Worksheet.

Exhibit D-11: Letter of Cooperation from Department of Health Investigator Nancy Maxson to the Respondent dated September 1, 2006.

Exhibit D-12: Not admitted.

Exhibit D-13: Patient A's Dental Records (provided by the Respondent).

Exhibit D-14: Not admitted.

Exhibit D-15: Not admitted.

Exhibit D-16: Not admitted.

Exhibit D-17: Not admitted.

Exhibit D-18: Not admitted.

Exhibit D-19: Not admitted.

Exhibit D-20: Memorandum of Dr. A.N. Morton, Director of Dental Services, to Dr. Marc Stern, Medical Director.

Exhibit D-21: Records request from Nancy Maxson, Department of Health Investigator, to St. Joseph Hospital Records Custodian, and Patient A's records.

Exhibit D-22: Records request from Nancy Maxson, Department of Health Investigator, to Harborview Medical Center Patient Data Services, Patient A's records and Emergency Department Report.

Exhibit D-23: Medical Records for Patient A provided by the Department of Corrections.

Exhibit D-24: Chart prepared by Amy Booth, Dental Assistant.

Exhibit D-25: Patient A's dental records from Dr. Charles Webber, South Sound Surgery.

Exhibit D-26: Not admitted (demonstrative exhibit).

Exhibit D-27: Not admitted (demonstrative exhibit).

Exhibit D-28: Radiographs taken of Patient A, dated December 29, 2004, May 26, 2004, and May 22, 2006.

CREDIBILITY FINDINGS

The Respondent denies the allegations set forth in the Statement of Charges regarding his treatment of Patient A. The Commission finds the testimony of Amy Booth to be credible and to be supported by the totality of the evidence presented in this matter.

The Commission does not find credible the Respondent's testimony regarding the exercise of his professional judgment or the exercise of his crisis management surrounding his treatment of Patient A on May 24, 2006.

Based upon the exhibits and testimony presented, the Commission enters the following:

I. FINDINGS OF FACT

1.1 The State of Washington issued the Respondent a license to practice as a dentist in January 1963. The Respondent's license was summarily suspended pursuant to an Ex Parte Order of Summary Suspension dated October 27, 2006.

1.2 The Respondent was employed as a dentist on a full-time basis at the McNeil Island Correction Center during the period 1989 to 2006. The Respondent provided dental services to the inmates incarcerated at the facility, which included dental treatment to Patient A on May 22, 2006 and May 24, 2006.[1]

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[1] Patient A is identified in the confidential schedule attached to the Statement of Charges. The identity of the patient is not to be released without the consent of the individual pursuant to RCW 42.56.240(1).

May 22, 2006 treatment.

1.3 On May 22, 2006, Patient A reported to the McNeil Island Correction Center dental clinic to complain of a toothache in the lower right quadrant of his jaw. The Respondent examined Patient A regarding this complaint. The Respondent examined the patient and determined the tooth causing Patient A's pain was tooth #30.[2]

1.4 The Respondent initiated a root canal treatment for Patient A's tooth #30 (the lower first molar). Prior to deciding to provide a root canal treatment to tooth #30, the Respondent did not take a pre-treatment X-ray of the tooth to adequately diagnose the treatment options for tooth #30 area. It is below the standard of care to fail to take an X-ray to allow adequate diagnosis of the treatment options for tooth #30.

1.5 The condition of tooth #30 required the extraction of the tooth on May 22, 2006. However, the Respondent decided to perform a root canal treatment in an attempt to restore the tooth. In the course of performing the root canal treatment, the Respondent perforated the root of Patient A's lower first molar, a condition confirmed by a post treatment X-ray. Perforation, by itself, is not evidence of negligence. The prudent course of action under the standard of care in Washington was for the immediate extraction of tooth #30 once the Respondent discovered that he had perforated the root of Patient A's tooth #30.

1.6 The Respondent's decision to perform a root canal treatment on tooth #30 was below the standard of care for a reasonably prudent dentist in that circumstance.

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[2] An adult has 32 teeth. For purposes of identification, the teeth in the upper jaw (counting from right to left) are #1-16. The teeth in the lower jaw (counting from left to right) are #17-32. Tooth #30 is the lower first molar).

There was no evidence to support the Respondent's decision to attempt the restoration of tooth #30. The Respondent's actions caused Patient A two days of pain and created the possibility of infection by his failure to extract tooth #30 on May 22, 2006.

