No. _____

IN THE

Supreme Court of the United States

HEALTH AND HOSPITAL CORPORATION OF MARION COUNTY, *ET AL.*,

Petitioners,

v.

GORGI TALEVSKI, BY HIS NEXT FRIEND IVANKA TALEVSKI,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

PETITION FOR A WRIT OF CERTIORARI

LAWRENCE S. ROBBINS
Counsel of Record
ALAN E. UNTEREINER
JOHN B. GOERLICH
ANNA L. DEFFEBACH
ROBBINS, RUSSELL, ENGLERT, ORSECK & UNTEREINER LLP
2000 K Street, N.W.,
Washington, D.C. 20006
(202) 775-4500
lrobbins@robbinsrussell.com

Counsel for Petitioners

QUESTIONS PRESENTED

Since the high-water mark in *Wilder* v. *Virginia Hospital Association*, 496 U.S. 498 (1990), this Court has consistently rebuffed efforts to find privately enforceable rights in Spending Clause statutes. Indeed, several Justices have suggested that the entire project of enforcing such rights under 42 U.S.C. § 1983 is mistaken: Spending Clause statutes are "much in the nature of a *contract*," *Barnes* v. *Gorman*, 536 U.S. 181, 185-86 (2002) (internal quotation marks omitted), and when Section 1983 was enacted, contracts in general—and contracts with governmental entities in particular—did not give rise to claims by third-party beneficiaries.

The Seventh Circuit's decision below illustrates just how flawed this project is. Notwithstanding the Court's instructions to the contrary, see *Pennhurst State Sch. and Hosp.* v. *Halderman*, 451 U.S. 1, 18 (1981), and *Gonzaga Univ.* v. *Doe*, 536 U.S. 273, 289 n.7 (2002), the court of appeals relied on the appearance of the word "right" several times in the Federal Nursing Home Amendments Act of 1987 ("FNHRA") to hold that patients may use Section 1983 to second-guess garden-variety transfer and medication decisions—thereby federalizing much medical-malpractice litigation and nullifying important state medical-malpractice rules.

This case presents the following questions:

1. Whether, in light of compelling historical evidence to the contrary, the Court should reexamine its holding that Spending Clause legislation gives rise to privately enforceable rights under Section 1983.

2. Whether, assuming Spending Clause statutes ever give rise to private rights enforceable via Section 1983, FNHRA's transfer and medication rules do so.

PARTIES TO THE PROCEEDING

Petitioners, defendants-appellees below, are Health and Hospital Corporation of Marion County, Indiana ("HHC"), Valparaiso Care and Rehabilitation ("VCR"), and American Senior Communities LLC ("ASC").

Respondent is Gorgi Talevski, through his wife and next friend Ivanka Talevski, plaintiff-appellant below.

CORPORATE DISCLOSURE STATEMENT

HHC is a municipal corporation/subdivision of the state of Indiana. VCR is one of the names under which HHC does business.

ASC is a privately-held nursing home management company. No publicly traded corporation owns 10% or more of ASC.

RELATED PROCEEDINGS

Pursuant to this Court's Rule 14.1(b)(iii), the following proceedings are related to this case:

United States District Court for the Northern District of Indiana:

Talevski v. Health and Hospital Corp. of Marion Cnty., Ind., et al., No. 2:19-cv-0013-JTM-APR (Mar. 26, 2020) (judgment)

United States Court of Appeals for the Seventh Circuit:

Talevski v. Health and Hospital Corp. of Marion Cnty., Ind., et al., No. 20-1664 (July 27, 2021) (judgment); (Aug. 25, 2021) (order denying petition for panel and en banc rehearing).

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PETITION FOR A WRIT OF CERTIORARI

Petitioners Health and Hospital Corporation of Marion County, Indiana ("HHC"), Valparaiso Care and Rehabilitation ("VCR"), and American Senior Communities, LLC ("ASC") respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit in this case.

OPINIONS AND RULINGS BELOW

The opinion of the Seventh Circuit is reported at 6 F.4th 713. App., *infra*, 2a-26a. The order of the Seventh Circuit denying rehearing is not reported. App., *infra*, 38a-39a.

JURISDICTION

The Seventh Circuit entered judgment on July 27, 2021. App., *infra*, 2a-26a. Petitioners timely filed a petition for panel and *en banc* rehearing which was denied on August 25, 2021. App., *infra*, 38a-39a. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

42 U.S.C. § 1983 provides:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in

any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

The Federal Nursing Home Amendments Act of 1987 ("FNHRA") can be found at 42 U.S.C. § 1396r. The relevant portions of FNHRA are voluminous, and per this Court's Rule 14(f) can be found in full at App., *infra*, 41a-73a.

STATEMENT

This case presents a fundamental and recurring question, which several Members of this Court have raised but which the Court has not yet squarely resolved: Whether, under the original understanding of 42 U.S.C. § 1983, a third-party beneficiary may enforce federal Spending Clause legislation that imposes conditions on a State's receipt of federal funds. The case also presents a significant and recurring question concerning whether claims by nursing facility residents and their families—second-guessing garden-variety treatment and transfer decisions made by physicians and nursing facility administrators—may be pursued under Section 1983 and the Federal Nursing Home Amendments Act of 1987 ("FNHRA"), 42 U.S.C. § 1396r, free from the limitations prescribed by state law.

A. Judicially Implied Private Rights of Action and Spending Clause Statutes

For most of this nation's history, individuals did not have a recognized private right to enforce rights and privileges guaranteed by federal statutes. It is only when the rights revolution of the 1960s and 1970s came into full force that this Court began to expand access to courts through judicially implied private rights of action. See, *e.g.*, *J.I. Case Co.* v. *Borak*, 377 U.S. 426, 433 (1964). In 1980, this Court held for the first time that 42 U.S.C. § 1983 provides a cause of action for deprivations of federal statutory rights. *Maine* v. *Thiboutot*, 448 U.S. 1, 4 (1980). And in *Wright* v. *Roanoke Redevelopment and Housing Authority*, 479 U.S. 419 (1987), and *Wilder* v. *Virginia Hospital Association*, 496 U.S. 498 (1990), the Court allowed Section 1983 suits brought by private parties to enforce rights contained in federal Spending Clause legislation, even though Congress had not expressly provided for a private right of action in the statute.

In the three decades since *Wilder*, this Court has declined to find new implied private rights of action to enforce Spending Clause legislation. Plaintiffs nevertheless continue to bring Section 1983 lawsuits in the federal and state courts based on this Court's jurisprudence. As a consequence, state and local governments have been burdened by litigation costs and hefty damages—arising from unpredictable and shifting multi-factor balancing tests—that they never anticipated when they agreed to accept federal funding. Spending Clause legislation, as this Court has noted, derives its legitimacy from an agreement between the states and the federal government. It is doubtful that third-party enforcement actions, with

sky's-the-limit damages, are among the commitments that contracting states elected to shoulder.

And the historical evidence strongly suggests that states should not have to absorb those costs at all. At the time that Section 1983 was enacted, third-party beneficiaries had no right to sue to enforce a contract. Even today, private parties typically lack a private right of action as third-party beneficiaries to government contracts. For those reasons, many Members of this Court have questioned whether Section 1983 provides a private right of action for third-party beneficiaries to enforce cooperative federal-state Spending Clause programs. See, *e.g.*, *Blessing* v. *Freestone*, 520 U.S. 329, 339 (1997) (Scalia, J., concurring, joined by Kennedy, J.); *Pharm. Research & Mfrs. of Am.* v. *Walsh*, 538 U.S. 644, 683 (2003) (Thomas, J. concurring); *Armstrong* v. *Exceptional Child Ctr., Inc.*, 575 U.S. 320, 332 (2015) (plurality opinion of Scalia, J., joined by Roberts, C.J., Thomas, J., and Alito, J.).

Because this argument was never raised in *Wright* and *Wilder*, the Court has never squarely addressed it.

B. Statutory Background

The federal nursing facility law, FNHRA, 42 U.S.C. § 1396r *et seq.*, establishes a cooperative federal-state program and was enacted under the Spending Clause. FNHRA imposes an obligation on states to regulate their nursing facilities in a certain manner; in exchange, the states receive Medicaid funding. App., *infra*, 41a-73a.

Two directives to nursing facilities are implicated here. The first is that a "nursing facility must protect

and promote * * * [t]he right to be free from * * * physical or chemical restraints" except in certain circumstances. 42 U.S.C. § 1396r(c)(1)(A)(ii). The second is that "[a] nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility" except when certain broad and vague conditions are met. *Id.* § 1396r(c)(2)(A). Both of these directives are contained in a portion of FNHRA entitled "Requirements relating to residents' rights." *Id.* § 1396r(c).

FNHRA also contains an extensive set of remedies intended to ensure that states and nursing facilities live up to their obligations under the statute. For example, states must survey nursing facilities on a yearly basis, and facilities that fail those surveys are subject to a variety of sanctions, including denial of access to Medicaid funds and replacement of management. *Id.* §§ 1396r(h)(2)(A)(i)-(iv). The federal Secretary of Health and Human Services may levy many of the same sanctions. *Id.* §§ 1396r(h)(3)(A)-(C). FNHRA also requires facilities to provide an individualized grievance system for patients to use if they object to their treatment or medication, *id.* § 1396r(c)(1)(A)(vi), and requires states to provide an independent administrative review system for patients who wish to appeal a transfer to another facility, *id.* § 1396r(e)(3).

C. Factual Background

Respondent Gorgi Talevski suffers from dementia. App., *infra*, 2a. His wife and next friend Ivanka placed him in VCR, a long-term care facility in Valparaiso, Indiana that is owned by HHC and

operated by ASC.[1] *Ibid.* Talevski's condition was progressive, and it worsened while he was in VCR's care; no doubt because of his condition, Talevski repeatedly acted in a violent and sexually aggressive manner toward members of VCR's staff and female residents. App., *infra*, 92a. These were not minor infractions; among other things, Talevski repeatedly (and inappropriately) touched female residents, led them into his room and closed the door, and tried to stab VCR staff members with knives and forks. App., *infra*, 92a-93a.

In an effort to arrest his decline and ameliorate his behavior, Talevski's doctors prescribed, and requested that VCR administer, several drugs. *Ibid.* Talevski's daughter disagreed with some of those prescriptions, so Talevski filed a grievance with the Indiana State Department of Health ("ISDH") and, in September 2016, a different doctor ordered that Talevski's medication be tapered down. App., *infra*, 81a. Unfortunately, Talevski's aggressive behavior persisted, and after an incident in December 2016 VCR chose to transfer him permanently to an all-male facility (after discussing that possibility with his family in March 2016 and transferring him temporarily to such a facility twice in the intervening months). App., *infra*, 81a; 94a.

Talevski's family again objected. App., *infra*, 82a. Nevertheless, a physician at the new facility—entirely independent of VCR—determined that Talevski should not return to VCR because of his behavior. App., *infra*, 94a. So VCR sought to transfer Talevski

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[1] We refer to these three entities—petitioners here and appellees below—collectively as "VCR" whenever possible.

again—this time from the facility to which VCR had originally transferred him to a new, different facility. After Talevski's family challenged that transfer before an Administrative Law Judge ("ALJ") of the ISDH, the ALJ ruled in Talevski's favor. App., *infra*, 95a. But, when VCR offered Talevski the opportunity to return to its facility, Talevski declined that invitation. App., *infra*, 83a.

More than two years later, Talevski filed suit in the United States District Court for the Northern District of Indiana. App., *infra*, 77a-88a. He claimed that VCR violated a panoply of resident "rights" under FNHRA and that 42 U.S.C. § 1983 provided him a means of enforcing those rights. *Ibid.* The district court dismissed his complaint for failure to state a claim, App., *infra*, 28a-36a, and Talevski appealed.

D. The Court of Appeals' Decision

The Seventh Circuit reversed. App., *infra*, 3a. In its view, the two supposed rights in FNHRA that Talevski specifically pressed on appeal—the rights (a) to be free from certain chemical restraints and (b) to remain in a facility without being transferred except in certain circumstances—were implied in the text of FNHRA, and therefore Talevski could sue to enforce them under Section 1983. *Ibid.*

In so concluding, the Seventh Circuit purported to apply the tests this Court set out in *Blessing*, 520 U.S. 329, and *Gonzaga University* v. *Doe*, 536 U.S. 273 (2002). It held that FNHRA, despite being a Medicaid grant condition telling states how to regulate Medicaid-participating nursing facilities, unambiguously focused on the rights of nursing facility residents. App., *infra*, 9a-10a. The court also

concluded that enforcing the supposed rights Talevski claimed would not strain judicial competence. App., *infra*, 12a-13a. And, even though FNHRA contains extensive administrative and individualized remedies for residents who are unhappy with medications or transfers, the Seventh Circuit concluded that those remedies did not foreclose access to Section 1983 remedies. App., *infra*, 13a-15a.