May 24, 2006 treatment:

1.7 Patient A continued to experience pain in tooth #30. On May 24, 2006, Patient A returned for treatment and requested the Respondent remove the tooth. After obtaining Patient A's informed consent to remove tooth #30, the Respondent then proceeded to extract the tooth without difficulty. In performing the extraction the Respondent used an elevator (a spoon-like instrument used to pry a tooth from the jawbone) to move the tooth. The tooth was then extracted using forceps.[3] After extracting tooth #30 the Respondent pressed down on the extraction site to cause some slight bleeding. A minimal amount of blood was stimulated, and this indicated that the patient would not experience a dry socket, that is the extraction site would not be prone to infection.

1.8 Patient A also complained of pain in the upper right quadrant of his mouth during the May 24, 2006 visit. The Respondent determined that the pain being complained of was Patient A's tooth #2. The Respondent tapped the tooth and the patient complained of pain. The Respondent also tested tooth #2 by inserting a dental probe into the tooth. This examination showed dental caries down into the pulp of the tooth. The Respondent determined that it was necessary to extract tooth #2.

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[3] Foreceps: Pincers for holding, seizing, or extracting. Taber's Cyclopedic Medical Dictionary, 14 Edition (1981), page 553.

1.9 The Respondent did not take an x-ray of the patient's mouth during the visit on May 24, 2006. The Respondent relied upon a December 2004 panoramic X-ray taken of Patient A's mouth in deciding to remove tooth #2. The Respondent began the extraction procedure on the tooth at approximately 9:35 a.m. Similar to his actions in extracting tooth #30, the Respondent began the extraction procedure using a tool known as an elevator. The Respondent first inserted the elevator between tooth #3 and tooth #2 to see whether the extraction of tooth #2 could be performed or facilitated in this manner. Achieving no movement of tooth #2 in this fashion, the Respondent tried the same approach by placing the elevator between tooth #2 and tooth #1 (an impacted adjacent third molar). The Respondent failed to obtain any movement of tooth #2 by using the elevator. At this point in the procedure a reasonable prudent dentist would stop and examine whether a surgical extraction of the tooth was appropriate. The Respondent's failure to stop and consider a surgical extraction of Patient A's tooth #2 at this point in the procedure was below the standard of care.

1.10 The Respondent then attempted to remove tooth #2 using forceps. When he first began the forceps extraction some minimal bleeding could be seen around the gum line surrounding the tooth. The Respondent continued to apply pressure to extract the tooth and heard a bone cracking sound. The Respondent believed this bone cracking sound indicated the root of tooth #2 was cracking. Continuing to apply pressure, the Respondent heard several additional cracking sounds. The Respondent

felt movement in the buccal and palatal areas of Patient A's upper jaw and mouth.[4] The Respondent realized his actions caused a maxillary fracture.[5] The Respondent realized he was removing a much larger bony segment of Patient A's jaw in addition to tooth #2. Patient A began bleeding profusely in the socket area of tooth #2 at this point. Despite the profuse bleeding the Respondent went forward with the extraction, with the goal of removing the bony segment and suturing the wound and socket area.

1.11 When a tooth cannot easily be moved with an elevator, the tooth is also unlikely to move with the use of forceps. If a tooth has not moved within one to two minutes of beginning the use of forceps, the standard of care in Washington indicates that the reasonably prudent practitioner stop and consider surgical intervention for removal of the tooth. The Respondent's failure to stop and consider a surgical intervention of tooth #2, instead of continuing the extraction by using forceps, was below the standard of care in the state of Washington.

1.12 The standard of care in the state of Washington in response to the feel and sound of Patient A's broken tooth or jaw segment is to stop the extraction procedure, identify the condition, and determine a prudent course of action. Such a response is appropriate given the close proximity of the maxillary sinus.[6] The feel of the broken portion of the jaw bone shifting as the Respondent pulled on tooth #2 should have alerted the Respondent to the maxillary fracture. An accurate assessment of the

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[4] Buccal: pertaining to the cheek and mouth. Palatal: pertaining to the roof of the mouth, the palate. Taber's Cyclopedic Medical Dictionary, 14th Edition (1981), pages 215 and 1028.
[5] Maxillary: pertaining to the upper jaw. Taber's Cyclopedic Medical Dictionary, 14th Edition (1981), page 862.
[6] Maxillary sinus: The antrum of Highmore air cavity in superior maxilla opening into middle meatus of nose. Taber's Cyclopedic Medical Dictionary, 14th Edition (1981), page 862.

fracture would have allowed an oral surgery referral, which could have preserved the integrity of Patient A's maxilla and would have avoided further injury to Patient A's jaw. It was not necessary to remove tooth #2 to stop the bleeding.