Petitioners' request for rehearing and rehearing *en banc* was denied without comment. App., *infra*, 38a-39a.

REASONS FOR GRANTING THE PETITION

This Court should grant review to revisit and squarely address the fundamental question whether Spending Clause legislation gives rise to rights enforceable by private parties under Section 1983. Only this Court has the authority to reconsider its holding in *Wilder* and replace the current multi-factor balancing tests with the clear and easily administrable bright-line rule required by history and common-law tradition.

Even if the Court declines to revisit *Wilder*, this case also presents an ideal opportunity to provide greater guidance concerning Spending Clause enforcement. Respondent here—a former resident of a nursing facility owned and operated by petitioners—brought a lawsuit under Section 1983. He claimed that petitioners violated his rights by (1) administering him certain medications (which he terms chemical restraints) that his doctors prescribed and (2) transferring him to an all-male facility without his consent (after his violent and sexually aggressive behavior threatened staff members and

female residents). The Seventh Circuit, parsing the language of some of this Court's cases, concluded that FNHRA provided Talevski a statutory right, and that Section 1983 provided him a cause of action. This decision parted ways with this Court's treatment of the statutes at issue in *Pennhurst* and *Gonzaga*, and it compounded the confusion surrounding how to apply the tests this Court has created for assessing judicially implied private rights of action.

In reaching its erroneous result, the Seventh Circuit in one fell swoop federalized medical malpractice law for patients in nursing facilities throughout its jurisdiction, sweeping aside carefully chosen state policies in favor of a one-size-fits-all resort to Section 1983. The states in the Seventh Circuit, of course, had no idea that they were consenting to such a bargain when they accepted Medicaid funds. But, respectfully, that kind of disruption of state policies is the inevitable consequence of this Court's private right of action jurisprudence. At the very least, then, the Court should clarify yet again that lower courts must cast a jaundiced eye on claims of implied private rights of action—and, as *Pennhurst* and *Gonzaga* should have sufficiently reminded the Seventh Circuit, the mere inclusion of the word "rights" in a statute is not "dispositive" for finding an implied private right of action. App., *infra*, 11a.

This Court should grant certiorari and reverse the Seventh Circuit.

I. REVIEW IS WARRANTED TO ESTABLISH THAT THIRD-PARTY BENEFICIARIES DO NOT HAVE PRIVATE RIGHTS OF ACTION TO ENFORCE SPENDING CLAUSE LEGISLATION

The last time this Court recognized an implied right of action under a Spending Clause statute was more than thirty years ago in *Wilder* v. *Virginia Hospital Association*, 496 U.S. 498 (1990). Although the Court has since "plainly repudiate[ed] the ready implication of a § 1983 action that *Wilder* exemplified," *Armstrong* v. *Exceptional Child Ctr., Inc.*, 575 U.S. 320, 330 n* (2015), it has never repudiated *Wilder* itself. As a result, the courts of appeals continue to imply new private rights of action under a wide array of Spending Clause statutes, typically seizing on one or more stray passages from this Court's Section 1983 jurisprudence.

The Seventh Circuit's opinion illustrates the problem. Respondent's fundamental complaint was that VCR administered a medicine that his daughter disliked and then transferred him to a different facility when, in the professional judgment of his physicians and facility administrators, his aggressive behavior became a threat to himself and others. App., *infra*, 92a-93a. Under the decision below, such garden-variety medical disputes now give rise to a *federal civil rights lawsuit*, based on little more than unelaborated references to "rights" in FNHRA. App., *infra*, 11a. Such lawsuits allow dissatisfied nursing facility residents to circumvent important state policies. Indiana, for example, has enacted a cap on damages and attorneys' fees in medical malpractice cases, see IC §§ 34-18-14-3, 34-18-18-1, but now any

resident (or, more realistically, any enterprising plaintiff's lawyer) can nullify those limitations by suing in federal court under Section 1983, which has no damages cap, and seeking fees under 42 U.S.C. § 1988(b), which does not cap fees.

This proliferating body of law reflects not simply an errant turn in the road. To the contrary, the implication of third-party beneficiary claims under Spending Clause statutes was problematic from the start: At the time Section 1983 was enacted, common-law contractual principles—which inform the construction of Spending Clause legislation—simply did not permit strangers to a contract to make third-party claims. This case is an ideal vehicle for clearing away the underbrush, restoring predictability and fairness to contracting states, and ensuring that run-of-the-mill malpractice cases are adjudicated under the limitations prescribed by state law.

1. The Spending Clause broadly authorizes Congress to "place conditions on the grant of federal funds" and, in so doing, exert federal power over states indirectly in a manner that Congress could not do directly through its other Article I legislative powers. *Barnes* v. *Gorman*, 536 U.S. 181, 185-86 (2002). In exchange for federal funds, "States agree to comply with federally-imposed conditions." *Pennhurst State Sch. and Hosp.* v. *Halderman*, 451 U.S. 1, 17 (1981). Spending Clause legislation, this Court has repeatedly noted, is "much in the nature of a contract." *Ibid.* As such, "[t]here can, of course, be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it." *Ibid.* The Spending Clause otherwise becomes a cudgel, asserting "undue influence" over state policy in areas

that Congress is powerless to regulate directly. *NFIB* v. *Sebelius*, 567 U.S. 519, 577 (2012) (internal quotation marks omitted).

These contractual principles, which serve important federalism concerns, constrain not only the conditions that states are required to fulfill but also the remedies available for alleged violations of Spending Clause rights. *Barnes*, 536 U.S. at 187. A remedy is "'appropriate relief' only if the funding recipient is *on notice* that, by accepting federal funding, it exposes itself to liability of that nature." *Ibid.* (internal citation and quotation marks omitted) (emphasis in original). "In legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State." *Pennhurst*, 451 U.S. at 28. When a court adds a remedy not stated in the contract, it alters the terms of the parties' bargain. *Id.* at 29; *Barnes*, 536 U.S. at 187. When one of those parties is Congress, moreover, a federal court's alteration also raises separation-of-powers concerns.

2. This Court generally assumes "that members of the 42d Congress were familiar with common-law principles * * * and that they likely intended these common-law principles to obtain, absent specific provisions to the contrary." *Will* v. *Michigan Dep't of State Police*, 491 U.S. 58, 67 (1989) (quoting *Newport* v. *Fact Concerts, Inc.*, 453 U.S. 247, 258 (1981)). At the time the 42d Congress enacted Section 1983 in 1871 (and revised it in 1874), it was established common law "that no stranger to the

consideration can take advantage of a contract, though made for his benefit." W. W. Story, A Treatise on the Law of Contracts 509 (5th ed. 1874).[2] "[U]nless the promise is made to the plaintiff, or the consideration moves from him, he cannot generally sue on it." *Id.* at 526; see also 2 Francis Wharton, A Commentary on the Law of Contracts 157-58 (1882) ("In equity as well as in law the right to sue is restricted to those who are parties to the contract."). See also Anthony Jon Waters, *The Property in the Promise: A Study of the Third Party Beneficiary Rule*, 98 Harv. L. Rev. 1109, 1149 (1985).

Several Members of this Court have noted this anomaly in urging a revision of the Court's post-*Wilder* jurisprudence. Justice Scalia, joined by Justice Kennedy, concurring in *Blessing* v. *Freestone*, 520 U.S. 329, 348 (1997), observed that when "[t]he State promises to provide certain services to private individuals, in exchange for which the Federal Government promises to give the State funds," the recipient of those services is merely a "third-party

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[2] In *Wilder*, the plaintiffs were public and private hospitals that provided medical services in exchange for Medicaid funds. 496 U.S. at 503. In that sense, they were unlike the typical Section 1983 plaintiff suing to enforce federal Spending Clause legislation, in that they had actually provided consideration in exchange for the funds. Perhaps for this reason, no party in *Wilder* argued that the plaintiffs, as third-party beneficiaries, lacked a right to sue, thus depriving this Court of developed argument on this issue. Cf., *e.g.*, *Hohn* v. *United States*, 524 U.S. 236, 251 (1998) (noting this Court is "less constrained to follow precedent" where an opinion was rendered without fully developed argument).

beneficiary." *Id*. at 349. And "[u]ntil relatively recent times, the third-party beneficiary was generally regarded as a stranger to the contract, and could not sue upon it." *Ibid*. Accordingly, Justice Scalia explained, the ability of a private citizen "to compel a State to make good on its promise to the Federal Government was not a 'right * * * secured by the * * * laws' under § 1983." *Id*. at 350.

Justice Thomas made the same point in his concurring opinion in *Pharmaceutical Research and Manufacturers of America* v. *Walsh*, 538 U.S. 644, 683 (2003). As Justice Thomas noted, "[t]his contract analogy raises serious questions as to whether third parties may sue to enforce Spending Clause legislation." *Ibid*. In an appropriate case, Justice Thomas added, he "would give careful consideration to whether Spending Clause legislation can be enforced by third parties in the absence of a private right of action." *Ibid*.

More recently, the four-Member plurality in *Armstrong* recognized that inferring private rights of action from Spending Clause legislation is difficult to square even with contemporary contract law. Although third-party beneficiary claims are given wider berth these days than they were when Section 1983 was enacted, private suits to enforce *government* contracts remain *verboten*. 575 U.S. at 332 (Op. of Scalia, J., joined by Roberts, C.J., Thomas, J., and Alito, J.). But that is just what a private litigant seeks to do when she brings a Section 1983 claim under a Spending Clause statute. *Ibid*. "[M]odern jurisprudence permitting intended beneficiaries to sue does not generally apply to contracts between a private party and the government—much less to

contracts between two governments." *Ibid.* (internal citation omitted). And Spending Clause legislation is not just contractual in nature—it represents a contract "*between two governments*." *Ibid.* (emphasis added).

To be sure, most if not all Spending Clause legislation aims to benefit members of the public, who accordingly are "intended beneficiaries" of the statute. But those third-party beneficiaries have no right—today, much less in 1871—to sue on a government contract. 13 Williston on Contracts, § 37:35 (4th ed.); see Restatement (Second) of Contracts § 313 (1981); *Astra USA, Inc.* v. *Santa Clara Cnty.*, 563 U.S. 110, 118 (2011).

3. Even if this Court's Spending Clause jurisprudence had any basis in history and common-law tradition (and it does not), it warrants reconsideration because it has spawned confusion and inconsistent application in the lower courts.

To discern whether a private party may enforce rights under a Spending Clause statute, this Court has in the past articulated a multi-factor balancing test, asking (1) whether Congress "intended" the "provision in question [to] benefit the plaintiff," (2) whether the asserted right is "vague and amorphous," and (3) whether the statute "impose[s] a binding obligation on the States." *Blessing*, 520 U.S. at 340-41. More recently, recognizing that its decisions "may not be models of clarity," this Court in *Gonzaga*, 536 U.S. at 278, seemed to have jettisoned *Blessing*'s "multifactor balancing test" (*id.* at 286), in favor of examining "the text and structure of [the] statute" to determine whether "Congress intend[ed] to create

new individual rights" enforceable under Section 1983. *Ibid.*

Not surprisingly, the courts of appeals have taken divergent cues from this Court's jurisprudence. The decision below illustrates the basic confusion. The panel in this case relied on the *Blessing* factors in finding a private right of action under a Spending Clause statute. But just months earlier, a different panel of the Seventh Circuit, in an opinion by Judge Easterbrook, declined even to *entertain* the *Blessing* inquiry, flatly holding that this Court's post-*Wilder* decisions counsel against recognizing *any* new Spending Clause rights. *Nasello* v. *Eagleson*, 977 F.3d 599, 601 (7th Cir. 2020). Given that this Court "has not added to the list of enforceable provisions since *Wilder*," the *Nasello* court explained, the courts of appeals are not permitted "to enlarge the list of implied private rights of action." *Ibid.*[3]

The Seventh Circuit is not alone in its confusion. Compare *DeCambr*e v. *Brookline Hous. Auth.*, 826 F.3d 1, 10 (1st Cir. 2016) (applying *Blessing* factors); *Cal. Ass'n of Rural Health Clinics* v. *Douglas*, 738 F.3d 1007, 1011-12 (9th Cir. 2013) (applying *Blessing* factors unaltered by *Gonzaga*) with *Rio Grande Cmty. Health Ctr., Inc.* v. *Rullan*, 397 F.3d 56, 73 & n.10 (1st Cir. 2015) (finding *Gonzaga* imposed "somewhat different factors" and applying "*Gonzaga* rather than the *Blessing* test"); *McCready* v. *White*, 417 F.3d 700, 703 (7th Cir. 2005) (applying *Gonzaga* without mentioning *Blessing*). The confusion permeates state

[3] Although Petitioners sought rehearing based on the palpable conflict with *Nasello*, the court of appeals declined further review without comment.

courts and federal courts alike. Compare *Bates* v. *Henneberry*, 211 P.3d 68, 72 (Colo. App. 2009) (applying *Blessing* test modified by *Gonzaga* to find no private right to enforce section 1396a(a)(17)) with *Mendez* v. *Brown*, 311 F. Supp. 2d 134, 140 (D. Mass 2004) (unable to decide whether to apply *Blessing* or *Gonzaga*, but concluding there *is* a private right to enforce 1396a(a)(17)); compare *Roll* v. *Howard*, 480 P.3d 192, 209 (Kan. Ct. App. 2020) (applying *Gonzaga* to conclude 1396n(c)(2)(C) confers a private right of action) with *M.A.C.* v. *Betit*, 284 F. Supp. 2d 1298, 1307 (D. Utah 2003) (applying *Gonzaga* to conclude it does not).

These developments have prompted one judge to ask, bluntly, "are *Wilder* specifically, and the *Blessing* factors, generally, still good law?" *Planned Parenthood S. Atl.* v. *Baker*, 941 F.3d 687, 709 (4th Cir. 2019) (Richardson, J., concurring); see also *id.* at 710 (noting the "confusion" and "uncertainty" in the circuits); *N.Y. State Citizens' Coal. for Children* v. *Poole*, 922 F.3d 69, 94 (2d Cir. 2019) (Livingston, J., dissenting) (observing that "the Supreme Court's more recent jurisprudence calls into question the vitality of" *Blessing*); *Sabree ex rel. Sabree* v. *Richman*, 367 F.3d 180, 194 (3d Cir. 2004) (Alito, J., concurring) (the analysis of the district court rejecting private rights of action "may reflect the direction that future Supreme Court cases in this area will take").

Indeed, at least three Members of this Court have concluded that "this Court made a mess of the issue." *Gee* v. *Planned Parenthood of Gulf Coast, Inc.*, 139 S. Ct. 408, 409 (2018) (Thomas, J., joined by Alito, J., and Gorsuch, J., dissenting from denial of cert.). Those Justices would have granted certiorari in *Gee* because

that case "implicate[d] fundamental questions about the appropriate framework for determining when a cause of action is available under § 1983—an important legal issue independently worthy of this Court's attention." *Ibid*. This Court's jurisprudence in the field of private rights of action under Section 1983 has become so muddled, those Justices observed, that "[c]ourts are not even able to identify which of our decisions are 'binding.'" *Id*. at 410. The confusion in the circuits has not abated since this Court denied certiorari in *Gee*.

None of this should be surprising given the incoherence of the basic inquiry. Congress knows how to enact a private cause of action when it wants to. See, *e.g.*, Individuals with Disabilities Education Act, 20 U.S.C. § 1415(i)(3)(A); Rehabilitation Act, 29 U.S.C. § 794a(a). So what is a court supposed to make of a Spending Clause statute that *lacks* any such express provision? How, exactly, should a court decide whether Congress "intended" to enact a provision that it chose not to actually adopt? By returning to first principles, and permitting third parties to sue under Spending Clause statutes only when Congress has expressly so authorized, this Court would put an end to this fruitless inquiry, dispel the confusion in the lower courts, and resolve in one fell swoop several circuit conflicts involving other Spending Clause statutes. See, *e.g.*, Brief for 137 Members of Congress as Amici Curiae Supporting Certiorari at 11-15, *Baker* v. *Edwards*, 141 S. Ct. 550 (2020) (No. 19-1186); Brief for States of Indiana et. al., Supporting Certiorari at 9-14, *Gee* v. *Planned Parenthood of Gulf Coast, Inc.*, 139 S. Ct. 408 (2018) (No. 17-1492).

4. Returning to first principles would also honor principles of federalism and the separation of powers.

Any robust conception of federalism must take seriously the ability of states to choose the burdens they wish to undertake at public expense. "There can, of course, be no knowing acceptance if a State is unaware * * * or is unable to ascertain" the conditions imposed by the Spending Clause legislation. *Pennhurst*, 451 U.S. at 17. That knowing and voluntary acceptance "is critical to ensuring that Spending Clause legislation does not undermine the status of the States as independent sovereigns in our federal system." *NFIB*, 567 U.S. at 576-77; *Pennhurst*, 451 U.S. at 25 ("crucial inquiry" is whether "the State could make an informed choice"). Particularly given the capaciousness of Congress's Spending Clause authority, a requirement that Congress make explicit its intention to create a private right of action would add to the very short list of limits on "[t]he breadth of this power." *S. Dakota* v. *Dole*, 483 U.S. 203, 206 (1987).

So long as this Court's Spending Clause jurisprudence remains in flux, however, state autonomy will differ from one circuit to the next. Compare *Baker*, 941 F.3d at 696 (finding free-choice-of-provider provision in Medicaid Act enforceable through Section 1983) with *Planned Parenthood of Greater Texas Fam. Plan. & Preventative Health Servs., Inc.* v. *Kauffman*, 981 F.3d 347, 363 (5th Cir. 2020) (en banc) (declining, over dissent, to find free-choice-of-provider provision in Medicaid Act enforceable through Section 1983); compare also *Poole*, 922 F.3d at 74 (holding Child Welfare Act allows private right of action enforceable through

Section 1983) with *Midwest Foster Care and Adoption Ass'n* v. *Kincade*, 712 F.3d 1190, 1194 (8th Cir. 2013) (holding it does not). As Judge Livingston explained in her dissenting opinion in *Poole*, 922 F.3d at 86, finding enforceable private causes of action "upend[s] the relationship between the federal government and state [agencies]." And "[i]f Congress intends to alter the 'usual constitutional balance between the States and the Federal Government,' it must make its intention to do so 'unmistakably clear in the language of the statute.'" *Gonzaga*, 536 U.S. at 286 (quoting *Will*, 491 U.S. at 65).

The current ahistorical conception of Spending Clause rights also turns separation-of-powers principles on their head. "Creating new rights of action is a legislative rather than a judicial task." *Nasello*, 977 F.3d at 601. As a general rule, "[w]hen Congress chooses not to provide a private civil remedy, federal courts should not assume the legislative role of creating such a remedy and thereby enlarge their jurisdiction." *Cannon* v. *Univ. of Chicago*, 441 U.S. 677, 730-31 (1979) (Powell, J., dissenting). When federal courts do so, they "bypass[]" "the legislative process with its public scrutiny and participation" and undermine "the normal play of political forces." *Id*. at 743 (Powell, J., dissenting).

As the Court explained in *Gonzaga*, "we fail to see how relations between the branches are served by having courts apply a multifactor balancing test to pick and choose which federal requirements may be enforced by § 1983 and which may not." 536 U.S. at 286. As noted above, Congress knows how to enact a private cause of action in federal Spending Clause

statutes when it wants to. See, *e.g.*, Individuals with Disabilities Education Act, 20 U.S.C. § 1415(i)(3)(A). Where it has not done so, it is not the Judiciary's job to fill in the blanks.

5. Although this Court has not found a right privately enforceable via Section 1983 in Spending Clause legislation in over thirty years, courts of appeals continue to create new private rights of action regularly. See, *e.g.*, *Poole*, 922 F.3d at 82 (over dissent); *Planned Parenthood of Kansas* v. *Andersen*, 882 F.3d 1205, 1229 (10th Cir. 2018) (over dissent). In the process, States have been subjected to any number of conditions on federal funding that were not apparent when they accepted the funding. Not surprisingly, the expansion of such private rights of action—which, of course, enjoy the fee-shifting provisions of Section 1988—has spawned a cottage industry of private attorneys general seeking to enforce a range of implied rights limited only by the powers of imagination. And, in their wake, the States have faced years of unanticipated litigation costs and large damages awards.

The judicial system itself likewise bears the cost of this ever-expanding universe of private rights of action. Trial courts, both state and federal, struggle to apply complicated multifactor balancing tests—often reaching disparate conclusions. None of this would be necessary if the Court were to clarify that third-party beneficiaries to Spending Clause legislation do not have personal rights enforceable under Section 1983.

Adhering to historical norms would not, to be clear, deprive private beneficiaries of the benefits of any rights to which they are entitled under federal

law.[4] The requirements of federal law remain in place. Federal agencies can investigate compliance and assess specific enforcement mechanisms. State and federal administrative processes are also a means by which private beneficiaries can challenge the implementation of Spending Clause programs. And if those agencies act in an arbitrary and capricious fashion, litigants may go to court by invoking the Administrative Procedure Act (or state counterparts). See, *e.g.*, 5 U.S.C. § 702.

And after all that, if Congress *still* finds that its Spending Clause legislation is being under-enforced, it can do what the Legislative Branch is supposed to do: Enact a law. That is all the more reason to stop suturing this judicially-created fabric.

II. IN WRONGLY HOLDING THAT FNHRA CONFERS RIGHTS PRIVATELY ENFORCEABLE UNDER SECTION 1983, THE DECISION BELOW UNDERMINES STATES' ABILITY TO PROVIDE SKILLED NURSING SERVICES

Even if the Court declines to revisit its Spending Clause jurisprudence, the decision below warrants

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[4] Reverting to the historically grounded rule of third-party beneficiary contract enforcement would not affect private enforcement of most civil rights statutes, because Congress has expressly ratified this Court's holding in *Cannon* by authorizing private rights of action to enforce those statutes. 441 U.S. 677 (1979); see Section 504 of the Rehabilitation Act, 29 U.S.C. § 794a(a); Title II of the Americans with Disabilities Act, 42 U.S.C. § 12133; Section 1557 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18116(a).

review because it wrongly resolved two questions of exceptional importance, with devastating consequences for States' provision of skilled nursing services.[5]

1. The Seventh Circuit erred, first, in finding that FNHRA gives rise to private rights of action challenging garden-variety medication and transfer decisions in state nursing facilities. Over the last thirty years the Court has repeatedly cautioned against freewheeling implication of Section 1983 and other private claims. As the Court explained in *Alexander* v. *Sandoval*, 532 U.S. 275 (2001), "[s]tatutes that focus on *the person regulated* rather than *the individuals protected* create no implication of an intent to confer rights on a particular class of persons." *Id.* at 289 (emphasis added) (internal quotation marks omitted). In *Sandoval* itself, the statute fell short because it "focuse[d] neither on the

[5] Petitioners also pointed out before the Seventh Circuit that Talevski's claims were untimely; the statute of limitations for personal injury claims in Indiana (which Section 1983 borrows) is two years, but Talevski filed his complaint more than two years after he left VCR's care for the last time. App., *infra*, 16a-21a. The Seventh Circuit refused to apply tolling rules for medical malpractice claims in Indiana despite the obviously-medical-malpractice nature of Talevski's claims, and so it severely cabined VCR's ability to prevail on that issue as well. *Ibid.* In any event, the fact that VCR and Talevski had to argue over which *state* tolling provision and which *state* statute of limitations should apply in *federal* court is a symptom of the erroneous creation of the implied private right itself, as well as being the kind of fact-intensive issue that States would not have to face if courts stopped implying private rights of action that Congress did not see fit to enact.

individuals protected nor even on the funding recipients being regulated, but on the agencies that will do the regulating." *Ibid.* See also *Gonzaga*, 536 U.S. at 284 (third-party rights do not exist unless the statute has an "*unmistakable focus* on the benefitted class") (internal quotation marks omitted).