1.13 Amy Booth was employed as a dental assistant by the McNeil Island Correctional Center on May 24, 2006. Ms. Booth was assisting Robert Webster D.M.D. (another dentist employed by McNeil Island Correctional Center) at the same time the Respondent was providing dental services to Patient A. The two dental stations were approximately 6 feet apart. Ms. Booth could both see and hear Patient A moaning and twisting in the dental chair and gripping the arms of the chair in pain in response to the Respondent's actions. Based on her observations Patient A was experiencing a difficult time with the extraction procedure.

1.14 Melissa Farrell was the dental assistant working with the Respondent. Ms. Booth observed that Ms. Ferrell appeared frightened in response to the Respondent's treatment of Patient A. In fact Ms. Farrell experienced a strong physical response to Patient A's pain and the amount of blood. Her response was so strong that she could no longer assist the Respondent in providing dental treatment to Patient A. For that reason Ms. Booth replaced Ms. Ferrell as the Respondent's dental assistant at 9:40 a.m.

1.15 Upon relocating to the dental assistant chair for the Respondent, Ms. Booth was able to observe the Respondent attempting to extract a large piece of bone which was loose in the upper right quadrant of Patient A's jaw. There was a large amount of blood which Ms. Booth began to suction out of the patient's mouth. Patient A

appeared in physical distress from the pain. The Respondent did not appear to notice the patient's condition and was not taking steps to stem the flow of blood at the site of the tooth. The Respondent was red faced and shaking at this point. All of Ms. Booth's attempts to communicate with the Respondent at this point were met with silence. Based on her observation of Patient A, and on the Respondent's actions, Ms. Booth determined the Respondent had lost control of the situation and that Patient A required emergency assistance in addition to the Respondent's treatment.

1.16 Based on the Respondent's failure to respond to questions, and based on Patient A's need for assistance, Ms. Booth took charge of the situation to address Patient A's obvious need for help. Without instructions from the Respondent, Ms. Booth obtained a #15 blade (a straight blade) and instructed the Respondent to use the blade to begin the surgical extraction of tooth #2. When it was apparent the Respondent's use of the #15 blade was unsuccessful, Ms. Booth obtained a #12 blade (a curved blade) to assist the Respondent in completing the surgical removal of tooth #2 and the surrounding bone segment. Ms. Booth observed the Respondent remove a 5 centimeter (2 inch) segment of bone from Patient A's mouth and put it on the instrument tray. By removing the bone segment, the Respondent caused a breech in Patient A's sinus cavity.

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1.17 Ms. Booth was monitoring Patient A's blood pressure[7] during the procedure, more specifically the diastolic pressure.[8] Patient A's diastolic blood pressure was dropping during the proceeding. Patient A's diastolic pressure dropped from 98 to 62 by the time the bone fragment was removed. By this time, Patient A was bleeding from both nostrils and his mouth and the suctioning was not keeping up with the patient's bleeding. Because of the breech in the sinus cavity, the blood also contained mucus draining from the sinus cavity into Patient A's mouth. All attempts to stop the bleeding by using gauze pads were unsuccessful. Ms. Booth was requesting the Respondent initiate an emergency 4444 call to the McNeil Island Correction Center emergency unit. The Respondent ignored these requests. Ms. Booth then approached Dr. Webster (the other dentist on duty that day) for help, but Dr. Webster did not offer Ms. Booth any assistance at this point. Ms. Booth initiated the 4444 emergency call on her own initiative.

1.18 The McNeil Island Correctional Center emergency personnel arrived at the dental clinic at approximately 11:00 a.m. on May 24, 2006. Patient A was given intravenous fluids and oxygen treatment, and the blood in the throat was continually aspirated to maintain the patient's airway. Exhibit D-4. The decision was made to transport Patient A from the correctional center to a mainland hospital. Ms. Booth

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[7] Blood pressure. As popularly used, the pressure, determined indirectly, existing in the large arteries at the height of the pulse wave. Taber's Cyclopedic Medical Dictionary, 14th Edition (1981), page 192.
[8] Diastolic pressure: The point of least pressure in the arterial vascular system. The failure of the diastolic pressure to drop in proportion to the systolic pressure is a danger sign. Taber's Cyclopedic Medical Dictionary, 14th Edition (1981), page 402.

volunteered to accompany Patient A to the hospital, and the emergency personnel accepted her offer, as Ms. Booth's presence provided a calming effect on the patient.