FNHRA has no such "unmistakable focus on the benefitted class." For one thing, as a Spending Clause statute it is a directive *to states* saying: "regulate your nursing facilities as the statute dictates, and in return you will receive Medicaid money." But that is not the end of the attenuation between the supposed rights-holder—Talevski—and the plain text of FNHRA. The chemical restraint provision Talevski invokes is addressed not to patients but instead to nursing facilities; "[a] nursing facility must protect and promote * * * [t]he right to be free from * * * physical or chemical restraints" except in certain circumstances. 42 U.S.C. § 1396r(c)(1)(A)(ii). So too the transfer provision: "[a] nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility," with certain exceptions. *Id.* § 1396r(c)(2)(A). And there is still an additional layer of attenuation; it is *doctors* who make the decisions on chemical restraints and transfers (as it was with Talevski). So, in effect, the statute is telling states how they must regulate their nursing facilities, and telling nursing facilities how the doctors that tend to their residents must behave, all before FNHRA gets to residents themselves. That is simply not the unmistakable focus on the benefitted class that *Gonzaga* requires.

Nor does it matter, as the court below mistakenly surmised, that FNHRA sprinkles the word "right"

throughout various parts of its text. App., *infra*, 9a. In *Pennhurst*, for example, this Court confronted a statute that contained a "bill of rights" for the developmentally disabled. 451 U.S. at 8, 13. The respondents insisted that the reference to "rights" was sufficient to give rise to privately enforceable rights, but this Court disagreed. "In expounding a statute," the Court explained, "we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy." *Id.* at 18 (internal quotation marks omitted).

The Court made the same point more recently in *Gonzaga*. Much like the court below, Justice Stevens pointed in dissent to provisions in the statute that used the term "rights," and he contended that "any reference to 'rights,' even as a shorthand means of describing standards and procedures imposed on funding recipients, should give rise to a statute's enforceability under § 1983." *Gonzaga*, 536 U.S. at 289 n.7. But the majority rejected that argument, explaining that, under *Pennhurst*, the mere reference to "rights" does not suffice to confer a private right of action.[6]

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[6] The court of appeals also misconceived the ability of federal courts to superintend the two new patient "rights" that it invented. Unwanted transfers, for example, are permitted where "the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility," 42 U.S.C. § 1396r(c)(2)(A)(i); "the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility," *id.* § 1396r(c)(2)(A)(ii); and "the safety of individuals in the facility is endangered," *id.* § 1396r(c)(2)(A)(iii). How is a

2. The Seventh Circuit also placed too little weight on the comprehensive and individualized remedies in FNHRA, which should foreclose access to Section 1983. "Even if a plaintiff demonstrates that a federal statute creates an individual right, there is only a rebuttable presumption that the right is enforceable under § 1983." *Blessing*, 520 U.S. at 341. Congress can rebut that presumption "expressly, by forbidding recourse to § 1983 in the statute itself, or impliedly, by creating a comprehensive enforcement scheme that is incompatible with individual enforcement under § 1983." *Ibid.*

Congress impliedly preempted any resort to Section 1983 for these particular "rights" in FNHRA. First off, the means of enforcing FNHRA's commands to nursing facilities are exceptionally comprehensive. Every facility that receives Medicaid money is subject to an annual survey for its compliance with FNHRA. See 42 U.S.C. § 1396r(g)(2)(A). If the state finds that a facility is out of compliance, it has a variety of remedies at its disposal—denial of payment to the facility under Medicaid, assessment of a civil monetary penalty against the facility, appointment of temporary management of the facility, or even closure of the facility and transfer of its residents. *Id.* §§ 1396r(h)(2)(A)(i)-(iv). The Secretary of Health and Human Services (the "Secretary") has access to all the same remedies in assessing state-owned facilities, *id.*

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federal court to decide whether a facility can meet a given resident's medical needs, or whether the resident is well enough to be transferred, or whether his behavior endangers others in the facility? Federal courts have no objective means of assessing questions like those that go to the core of the doctor-patient relationship.

§ 1396r(h)(3)(A), but he can also deny payment under Medicaid, impose civil monetary penalties, or appoint temporary management for non-state-owned facilities, *id.* §§ 1396r(h)(3)(B)-(C).

FNHRA also contains individualized remedies, including, as most relevant here, individualized remedies for both Talevski's transfer and chemical restraint claims. For transfers, states must "provide for a fair mechanism * * * for hearing appeals on transfers and discharges of residents of such facilities." *Id.* § 1396r(e)(3). For the alleged chemical restraint, FNHRA requires facilities to allow residents to "voice grievances with respect to treatment or care that is (or fails to be) furnished." *Id.* § 1396r(c)(1)(A)(vi). And the Secretary has promulgated guidelines that, in turn, require an individualized care and treatment grievance process for residents with appeal to an independent arbiter. 42 C.F.R. § 483.10(j).[7]

Tellingly, Talevski made use of both sets of administrative procedures. As detailed above, he filed a "formal complaint" with the ISDH about his medication, and as a result his medicines were tapered down. *Supra* at 6. As to the transfer, Talevski likewise filed an appeal to the ISDH, which again ruled in his favor—meaning that he was permitted, had he chosen to do so, to return to VCR. *Id.* at 7. In short, Talevski not only had ample means to reverse the VCR actions that grieved him: he

[7] Regulations that the Secretary is authorized to promulgate "authoritatively construe the statute itself," *Alexander*, 532 U.S. at 284, and therefore express Congress's intent just the same.

actually *deployed* those means successfully. Offering "a direct route to court via § 1983" would "circumvent[] these procedures and give[] [him] access to tangible benefits—such as damages, attorney's fees, and costs—that [are] unavailable under [FNHRA]." *Fitzgerald* v. *Barnstable Sch. Comm.*, 555 U.S. 246, 254 (2009).

None of that made a whit of difference to the Seventh Circuit. In its view, Congress had failed to enact "the type of comprehensive enforcement scheme, incompatible with individual enforcement, that we are looking for." App., *infra*, 14a. It is not easy to discern what the court of appeals was "looking for," as its reasoning is at best conclusory. With respect to the "right" against unwanted transfers, for example, the Seventh Circuit proclaimed without elaboration that "[t]he administrative appeals process for involuntary transfers does not indicate a comprehensive enforcement scheme either." App., *infra*, 15a. Well, why not? What more is required to assure against improper transfers from a facility? And doesn't the very fact that FNHRA expressly provides for an administrative grievance process "suggest[] that Congress intended to preclude other[]" remedies? *Alexander*, 532 U.S. at 290.

Nor does FNHRA's savings clause, as the court of appeals mistakenly supposed (App, *infra*, at 16a), make any difference. See 42 U.S.C. § 1396r(h)(8) (providing that the remedies in the statute "shall not be construed as limiting such other remedies, including any remedy available to an individual at common law"). As this Court has explained (in language the court of appeals failed even to acknowledge), "[i]t is doubtful" that a phrase like

"other remedies" in a savings clause "includes the very statute in which this statement was contained." *Middlesex Cnty. Sewerage Auth.* v. *Nat'l Sea Clammers Ass'n*, 453 U.S. 1, 15-16 (1981).

3. The Seventh Circuit's discovery of implied rights under FNHRA is just the latest incursion on state sovereignty under that statute. The Third Circuit, in *Grammer* v. *John J. Kane Regional Centers-Glen Hazel*, 570 F.3d 520 (2009), and the Ninth Circuit, in *Anderson* v. *Ghaly*, 930 F. 3d 1066 (2019), also concluded that some or all of the provisions Talevski invokes here imply a private right of action. Making the same errors that the Seventh Circuit did (*Grammer*, for example, likewise placed excessive weight on the word "rights," see 570 F.3d at 529-30), these decisions reflect a steady erosion of state policy in an area—medical malpractice and healthcare regulation—that is traditionally the domain of the states.

At heart, Talevski's claim (and the claims in *Grammer* and *Anderson*) were garden-variety medical malpractice disputes. Talevski's family disagreed with the medicine VCR was asked to administer, App., *infra.*, 6a; disputes over medicine administered to a patient are quintessentially medical malpractice in nature. See, *e.g.*, *Madison Ctr., Inc.* v. *R.R.K.*, 853 N.E.2d 1286, 1288-89 (Ind. Ct. App. 2006) ("The * * * failure to properly medicate, restrain, or confine the [patient] who struck and injured [a resident] may have constituted malpractice as to that [patient.]"). So, too, the decision whether to transfer Talevski—at bottom, that involved professional judgments concerning whether VCR could both meet his medical needs and keep its other patients safe while doing so.

Such decisions quintessentially require a physician's judgment. Traditionally, nursing facility patients have brought such claims under state law, subject to whatever constraints and limitations the state has imposed. See, *e.g.*, *Pegram* v. *Herdrich*, 530 U.S. 211, 237 (2000) (health care is a "subject of traditional state regulation"). Now, at least in the Third, Seventh, and Ninth Circuits, there is no reason to worry about state law at all.

That is no small matter to the States. Many states, for example, have capped the damages available in a medical malpractice claim. See, *e.g.*, IC § 34-18-14-3 (Indiana, $1.8 million); Colo. Rev. Stat. § 13-64-302(1)(b) (Colorado, $1 million). Other states have capped the noneconomic damages (*e.g.*, damages for pain and suffering) that plaintiffs may receive. See, *e.g.*, Tex. Civ. Prac. & Rem. Code § 74.301(a) (Texas, $250,000); Cal. Civ. Code § 3333.2(b) (California, $250,000); Mo. Rev. Stat. § 538.210(2)(1) (Missouri, $400,000, adjusted for inflation, for non-catastrophic injuries); Mass. Gen. Laws ch. 231, § 60H (Massachusetts, $500,000 except for certain very severe injuries). Such statutes reflect state policy choices that federal courts should respect: Patients are entitled to compensation for injuries that occur in the course of medical treatment, but only up to a point. The decisions implying a private right under FNHRA permit any competent plaintiff's lawyer to circumvent those caps simply by recourse to Section 1983.

So too for laws that allocate available damages between the medical provider and state funds. See, e.g., IC § 34-18-14-3(d)(3) (Indiana, $500,000 cap on what medical provider has to pay); La. Rev. Stat.

40:1231.2(B)(2) (Louisiana, $100,000). Statutes like these reflect a state policy judgment that there should be limits on the liability of the actual providers. Needless to say, providers in those states rely on these statutes in planning and running their operations. Decisions like the Seventh Circuit's subject healthcare providers to unlimited damages (see *supra* at 30) with no state backstop.

Invoking Section 1983 relief is also an easy way to elude state-law caps on attorneys' fees in malpractice actions. If Talevski had filed his claim in Indiana state court, his attorneys would have been entitled to no more than 32% of any recovery. IC § 34-18-18-1. Similar limits abound in other states. See, *e.g.*, Del. Code Ann. tit. 18, § 6865 (Delaware, sliding scale based on amount of recovery); Nev. Rev. Stat. § 7.095 (Nevada, sliding scale based on amount of recovery); Tenn. Code Ann. § 29-26-120 (Tennessee, no more than 1/3 of damages awarded to claimant). Federal civil rights lawsuits have no such limitation; plaintiff's lawyers can claim as much of any fee award as their clients will allow.

But it gets worse: Section 1983 also permits plaintiffs to circumvent states' limits on their *own* liability. States across the country—from Indiana (see IC § 34-13-3-4(a)) to Vermont (see 12 V.S.A. § 5601(b)) to Florida (see Fla. Stat. § 768.28(5)(a)) to Idaho (see Idaho Code § 6-926(1))—have enacted caps on the amount of damages for which they or their employees may be liable in tort suits under state law. These statutes are in effect limited waivers of state sovereign immunity; they allow states to be held liable in court by their citizens, *but only up to a certain amount*. Many states, however, own nursing

facilities; Petitioners here, for example, are "state-run." App., *infra*, 2a. Allowing resort to Section 1983—with, again, its unlimited damages—effectively abrogates those states' limited waiver of sovereign immunity with regard to tort claims. A patient in a state-owned or -run facility with a claim that can be couched as a FNHRA violation can hale the state into federal court and avoid any tort damages cap.[8]

4. Decisions finding implied private rights under FNHRA also threaten the quality of care in nursing facilities.[9]

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[8] For all of these reasons and others, a group of states filed an amicus brief supporting respondents before the Seventh Circuit. See Br. of Indiana, Alabama, Alaska, Kentucky, Mississippi, and Nebraska as *Amici Curiae* in Support of Defendants-Appellees at 13-15, *Talevski* v. *Health & Hospital Corp. of Marion Cnty.*, 6 F.4th 713 (7th Cir. 2021) (No. 20-1664)(noting that implication of private right of action would "rob[] States of one of the benefits of the Medicaid bargain—the ability and flexibility to regulate nursing homes in the way that is best suited for each State" and "would surely have a disruptive effect on the nursing home industry").

[9] See, *e.g.*, M. Wortham, *The Role of Litigation in the Quest for Better Care: A Critique of "Litigating the Nursing Home Case"*, 12 No. 1 ANDREWS NURSING HOME LITIG. REP. 1 (July 2009) at 3 ("Numerous scholars have determined that actions by overly vigorous plaintiffs' counsel have resulted in an actual decrease in nursing home quality."); J. Troyer and H. Thompson, Jr., *The Impact of Litigation on Nursing Home Quality*, 29 J. HEALTH POLITICS, POLICY & LAW 11–42 (2004) (Duke University researchers finding that increased legal claims against nursing facilities are associated with a decline in quality of care); A. Gruneir and

Even before the further incursions occasioned by the newfound rights under FNHRA, one researcher had identified "[r]apidly increasing liability insurance rates for nursing homes" as a "substantial financial issue that threatens the stability of the industry." H. White, *Promoting Quality Care in the Nursing Home*, 13 ANNALS OF LONG TERM CARE (Apr. 2005). And that is all against a backdrop of chronic underfunding of nursing facilities to begin with. Many facilities derive a substantial portion of their revenue from Medicaid patients. See, *e.g.*, David C. Grabowski, Ph.D. & Vincent Mor, Ph.D., *Nursing Home Care in Crisis in the Wake of COVID-19*, JAMA Network (May 22, 2020), https://perma.cc/7RUW-MKMC. But Medicaid "often pays below the cost of caring" for each patient in a nursing home, *ibid.*; indeed Medicaid's expected shortfall in reimbursement cost per Medicaid patient per day in 2015 was $22.46. See Eljay, LLC & Hansen Hunter & Co., PC, *A Report on Shortfalls in Medicaid Funding for Nursing Center Care* (Apr. 2016), https://perma.cc/FH2R-7WN3 (report produced for the American Health Care Association ("AHCA")). A similar report found similar underpayment in 2017. See Hansen Hunter & Co., PC, *A Report on Shortfalls in Medicaid Funding for Nursing Center Care*, at 4 (Nov. 2018), https://perma.cc/42DT-3YZU (report produced for AHCA). That can translate to hundreds of thousands or even millions of dollars in underfunding per facility per year, depending on how many Medicaid patients a facility treats.

V. Mor, *Nursing Home Safety: Current Issues and Barriers to Improvement*, 29 ANNUAL REVIEW OF PUBLIC HEALTH (2008) (Brown University researchers finding that difficult regulatory environment slows care advances).

COVID-19 has only worsened the situation. Nursing facilities have faced an estimated additional $60 billion in COVID-19-related costs in 2020 and 2021, with federal government rescue funding for nursing facilities able to cover only slightly more than half of that. American Health Care Association, *Protect Access to Long Term Care for Vulnerable Residents*, https://perma.cc/Q57A-6VY4 (last visited Nov. 4, 2021) [hereinafter "AHCA, *Protect Access*"]. Nursing facilities nationwide also saw a revenue decline in 2020 ($11.3 billion, an 8% decline) and projected one in 2021 ($22.6 billion, 16% decline). *Ibid.* Meanwhile, nursing facilities suffered substantial liability insurance rate increases in 2020, with many insurance carriers choosing to exit the nursing facility market even before the COVID-19 pandemic made things worse yet. Amy O'Connor, *Nursing Home Insurance Market In Need of Care*, INSURANCE JOURNAL (May 4, 2020), https://perma.cc/4RF7-FTTD.

The natural consequence of these increased expenses and decreased revenues was facility closures or mergers: 143 in 2020, and a projected 1,670 in 2021. See AHCA, *Protect Access*. Decisions implying private rights under FNHRA can only exacerbate the pressures on nursing facilities, and in turn narrow the choices available to America's aging population.

As for the facilities whose finances can weather the storm, the availability of freewheeling Section 1983 liability is apt to impair, not strengthen, the standard of care. Merely because a facility's operations have gotten the seal-of-approval from the State and HHS will not insulate the nursing home from the specter of private litigation. Take Talevski's

purported "transfer" right under FNHRA, under which transfers are permitted where "necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility," 42 U.S.C. § 1396r(c)(2)(A)(i). As detailed above, facilities are subject to annual surveys to make sure that they comply with FNHRA's requirements, *supra* at 26, which means that either the state, the Secretary, or both have to assess whether a facility's transfers meet that standard. But under the Seventh (and Ninth) Circuit decisions, the fact that the Secretary or State has approved a facility's compliance won't estop an enterprising resident (or lawyer) from filing a Section 1983 lawsuit to second-guess that approval. Lay juries are apt to apply a different standard than would the Secretary or the State; surely plaintiffs will be able to find at least one expert willing to swear that a resident's welfare could have been "met in the facility." 42 U.S.C. § 1396r(c)(2)(A)(i). The prospect of nursing facilities having to meet such conflicting standards will only add to compliance costs, decrease the quality of care provided, and accelerate the ongoing exodus of high-quality nursing facilities from the market.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

LAWRENCE S. ROBBINS
Counsel of Record
ALAN E. UNTEREINER
JOHN B. GOERLICH
ANNA L. DEFFEBACH
ROBBINS, RUSSELL, ENGLERT,
ORSECK & UNTEREINER LLP
2000 K Street, N.W.,
Washington, D.C. 20006
(202) 775-4500
lrobbins@robbinsrussell.com

Counsel for Petitioners

November 2021

APPENDIX A

APPENDIX A

In the United States Court of Appeals
For the Seventh Circuit

No. 20-1664

GORGI TALEVSKI, by next friend IVANKA TALEVSKI,

Plaintiff-Appellant,

v.

HEALTH AND HOSPITAL CORPORATION OF MARION COUNTY, *et al.*,

Defendants-Appellees.

Appeal from the United States District Court for the Northern District of Indiana, Hammond Division.
No. 2:19 CV 13 — James T. Moody, *Judge*.

ARGUED DECEMBER 4, 2020 —
DECIDED JULY 27, 2021

Before KANNE, WOOD, AND SCUDDER, *Circuit Judges*.

WOOD, *Circuit Judge*. For Gorgi Talevski, living with dementia went from difficult to worse during his stay at Valparaiso Care and Rehabilitation, a state-run nursing facility near his family home in Indiana. Through his wife, Ivanka Talevski, he sued Valparaiso Care, the Health and Hospital Corporation of Marion County (HHC), and American Senior

Communities, LLC (ASC) under 42 U.S.C. § 1983 for violations of the Federal Nursing Home Reform Act (FNHRA), see 42 U.S.C. § 1396r *et seq*. (We refer to the defendants collectively as Valparaiso Care unless the context requires *otherwise*.) The district court dismissed the action for failure to state a claim on which relief can be granted, based on its finding that FNHRA does not provide a private right of action that may be redressed under 42 U.S.C. § 1983.

This is a difficult area of law, no doubt, and we appreciate the careful attention that both this district court and several others within our circuit have given to this issue. See *Terry v. Health & Hospital Corporation*, 2012 U.S. Dist. LEXIS 43702 (S.D. Ind. Mar. 29, 2012); *Schwerdtfeger v. Alden Long Grove Rehab. & Health Care Ctr., Inc.*, No. 13 C 8316, 2014 WL 1884471 (N.D. Ill. May 12, 2014); *Fiers v. La Crosse County*, 132 F. Supp. 3d 1111 (W.D. Wis. 2015). We conclude, however, in keeping with the views of two of our sister circuits, that the court erred. See *Grammer v. John J. Kane Reg'l Centers-Glen Hazel*, 570 F.3d 520 (3d Cir. 2009); *Anderson v. Ghaly*, 930 F.3d 1066 (9th Cir. 2019); see generally *Maine v. Thiboutot*, 448 U.S. 1, 4 (1980) ("[T]he [section] 1983 remedy broadly encompasses violations of federal statutory as well as constitutional law."). We therefore reverse and remand for further proceedings.

I

FNHRA establishes the minimum standards of care to which nursing-home facilities must adhere in order to receive federal funds in the Medicaid program, 42 U.S.C. § 1396 *et seq*. In addition to specifying rules for the facilities, it also includes "[r]equirements relating to residents' rights." *Id*. §§

1395i-3(c); 1396r(c). This case involves two of those rights: the right to be free from chemical restraints imposed for purposes of discipline or convenience rather than treatment, see id. §§ 1395i-3(c)(1)(A)(ii); 1396r(c)(1)(A)(ii); and the right not to be transferred or discharged unless certain criteria are met, see *id.* §§ 1395i-3(c)(2)(A), 1396r(c)(2)(A).

The Medicaid program "allows states to provide federally subsidized medical assistance to low-income individuals and families." *Bontrager v. Ind. Fam. & Soc. Servs. Admin.*, 697 F.3d 604, 605 (7th Cir. 2012); see 42 U.S.C. § 1396-1. Among other services, "medical assistance" includes treatment at nursing-home facilities. 42 U.S.C. § 1396d(a). In return for federal funding, participating states must comply with the program's statutory and regulatory requirements, including FNHRA. *Bontrager*, 697 F.3d at 606.

FNHRA was enacted pursuant to Congress's Spending Clause powers as part of the Omnibus Budget Reconciliation Act of 1987, codified at 42 U.S.C. §§ 1395i-3; 1396r. (The two sections are identical, and so from this point we will cite only to section 1396r.) It outlines several ways in which government-certified nursing facilities must avoid sub-standard care. The Act provides comprehensive guidance on the regulation and operation of nursing homes. Committee on Nursing Home Regulation, Institute of Medicine, *Improving the Quality of Care in Nursing Homes*, 2-3 (1986). See, *e.g.*, 42 U.S.C. § 1396r(a) (defining nursing facility); 42 U.S.C. § 1396r(b) (provision of services, performance reviews, and training expectations); 42 U.S.C. § 1396r(c) (requirements related to residents' rights, including a

list of specified rights and accompanying notice requirements); 42 U.S.C. § 1396r(d) (requirements related to the administration of nursing home facilities); 42 U.S.C. § 1396r(e) (requirements for states related to nursing facility requirements, including a state appeals process for resident transfers and discharges); 42 U.S.C. § 1396r(f) (responsibilities of the Secretary of Health and Human Services related to nursing facility requirements); 42 U.S.C. § 1396r(g) (instructions for states to conduct annual compliance surveys and associated certification processes); 42 U.S.C. § 1396r(h) (an enforcement scheme that authorizes states and the Secretary to take several remedial steps for noncompliant facilities); 42 U.S.C. § 1396r(i) (instructions to the Secretary for maintenance of a "Nursing Home Compare" website for Medicare beneficiaries).

Ivanka Talevski's complaint, brought on behalf of her disabled husband, accused Valparaiso Care of failing to adhere to FNHRA's requirements in numerous respects, including the following: failure to provide Gorgi Talevski with adequate medical care; the administration of powerful and unnecessary psychotropic medications for purposes of chemical restraint, the use of which resulted in Gorgi's rapid physical and cognitive decline; the discharge and transfer of Gorgi to other facilities in Indiana without the consent of his family or guardian, and without his dentures; the refusal to fulfill an administrative law judge's order to readmit him to Valparaiso Care; and the "maint[enance of] a policy, practice, or custom, [sic] that failed to care for Mr. Talevski in such a manner and in such an environment as to promote

maintenance or enhancement of the quality of life of each resident."

On appeal, Ivanka has abandoned all but two of these particulars. Those that remain appear in sections 1395i-3(c) and 1396r(c) of the Act, "Requirements relating to residents' rights," known as the "Residents' Bill of Rights," H.R. Rep. No. 100–391, pt. 1, at 452. Ivanka alleges that Valparaiso Care violated Gorgi's statutory right to be free from chemical restraints by over-prescribing psychotropic drugs to restrain him chemically for purposes of discipline or convenience, 42 § 1396r(c)(1)(A)(ii), and his rights related to resident-transfer and discharge procedures, insofar as he was deprived of his rights to remain at Valparaiso Care and to receive timely notice of a transfer or discharge, 42 U.S.C. § 1396r(c)(2). We thus limit our inquiry to those two provisions.