1.19 Patient A was transported to the mainland from the McNeil Island Correction Center and was transported by ambulance to the hospital.[9] Patient A was originally transported to and seen at St. Joseph Hospital. Patient A was experiencing breathing difficulties and was intubated to maintain the patient's airway. As St. Joseph did not have an oral surgeon, the patient was then transported by ambulance to Harborview Medical Center for additional care. Exhibit D-21.

1.20 In the course of attempting the extraction of tooth #2, the Respondent fractured Patient A's upper jaw bone. The Respondent proceeded to remove a half-dollar size portion (5 cm by 5 cm) of the patient's jaw bone, the tuberosity, tooth #2, and the adjacent third upper molar (tooth #1).[10] The Respondent's actions caused a tear in the palatal tissue up to or nearly up to the midline of Patient A's palate. The Respondent's extraction of this portion of the bone also caused a breech of the sinus cavity.

1.21 The Respondent's treatment and crisis management of Patient A's condition in the course of extracting tooth #2 was below the standard of care in Washington. The Respondent's actions and treatment resulted in pain and injury to the patient. The Respondent's actions did not constitute an abandonment of Patient A, in

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[9] During the transport to the hospital the ambulance was involve in a motor vehicle accident. This did not stop the ambulance from completing the emergency run. There was no medical evidence that this motor vehicle accident exacerbated Patient A's condition.
[10] Tuberosity: An elevated round process of a bone. Taber's Cyclopedic Medical Dictionary, 14 Edition (1981), page 1497.

that the Respondent did complete the extraction procedure.[11] The Respondent failed to exercise appropriate control regarding the treatment and crisis management of Patient A's condition as required of a reasonably prudent dentist. His failure to do so required dental assistant Amy Booth to act to alleviate Patient A's suffering. The Respondent's conduct in failing to exercise appropriate control and crisis management for Patient A on May 24, 2006, was below the standard of care in the state of Washington.

Informed Consent:

1.22 The Respondent obtained Patient A's signed written consent to extract tooth #30 on May 24, 2006. The Respondent did not obtain Patient A's signed written consent to extract tooth #2 on May 24, 2006. The Respondent added tooth #2 to the signed written consent form obtained from Patient A for tooth #30 after Patient A was transported from McNeil Island Correction Center to the mainland for further treatment. It is below the standard of care in the state of Washington to add information to a signed dental consent form after it is signed by a patient.

II. CONCLUSIONS OF LAW

2.1 At all times material to the Statement of Charges, the Respondent has been licensed to practice dentistry in the state of Washington, subject to a Commission order which summarily suspended the Respondent's license to practice. The Commission has jurisdiction to hear this matter pursuant to chapters 18.32 RCW and 18.130 RCW.

[11] The attending dentist, without reasonable cause, shall not neglect, ignore, abandon, or refuse to complete the current procedure for a patient. WAC 246-817-380.

2.2 The Washington Supreme Court held that the constitutional standard of proof in a professional disciplinary hearing is clear and convincing evidence. *Ongom v. Department of Health*, No. 76618-5, slip op. (Wash., December 14, 2006).

2.3 The Commission used its experience, competency, and specialized knowledge in evaluating the evidence presented in this case. RCW 34.05.461(5).

2.4 The Uniform Disciplinary Act defines what conduct, acts, or conditions constitute unprofessional conduct. RCW 18.130.180. Under RCW 18.130.180(4), unprofessional conduct is defined to mean:

> Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed.

2.5 Based on Findings of Fact 1.3 to 1.6, the Department has proven by clear and convincing evidence that the Respondent's conduct violated RCW 18.130.180(4), as it relates to the root canal treatment provided to Patient A for tooth #30 on May 22, 2006.

2.6 Based on Findings of Fact 1.7 to 1.21, the Department has proven by clear and convincing evidence that the Respondent's conduct violated RCW 18.130.180(4), as it related to the dental treatment provided to Patient A for tooth #2 on May 24, 2006.

2.7 Under RCW 18.130.180(7), unprofessional conduct is defined to mean:

> Violation of any state or federal statute or administrative rule regulating the profession in question, including any

statute or rule defining or establishing standards of patient care or professional conduct or practice.