Section 1396r(c)(1)(A) provides:

> A nursing facility must protect and promote the rights of each resident, including each of the following rights:
>
> …
>
> (ii) Free from restraints
>
> The *right* to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed--
>
> (I) to ensure the physical safety of the resident or other residents, and

> (II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

42 U.S.C. § 1396r(c)(1)(A)(ii) (emphasis added).

Section 1396r(c)(2) describes the circumstances in which a facility is permitted to transfer or discharge a resident. Facilities "must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless[:]"

> (i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;
>
> (ii) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
>
> (iii) the safety of individuals in the facility is endangered;
> (iv) the health of individuals in the facility would otherwise be endangered;
>
> (v) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under this sub- chapter or subchapter XVIII on the resident's behalf) for a stay at the facility; or
>
> (vi) the facility ceases to operate.

Like section 1396r(c)(1)(A), this section focuses on the residents' rights; in substance it creates a right to

remain in a facility in the absence of the specified justifications. It dictates pre-transfer and pre-discharge notice requirements and clinical record documentation. 42 U.S.C. § 1396r(c)(2)(A). As we indicated earlier, the question before us is whether sections 1396r(c)(1)(A)(ii) and 1396r(c)(2)(A) confer a privately enforceable right upon nursing home residents such as Talevski.

II

A

Several decisions of the Supreme Court provide the starting point for our analysis. In *Blessing v. Freestone*, 520 U.S. 329 (1997), and *Gonzaga University v. Doe*, 536 U.S. 273 (2002), the Supreme Court emphasized that plaintiffs seeking redress for an alleged violation of a statute through a section 1983 action "must assert the violation of a federal right, not merely a violation of federal *law*." *Blessing*, 520 U.S. at 340 (emphasis in original). "Three factors help determine whether a federal statute creates private rights enforceable under § 1983." *Planned Parenthood of Ind., Inc. v. Comm'r of Indiana State Dep't Health*, 699 F.3d 962, 972 (7th Cir. 2012).

> First, Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on the States. In other words, the provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms.

Blessing, 520 U.S. at 340–41 (cleaned up). *Gonzaga* clarified that it is not enough for plaintiffs to fall "within the general zone of interest that the statute is intended to protect;" nothing "short of an unambiguously conferred right … phrased in terms of the persons benefited" can support a section 1983 action. 536 U.S. at 283–84. See also *Cannon v. Univ. of Chi.*, 441 U.S. 677, 692, n.13 (1979). *Gonzaga* further explained that courts must "determine whether Congress *intended to create a federal right*." 536 U.S. at 283 (emphasis in original). In applying *Blessing's* three factors in light of *Gonzaga*, we must decide whether the text and structure of the relevant parts of FNHRA unambiguously reveal that it establishes individual rights for a particular class of beneficiaries. See *id*. at 286.

B

We begin with the question whether Congress intended sections 1396r(c)(1)(A)(ii) and 1396r(c)(2)(A) to benefit nursing-home residents. We find that it did. Although other parts of section 1396r address measures that nursing homes must take, section (c) explicitly uses the language of rights. We do not know how Congress could have been any clearer. After the heading, the statute says "[a] skilled nursing facility *must protect and promote the rights of each resident, including each of the following rights*." 42 U.S.C. § 1396r(c)(1)(A) (emphasis added). For this part of the statute, therefore, nursing-home residents are the expressly identified beneficiaries.[1] *Gonzaga*, 536 U.S.

[1] We do not have before us, and we make no comment on, the existence of a private right of action under any other provisions of FNHRA.

at 283. The facilities in which they reside "must protect and promote the right[] of each resident" to be free from chemical restraints, and "must permit each resident to remain in the facility and must not transfer or discharge the resident." See 42 U.S.C. §§ 1396r(c)(1)(A)(ii) and (c)(2). Congress's unmistakable focus" on the entitlements of individual residents is ap- parent. *Cannon*, 441 U.S. at 691. And, to reiterate, both protections contain exactly the type of "rights-creating language" Gonzaga described as critical: they set forth "the rights of each resident" and appear under the "specified rights" heading of 42 U.S.C. § 1396r(c). *Gonzaga*, 536 U.S. at 284; see also *Alexander v. Sandoval*, 532 U.S. 275, 288–89 (2001).

Valparaiso Care argues that Ivanka cannot show the necessary individual focus because the protections at issue serve only as directives to nursing facilities and physicians, and FNHRA as a whole is addressed to states that receive federal Medicaid funding. But it is ignoring the language Congress chose in the sections on which Ivanka is relying. Congress told the facilities to respect the *rights* it had singled out, just as a facility must respect a person's right to be free from sex or race discrimination. It is thus of no consequence that section 1396r(c)(1)(A) begins with the phrase "[a] nursing facility must … ." What must it do? "[P]rotect and promote the rights of each resident … ."

Faced with similar language in *Anderson v. Ghaly*, the Ninth Circuit found an unambiguous conferral of individual rights. 930 F.3d 1066, 1074–75 (9th Cir. 2019). The statute it was evaluating, 42 U.S.C. § 1396r(e)(3), requires states to "provide for a fair mechanism … for hearing appeals on transfers

and discharges." The court rejected the argument that "a statute cannot create rights when phrased as a directive to the state," *id.* at 1074, and held instead that the rights-creating language of the statute was what mattered. *Id.* The fact that "cooperative federalism programs like Medicaid, under which 'Congress provides funds to the states on the condition that the state spend the funds in accordance with federal priorities,' are necessarily phrased as a set of directives to states that wish to receive federal funding," *id.* (citation omitted), was of no moment.

Congress enacted FNHRA as an amendment to the Medicaid statute in response to widespread abuses among government-certified nursing facilities. Nursing facilities have an important role to play in ending that abuse. Contrary to Valparaiso Care's argument that the acknowledgement of the role of the nursing facilities must mean that the statute only tangentially touches on the rights of residents, however, we find dispositive the fact that Congress spoke of resident *rights*, not merely steps that the facilities were required to take. This shows an intent to benefit nursing home residents directly. As the Ninth Circuit put it in *Anderson*, "[i]t has never been a requirement that a statute focus *solely* on individuals, to the exclusion of all others, to demonstrate congressional intent to create a statutory right." *Id*. (emphasis in original). If it were, "plaintiffs [would be] now flatly forbidden in section 1983 actions to rely on a statute passed pursuant to Congress's Spending Clause powers." *BT Bourbonnais Care, LLC v. Norwood*, 866 F.3d 815, 820–21 (7th Cir. 2017). But that is not the law. Indeed, the Supreme Court has cautioned against such a blunt approach in favor of a

"methodical inquiry" into the plaintiff's claims. See *Blessing*, 520 U.S. at 342–43.

Blessing's second factor requires the plaintiff to demonstrate that the right assertedly protected by the statute is not so vague and amorphous that its enforcement would strain judicial competence. Sections 1396r(c)(1)(A)(ii) and 1396r(c)(2)(A) do not suffer from those flaws. The rights they protect "fall[] comfortably within the judiciary's core interpretive competence." *Planned Parenthood of Ind., Inc.,* 699 F.3d at 974. Facilities "must not" do exactly what Ivanka alleged has occurred: subject residents to chemical restraints for purposes of discipline or convenience and involuntarily transfer or discharge any resident absent one of several allowable justifications and notice. It does not take a medical review board to determine whether these rights have been violated.

Valparaiso Care's arguments to the contrary are unconvincing. Clinging to FNHRA's use of the undefined words "protect," "promote," "discipline," and "convenience" in section 1396r(c)(1)(A), it asks how a court could determine whether a nursing facility has sufficiently protected and promoted freedom from chemical restraints or assess whether a decision to use restraints falls under an acceptable exception. Similarly, it doubts a court's ability to assess whether a transfer or discharge decision falls into one of the six enumerated circumstances under section 1396r(c)(2)(A). But these are focused, straightforward inquiries that agencies and courts are well equipped to resolve. It is worth noting that there is no evidence of this kind of hand-wringing in the

administrative law judge's decision rejecting Valparaiso Care's transfer decision.

Finally, there is no dispute that plaintiffs meet *Blessing*'s third factor, which asks whether the provision giving rise to the asserted right is couched in mandatory rather than precatory terms. Facilities *must* protect and promote the right against chemical restraints, *must* allow residents to remain in the facility, *must* not transfer, and *must* not discharge the res- ident; these are unambiguous obligations. Ivanka points to this language to show that "the meaning of the statute's terms is plain" and our job is over. See *Bostock v. Clayton County*, 140 S. Ct. 1731, 1749 (2020). We agree with her that a common-sense reading of its provisions leaves no room for disagreement.

In sum, we find that sections 1396r(c)(1)(A)(ii) and 1396r(c)(2)(A) unambiguously confer individually enforceable rights on nursing-home residents such as Gorgi Talevski.

C

Once a plaintiff satisfies the *Blessing* criteria, the right is presumptively enforceable under section 1983. A defendant may rebut this presumption only by "showing that Congress specifically foreclosed a remedy under § 1983 … expressly, through specific evidence from the statute itself, or impliedly, by creating a comprehensive enforcement scheme that is in- compatible with individual enforcement under § 1983[.]" *Gonzaga*, 536 U.S. at 284 n.4 (cleaned up). The express route is not available here, as FNHRA does not contain any such language. We thus confine ourselves to rebuttal by implication.

Valparaiso Care argues that FNHRA impliedly forecloses section 1983 claims because it provides federal and state enforcement schemes in addition to individualized mechanisms for recourse other than section 1983. In support, it cites section 1396r(g)(2)(A), which is entitled "Annual standard survey." Under that provision, each nursing facility is subject to an annual, unannounced survey conducted by the state. If the survey reveals that a nursing facility is out of compliance with the rest of the statute, including the residents' bill of rights, the state has several options. It can terminate the facility's participation in the state's Medicaid plan; deny payment to the facility; assess a civil monetary penalty; appoint temporary managers; close the facility; transfer residents; or take some combination of these measures. See 42 U.S.C. §§ 1396r(h)(2)(A)(i)–(iv). The statute gives the Secretary of Health and Human Services the same authority and duties as a state and provides rules for situations "where State and Secretary do not agree on [a] finding of noncompliance." 42 U.S.C. § 1396r(h)(3)(A); *id.* at § 1396r(h)(6). Valparaiso Care also draws our attention to 42 U.S.C. § 1396r(e)(3), which says that "State[s] … must provide a fair mechanism…for hearing appeals on transfers and discharges of residents," and 42 U.S.C. § 1396r(c)(1)(A)(vi), which requires nursing facilities to protect and promote the rights of each resident "to voice grievances with respect to treatment or care that is (or fails to be) furnished … and the right to prompt efforts by the facility to resolve grievances the resident may have."

This is not the type of comprehensive enforcement scheme, incompatible with individual enforcement, that we are looking for. "The provision

of an express, private means of redress in the statute itself is ordinarily an indication that Congress did not intend to leave open a more expansive remedy under § 1983." *Planned Parenthood of Ind., Inc.*, 699 F.3d at 975 (quoting *City of Rancho Palos Verdes v. Abrams*, 544 U.S. 113, 121 (2005)). Valparaiso Care has not identified anything close to the type of "unusually elaborate, carefully tailored, and restrictive enforcement schemes" that section 1983 claims would frustrate. *Fitzgerald v. Barnstable Sch. Comm.*, 555 U.S. 246, 255 (2009) (cleaned up). Nursing-home residents are free to file a complaint or grievance with the nursing facility and state survey and certification agents. But regulatory surveys and any accompanying enforcement processes are designed only to ensure facilities' compliance with FNHRA's various standards. They do not address, and thus do not protect, individual entitlements to be free from chemical restraints or involuntary transfer or discharge. The administrative appeals process for involuntary transfers does not indicate a comprehensive enforcement scheme either. "[A] plaintiff's ability to invoke § 1983 cannot be defeated simply by 'the availability of administrative mechanisms to protect the plaintiff's interests.'" *Blessing*, 520 U.S. at 347 (quoting *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 106 (1989)).

The Supreme Court has found that a statutory scheme implicitly forecloses section 1983 liability in only three cases. See *Middlesex Cty. Sewerage Auth. v. Nat'l Sea Clammers Ass'n*, 453 U.S. 1 (1981) (comprehensive enforcement mechanisms included citizen-suit provisions); *Smith v. Robinson*, 468 U.S. 992 (1984) (statute afforded rights holders state

hearings, detailed procedural safeguards, and judicial review); and *City of Rancho Palos Verdes*, 544 U.S. 113 (statute provided an express, private means of redress in the statute itself). It has never flatly ruled out private actions under statutes passed pursuant to Congress's Spending Clause powers. See *BT Bourbonnais Care*, 866 F.3d at 820–21.