The rules relating to the practice of dentistry in the state of Washington are set forth in chapter 246-817 WAC. The rule addressing the maintenance and retention of records is set forth in WAC 246-817-310. That rule states in relevant part:

> Any dentist who treats patients in the state of Washington shall maintain complete treatment records regarding patients treated. These records shall include, but shall not be limited to X rays, treatment plans, patient charts, patient histories, correspondence, financial data and billing.

WAC 246-817-310.

2.8 Based on Finding of Fact 1.22, the Department has proven by both clear and convincing evidence that the Respondent's conduct violated RCW 18.130.180(7) (incorporating WAC 246-817-310), as it relates to the dental treatment records for Patient A.

2.9 The Commission concludes the Department did not present sufficient evidence to show that the Respondent engaged in unprofessional conduct as alleged under RCW 18.130.180(7) (incorporating WAC 246-817-320 and WAC 246-817-380) and RCW 18.130.180(24) (abuse of a client or patient).[12] Those charges are therefore dismissed.

2.10 The Commission concludes that sanctions are necessary pursuant to RCW 18.130.160. That statute provides, in relevant part:

> Safeguarding the public's health and safety is the paramount responsibility of every disciplining authority and in determining what action is appropriate, the disciplining

[12] See paragraphs 1.3, 1.6.3, 1.6.6, 1.6.8, 1.7, and 1.8 of the Statement of Charges.

> authority must first consider what sanctions are necessary
> to protect or compensate the public.

RCW 18.130.160.

2.11 The Commission concludes the Respondent failed to exercise any professional judgment, and failed to exercise any crisis management, at several stages in his treatment of Patient A. The Respondent could have, at several stages of providing treatment to Patient A, stopped and considered other treatment options for Patient A. The Respondent failed to do so. The Commission considers the Respondent's failure to exercise that professional judgment, given the level of the Respondent's experience and training, as an aggravating circumstance. The Respondent's failure to exercise his professional judgment, and failure to exercise crisis management, cannot be corrected by additional training or continuing education. As required by RCW 18.130.160, the Commission must exercise its paramount duty to protect the public and issue sanctions in this matter.

III. ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, the Commission Orders:

3.1 The Respondent's license to practice as a dentist in the state of Washington is REVOKED.

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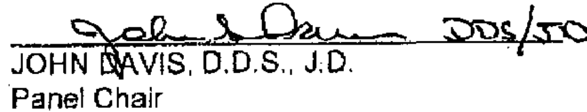
3.2 The allegations that the Respondent engaged in unprofessional conduct under RCW 18.130.180(7) (relating to WAC 246-817-320 and WAC 246-817-380) and RCW 18.130.180(24) are DISMISSED.

Dated this 4 day of January, 2007.

Dental Quality Assurance Commission



JOHN DAVIS, D.D.S., J.D.
Panel Chair

CLERK'S SUMMARY

Charges	**Action**
RCW 18.130.180(4)	Violated
RCW 18.130.180(7)	Violated
RCW 18.130.180(7)	Dismissed
RCW 18.130.180(24)	Dismissed
WAC 246-817-310	Violated
WAC 246-817-320	Dismissed
WAC 246-817-380	Dismissed

NOTICE TO PARTIES

This order is subject to the reporting requirements of RCW 18.130.110, Section 1128E of the Social Security Act, and any other applicable interstate/national reporting requirements. If adverse action is taken, it must be reported to the Healthcare Integrity Protection Data Bank.

Either party may file a **petition for reconsideration**. RCW 34.05.461(3); RCW 34.05.470. The petition must be filed within 10 days of the date of service of the Order with:

Adjudicative Service Unit
P.O. Box 47879
Olympia, WA 98504-7879

and a copy must be sent to:

Dental Quality Assurance Commission
P.O. Box 47876
Olympia, WA 98504-7876

The petition must state the specific grounds upon which reconsideration is requested and the relief requested. The petition for reconsideration is considered denied 20 days after the petition is filed if the Adjudicative Service Unit has not responded to the petition or served written notice of the date by which action will be taken on the petition.

A **petition for judicial review** must be filed and served within 30 days after service of this Order. RCW 34.05.542. The procedures are identified in chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. A petition for reconsideration is not required before seeking judicial review. If a petition for reconsideration is filed, however, the 30-day period will begin to run upon the resolution of that petition. RCW 34.05.470(3).

The Order remains in effect even if a petition for reconsideration or petition for review is filed. "Filing" means actual receipt of the document by the Adjudicative Service Unit. RCW 34.05.010(6). This Order was "served" upon you on the day it was deposited in the United States mail. RCW 34.05.010(19).