Valparaiso Care and its fellow defendants have not shown that, despite the express rights-creating language in the statute we are considering, there is no private action here. Were *there* any lingering doubt, it should be put to rest in the general guidance provided in section 1396r(h)(8): "The remedies provided under this subsection are in addition to those other- wise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law." Defendants read this clause to protect only existing state law, but the text has no such limitation, and in fact specifically mentions federal law. That means all federal law; there is nothing that supports carving out section 1983, and we will not rewrite the statute to create any such exception.

III

Valparaiso Care makes an additional argument that the district court did not reach in favor of dismissal: it contends that both of Ivanka's claims are too late. It is worth recalling, in this connection, that the proper way to raise a limitations defense is in the answer, as an affirmative defense. See FED. R. CIV. P. 8(c), bullet 17. If the pertinent facts are undisputed or can be taken favorably to the nonmoving party, the defendant may move for judgment on the pleadings. See FED. R. CIV. P 12(c). Occasionally (perhaps all too

often) both parties and courts short-circuit this process and permit a limitations defense to be raised in a motion under Rule 12(b)(6), if the com- plaint alone alleges enough facts to eliminate all doubt about timeliness. See, *e.g.*, *Amin Ijbara Equity Corp. v. Village of Oak Lawn*, 860 F.3d 489, 492 (7th Cir. 2017). The latter qualification is critical, however, and it highlights what is missing in this case.

Section 1983 claims do not have a built-in statute of limitations; instead, they borrow state statutes of limitations and tolling rules for general personal injury actions. *Wilson v. Garcia*, 471 U.S. 261, 275 (1985); see *Dixon v. Chrans*, 986 F.2d 201, 203–04 (7th Cir. 1993). In Indiana, the pertinent statute of limitations is two years. See *Devbrow v. Kalu*, 705 F.3d 765, 767 (7th Cir. 2013); Ind. Code Ann. § 34-11-2-4. A brief timeline of events is helpful here to understanding the dispute in this case.

Gorgi began his stint at Valparaiso Care in January 2016. Around August of that same year, his daughter observed the rapid deterioration of her father's cognitive and physical abilities; he could no longer feed himself and lost the ability to speak English, though he could still speak his mother tongue, Macedonian. Skeptical of Valparaiso Care's insistence that any change in her father's condition could be traced to the natural advancement of dementia, Talevski's daughter requested a list of her father's medications in September 2016. The list she received showed ten medications, six of which were identified as powerful psychotropic drugs—that is, drugs capable of affecting the chemical composition of the brain. The family hired a private neurologist, who had the drugs removed. Around the same time, the

Indiana Department of Health conducted its "annual standard survey" of the facility. 42 U.S.C. § 1396r(g)(2)(A). The Talevskis filed a formal complaint during the week of September 27, 2016. Before the end of the year, Valparaiso Care began trying to transfer Talevski to a facility over an hour away. It made several efforts: initially between November 23, 2016, and December 15, 2016; then December 19, 2016, and December 29, 2016; and finally, December 30, 2016, and January 9, 2017.

At this point, Valparaiso Care tried to discharge Talevski involuntarily to an all-male dementia facility two-and-a-half hours away in Indianapolis. The Talevskis filed a petition for review of the transfer decision with the ISDH while Talevski moved to yet another facility an hour away. See 42 U.S.C. § 1396r(e)(3). An administrative law judge eventually rejected Valparaiso Care's transfer efforts, but Talevski never returned to Valparaiso Care. Ivanka Talevski filed the complaint in this case on January 20, 2019.

Valparaiso Care argues that Talevski's chemical-restraint claim accrued in September 2016 when the Talevski family received a list of medications that confirmed the use of chemical restraints. The complaint does not specify when the facility stopped using the medications. But Valparaiso Care reasons that the claim most likely accrued in September 2016, or perhaps as late as November 23, 2016, when Valparaiso Care began the transfer process. At the very latest, it contends, the claim accrued on December 30, 2016, the last time Gorgi was at the facility and more than two years before the filing of the complaint. As for the transfer claim, Valparaiso

Care transferred Talevski on December 30, 2016, and refused to readmit him on January 9, 2017, making one of those two dates the likely date of accrual. Both dates fall more than two years before the complaint.

Ivanka responds that Gorgi's claims are not time barred because the statute of limitations was tolled as a result of his legal disability. Indiana law states that "[a] person who is under legal disabilities when the cause of action accrues may bring the action within two (2) years after the disability is removed." Ind. Code Ann. § 34-11-6-1. Indiana defines "Under legal disability" to include "persons less than eighteen (18) years of age, mentally incompetent, or out of the United States." Ind. Code Ann. § 1-1-4-5 (12) & (24). Gorgi Talevski may be considered incapacitated under Indiana's Constitution because of his dementia. If he is, there is no statute of limitations issue.

Looking to *Dixon v. Chrans*, 986 F.2d 201 (7th Cir. 1993), Valparaiso Care contends that tolling should not take place here. *Dixon* dealt with Illinois's legal disability tolling provision. That law differentiated among various types of disabilities: for suits brought by incarcerated persons under section 1983 against officials or employees of the Illinois Department of Corrections, there was no tolling; suits against other defendants were tolled. The plaintiff in that case was incarcerated and sued IDOC officials under section 1983. He did not get the benefit of tolling. We concluded that absent a "tolling rule designed *specifically* for general personal injury claims … the process of deciding which state tolling rule to apply involves the straightforward application of the rules as written." *Id*. at 204 (emphasis in original).

This case is not like *Dixon* because Indiana has only one tolling rule for personal injury actions. But Valparaiso Care asks that we apply an exception to the legal-disability tolling provision because Indiana's Medical Malpractice Act contains an exception to that rule:

> A claim, whether in contract or tort, may not be brought against a health care provider based upon professional services or health care that was provided or that should have been provided unless the claim is filed within two (2) years after the date of the alleged act, omission, or neglect[.]

Ind. Code Ann. § 34-18-7-1(b). This provision applies without regard to legal disability. *Id.* at § 34-18-7-1(a).

The problem with this argument is that a section 1983 action is not a medical malpractice action. It is analogous to a personal-injury claim. It is well established that "the characterization of civil rights statutes for limitations purposes is a federal question." *Allen v. Hinchman*, 20 N.E.3d 863, 873 (Ind. Ct. App. 2014). The Supreme Court has spoken, and section 1983 claims are "best characterized as personal injury actions." *Dixon*, 986 F.3d at 203 (citing *Wilson v. Garcia*, *supra*, 471 U.S. 261).

This makes sense. The choice of a limitations period cannot depend on the facts of a plaintiff's specific circumstances. See *Allen*, 20 N.E.3d at 873 (quoting *Garcia*, 471 U.S. at 274) ("[I]f the choice of the statute of limitations were to depend upon the particular fact or the precise legal theory of each claim, counsel would almost always argue, with considerable force, that two or more periods of limitations should apply to each § 1983 claim[.]").

Moreover, assuming for present purposes that the legal disability tolling exception is at issue, there is no record from the district court to determine whether the doctors who administered six chemical restraints to Talevski did so "based upon professional services of health care that was provided" rather than for reasons of convenience or restraint. The proper course at this point is for the district court to develop the record and rule accordingly.

IV

In a last-ditch effort to circumvent *Blessing*, Valparaiso Care argues that our recent decision in *Nasello v. Eagleson*, 977 F.3d 599 (7th Cir. 2020), indicates an unwillingness to find enforceable private rights in statutes passed pursuant to Congress's powers under the Spending Clause. There we found that a provision of the Medicaid Act that requires states to count earlier medical expenses not covered by third parties when calculating a "medically needy" persons' income "sets conditions on states' participation in a program, rather than create direct private rights" and that plaintiffs' other claim fell outside of the scope of the provision they invoked. *Id.* at 601–02. We also observed that since *Wilder v. Virginia Hospital Association*, 496 U.S. 498 (1990), the Supreme Court has "repeatedly declined to create private rights of action under statutes that set conditions on federal funding of state programs," *Nasello*, 977 F.3d at 601.

It has indeed been more than 30 years since *Wilder*, and we realize that the Supreme Court itself has not recognized new Spending Clause-based private rights of action during that period. But it is just as true that the Court has never disapproved

Wilder. As a careful look at its decisions shows, it has instead insisted on a high bar for these private rights of action, and it has found that the parties in the cases before it have not cleared that bar.

Astra USA, Inc. v. Santa Clara County, 563 U.S. 110 (2011), illustrates this point well. It dealt with section 340B of the Public Health Services Act, 42 U.S.C. § 256b, which imposes ceilings on the prices that drug manufacturers may charge to public and community health centers. The price ceilings are enforced through Pharmaceutical Pricing Agreements be- tween the drug manufacturers and a unit of the Department of Health and Human Services (HHS). The suit was brought by the health centers (called 340B entities) against manufacturers for alleged overcharges. Notably, the centers conceded that they had no private right of action under the statute to bring a direct action against the manufacturers. *Id.* at 113. But they argued nonetheless that the statute permitted them to sue the manufacturers as third-party beneficiaries of the Agreements. Not so fast, said the Court: "[i]f 340B entities may not sue under the statute, it would make scant sense to allow them to sue on a form contract implementing the statute … ." *Id.* at 114. Since the recognition of a private right of action for violating a federal statute is proper only if Congress in- tended to provide a private remedy, *id.* at 117, and Congress did no such thing in the relevant statute, plaintiffs were out of luck.

Another case that touches on this issue is *Sossamon v. Texas*, 563 U.S. 277 (2011). It relies on the uncontroversial rule that it is ultimately Congress that controls whether a private right of action should be recognized in legislation that rests to some extent

on the Spending Clause. In fact, the central issue in *Sossamon* was tangential to our inquiry. The question was whether a state, by accepting federal funds, automatically consents to waive its sovereign immunity to suits for money damages under the Religious Land Use and Institutionalized Persons Act of 2000 (RLUIPA), 42 U.S.C. § 2000cc *et seq*. *Id.* at 280. For reasons irrelevant to our case, Congress had relied on its Spending and Commerce Clause powers when it passed RLUIPA. The statute included an express private right of action against various governmental entities, including states. See 42 U.S.C. § 2000cc-2(a). Noting that the test for finding a waiver of sovereign immunity is "a stringent one," 563 U.S. at 284, and that "[a] State's consent to suit must be unequivocally expressed in the text of the relevant statute," *id.* (quotations omitted), the Court found that the mere act of accepting federal funds was not adequate to serve as a waiver of sovereign immunity. The fact that RLUIPA rested in part on the Spending Clause made no difference. As the Court put it:

> It would be bizarre to create an "unequivocal statement" rule and then find that every Spending Clause enactment, no matter what its text, satisfies that rule because it includes unexpressed, implied remedies against the States. The requirement of a clear statement in the text of the statute ensures that Congress has specifically considered state sovereign immunity and has intentionally legislated on the matter.

Id. at 290.

The third case in this line is *Armstrong v. Exceptional Child Center,* Inc., 575 U.S. 320 (2015). Its facts are closer to our case than those of the other

two, insofar as it involved an effort to enforce certain aspects of the Medicaid program. The Court put the question presented succinctly, as "whether Medicaid providers can sue to enforce § (30)(A) of the Medicaid Act." *Id.* at 322. That section requires a state plan to include the provision of certain in-home care services for eligible people. Relying on the theory that they had an implied private right of action under the Supremacy Clause of the Constitution, Art. VI, cl. 2, the providers of those services filed a suit in which they argued that Idaho's reimbursement rates were too low to support the required level of services.

The Supreme Court held that the premise of the suit was wrong—the Supremacy Clause does not support a private right of action whenever someone asserts that state law conflicts with a federal mandate. The Court then addressed the question whether the providers could base their right of action directly in section 30(A) of the Act. It also answered this in the negative. Critically, it found that section 30(A)'s text was "judicially unadministrable," *id.* at 328, and that by providing an express administrative remedy, the Act precluded private enforcement. Finally, the Court rejected the idea that the Medicaid Act itself provided a private right of action to the providers, because "[s]ection 30(A) lacks the sort of rights-creating language needed to imply a private right of action." *Id.* at 331. It is phrased, the Court pointed out, as a directive to the federal agency, "not as a conferral of the right to sue upon the beneficiaries of the State's decision to participate in Medicaid." *Id.*

Armstrong thus confirms the inquiry we must make to see if a different part of the Medicaid Act, in a suit brought by different parties, can support a

private right of action: do we have the necessary rights-creating language to support a private right of action? The Court could have saved itself a great deal of time if it had wanted to establish an unbending rule that Spending Clause legislation *never* supports a private action. It did not do so in *Armstrong*, and it did not even hint that it was overruling *Wilder*. In keeping with that guidance, neither we nor other courts have found any such categorical rule. See, *e.g.*, *Bontrager,* 697 F.3d at 607 (section 1396a(a)(10) satisfies *Wilder* and permits private right of action enforceable through section 1983) (alterations in original); *Planned Parenthood of Ind., Inc.,* 699 F.3d at 974 (private right of action under section 1396a(a)(23), which says that "all state Medicaid plans provide that 'any individual eligible for medical assistance ... may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required'"); *BT Bourbonnais Care, LLC v. Norwood*, 866 F.3d at 817 (private right of action under section 1396a(a)(13)(A), which says "[a] State plan for medical assistance must … provide … for a public process for determination of rates of payment under the plan for ... nursing facility services").

Our sister courts have agreed that FNHRA confers such rights. See Grammer *v. John J. Kane Reg'l Centers-Glen Hazel*, 570 F.3d 520, 524–25, 527 (3d Cir. 2009); *Anderson v. Ghaly*, 930 F.3d 1066, 1074 (9th Cir. 2019); *cf. Concourse Rehabilitation & Nursing Center Inc. v. Whalen*, 249 F.3d 136 (2d Cir. 2001) (section 1396r(b)(4)(A) "is obviously intended to benefit Medicaid beneficiaries" and thus does not entitle health care providers to bring suit under section 1983). *Nasello* reflects the caution with which

we approach finding an enforceable private right of action, but, as *Armstrong* clarified, the position of providers is different from that of recipients, and it is critical in our case that the statute itself contains the necessary rights-creating language for the recipients.

* * *

We therefore hold that it was error to dismiss this case for failure to state a claim. The judgment of the district court is REVERSED and the case is REMANDED for further proceedings consistent with this opinion.

APPENDIX B

APPENDIX B

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF INDIANA
HAMMOND DIVISION

GORGI TALEVSKI, by Next Friend Ivanka Talevski,	)	
Plaintiff,	)	
v.	)	
	)	No. 2:19 CV 13
HEALTH AND HOSPITAL CORPORATION OF MARION COUNTY, AMERICAN SENIOR COMMUNITIES, LLC, and VALPARAISO CARE AND REHABILITATION,	)	
Defendants.	)	

OPINION and ORDER

I. BACKGROUND

In January 2016, plaintiff was a patient at a nursing home facility named as a defendant in this case, Health and Hospital Corporation ("HHC") of Marion County (d/b/a Valparaiso Care and Rehabilitation). HHC was managed by another

named defendant, American Senior Communities, LLC.

Plaintiff sued defendants, pursuant to 42 U.S.C § 1983, for violation of his alleged rights under the Federal Nursing Home Reform Act, 42 U.S.C. § 1396r *et seq.* ("FNHRA"). Plaintiff alleges that defendants failed to abide by the statute in numerous respects, including by failing to "attain or maintain [plaintiff's] highest practicable physical, mental, and psychological well-being." (DE # 1 at 6-7.)

Defendants now move to dismiss plaintiff's complaint for failure to state a claim upon which relief may be granted pursuant to Federal Rule of Civil Procedure 12(b)(6). (DE # 14). One of the issues raised therein is dispositive: whether the FNHRA provides for a federal private right of action that may be redressed under 42 U.S.C. § 1983.

Because the court finds that it does not, defendants' motion to dismiss shall be granted.

II. LEGAL STANDARD

A judge reviewing a complaint pursuant to Rule 12(b)(6) must construe the allegations in the complaint in the light most favorable to the non-moving party, accept all well-pleaded facts as true, and draw all reasonable inferences in favor of the non-movant. *Erickson v. Pardus*, 551 U.S. 89, 93 (2007); *Reger Dev., LLC v. Nat'l City Bank*, 595 F.3d 759, 763 (7th Cir. 2010). Under the liberal notice-pleading requirements of the Federal Rules of Civil Procedure, the complaint need only contain "a short and plain statement of the claim showing that the pleader is entitled to relief." Fed. R. Civ. P. 8(a)(2). A plaintiff must plead "factual content that allows the court to

draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ashcroft v. Iqbal*, 129 S. Ct. 1937, 1949 (2009).

III. DISCUSSION

The question before the court is whether Section 1983 may serve as a vehicle for a private right of action for a violation of the FNHRA. Section 1983 provides a cause of action to enforce individual rights conferred by federal statute (as well as the Constitution). *City of Rancho Palos Verdes v. Abrams,* 544 U.S. 113, 119 (2005). "[T]o seek redress through § 1983, however, a plaintiff must assert the violation of a federal right, not merely a violation of federal law." *Blessing v. Freestone,* 520 U.S. 329, 340 (1997). Under *Blessing*, courts consider three factors when determining whether a federal statute creates and confers a federal right: (1) "Congress must have intended that the provision in question benefit the plaintiff"; (2) the asserted right must not be "so vague and amorphous that its enforcement would strain judicial competence"; and (3) "the provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms." *Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't of Health,* 699 F.3d 962, 972–73 (7th Cir. 2012) (quoting *Blessing,* 520 U.S. at 340–41).

In *Gonzaga University v. Doe,* the Supreme Court clarified the *Blessing* factors, holding that federal statutes must unambiguously create and confer federal rights to support a cause of action under Section 1983. 536 U.S. 273 (2002). Post-*Gonzaga*, the *Blessing* factors "are meant to set the bar high" as "nothing 'short of an unambiguously conferred right [will] support a cause of action brought under § 1983.'"

Planned Parenthood, 699 F.3d at 973 (quoting *Gonzaga,* 536 U.S. at 283). *Gonzaga* specifically addressed Spending Clause legislation, clarifying that "unless Congress 'speak[s] with a clear voice,' and manifests an 'unambiguous' intent to confer individual rights, federal funding provisions provide no basis for private enforcement by § 1983." *Gonzaga,* 536 U.S. at 280 (quoting *Pennhurst State Sch. and Hosp. v. Halderman,* 451 U.S. 1, 17, 28, n. 21 (1981)). *Gonzaga* also clarified that even federal statutes intended to benefit a particular class do not necessarily confer federal rights; falling within a federal statute's "general zone of interest" is insufficient. *Gonzaga,* 536 U.S. at 283. This is because Section 1983 provides a cause of action for deprivations of rights, not broader benefits or interests. *Id.*

The issue in this case is whether the FNHRA confers federal rights under the *Blessing–Gonzaga* standard articulated above. The parties do not appear to dispute that the third *Blessing* factor should be resolved in plaintiff's favor, so the court's discussion focuses on the remaining two.

First, the court must determine whether Congress intended the FNHRA to benefit the plaintiff. *Blessing,* 520 U.S. at 340. At first glance, it appears that Congress did, in fact, intend for the FNHRA to benefit nursing home residents such as plaintiff, when it passed statutory requirements that nursing homes must, for example, "attain or maintain [a resident's] highest practicable physical, mental, and psychological well- being" in order to receive certain federal funding. 42 U.S.C. § 1396r(b)(2). One can easily infer that when a nursing home facility

complies with the statute, nursing home residents ultimately reap benefits.

However, the court is mindful that *Gonzaga* holds that falling within the statute's "general zone of interest" does not confer upon an individual a private right of action under the statute. 536 U.S. at 283. It is important to note that the FNHRA was specifically and consistently drafted in terms of what nursing facilities must do in order to receive government funding. *See* 42 U.S.C. § 1396r *et seq*. Generally speaking, "statutes that focus on the person regulated rather than the individuals protected create 'no implication of an intent to confer rights on a particular class of persons.'" *Ind. Prot. & Advocacy Servs. v. Ind. Family & Soc. Servs. Admin.,* 603 F.3d 365, 377 (7th Cir. 2010) (quoting *Alexander v. Sandoval,* 532 U.S. 275, 289 (2001)).

Therefore, while the first factor weighs somewhat in favor of plaintiff, it does so insignificantly given the lack of clear statutory language to indicate that nursing home residents are more than simply individuals in the FNHRA's "general zone of interest," benefitting from what is otherwise a primarily funding-oriented piece of legislation. Several fellow district courts under the purview of the Seventh Circuit Court of Appeals came to a similar conclusion. *Fiers v. La Crosse Cnty.,* 132 F. Supp. 3d 1111, 1119 (W.D. Wis. 2015) (no private right of action because FNHRA focuses on facility regulation rather than articulating a right granted to the protected class)*; Schwerdtfeger v. Alden Long Grove Rehab. & Health Care Ctr., Inc.,* No. 13–cv–8316, 2014 WL 1884471 (N.D. Ill. May 12, 2014) (no private right of action under FNHRA, because while statute derivatively

benefits residents, statute's "focus [is] twice removed from the individuals who will ultimately benefit from the [statute]"); *Terry v. Health & Hosp. Corp. of Marion Cnty.*, No. 1:10-cv-00607-DML-JMS, slip op. at 16 (S.D. Ind. Mar. 29, 2012) (no private right of action because "FNHRA is couched in terms of what the state must require of a skilled nursing facility for its certification for participation in the federal Medicaid and Medicare programs").

The second *Blessing-Gonzaga* factor requires this court to consider whether the asserted right is "so vague and amorphous that its enforcement would strain judicial competence." *Planned Parenthood*, 699 F.3d at 972–73. None of the parties in this case pay particular attention to this factor in their briefing, least of whom plaintiff, who devotes a mere sentence to an analysis of the issue: "[N]one of [plaintiff's] allegations is sufficiently different from the kinds of issues courts deal with on a daily basis in many other areas of law." (DE # 19 at 10.) The court disagrees, as the allegations contain indefinite terms such as "enhancement of quality of life" and "highest practicable physical, mental, and psychosocial well-being" (DE # 1), which other district courts in this circuit have found too vague and amorphous to support an argument for the existence of a private right of action under the FNHRA. *See, e.g., Terry,* No. 1:10-cv-00607-DML-JMS, slip op. at 19 ("quality of care standards Ms. Terry points to are not specific, but in fact express a generalized standard—attainment of "highest practicable well-being"); *Fiers,* 132 F. Supp. 3d at 1117 (allegations related to "maintenance or enhancement of his quality of life," "maintain[ance of] the highest practicable physical, mental, and psychosocial well-being," and "inadequate policies and

plans of care to properly supervise and provide care for its residents" were so vague and amorphous that enforcement would strain judicial competence).

Further, the Seventh Circuit has held that a statutory provision similar to the FNHRA's general "quality of life" protections was insufficiently clear to confer a federal right in *Bruggeman ex rel. Bruggeman v. Blagojevich*, 324 F.3d 906 (7th Cir. 2003). In that case, the Seventh Circuit held that the portion of the Medicaid Act requiring state plans for medical assistance to provide care and services in the "best interests" of the recipients was "insufficiently definite to be justiciable, and in addition cannot be interpreted to create a private right of action, given the Supreme Court's hostility . . . to implying such rights in spending statutes." *Id.* at 911. Like the allegations related to the Medicaid Act provision at issue in *Bruggeman*, plaintiff's allegations related to the FNHRA require reading rights into the statute that would be so vague and amorphous that enforcement would strain judicial competence. Thus, this factor weighs heavily in defendants' favor.

When balancing the *Blessing* factors, the court is mindful of the Supreme Court's admonishment that the court listen for Congress's "clear voice" in discerning a private right of action from statutory text, while keeping in sight the ultimate question of whether Congress unambiguously intended to confer a private right of action. *Gonzaga,* 536 U.S. at 283. As previously explained, the FNHRA was surely intended to benefit nursing home patients, but the indirect nature of this benefit renders the first *Blessing* factor's weight, in plaintiff's favor, rather insignificant. The second factor weighs heavily in

defendant's favor, as the nature of the rights asserted are vague. Though the third factor – the mandatory nature of the statutory requirements – weighs in plaintiff's favor, it carries little weight, as the mandatory nature of statutory provisions seems inconsequential compared to the competing factors suggesting that a private right of action should not be inferred from vague Congressional statements regarding indirect beneficiaries in the first place. The *Blessing* factors, when weighted and compared with *Gonzaga* as a guiding principle, indicate that this court should not infer that Congress intended to create private right of action when it drafted the FNHRA. The same result was reached by other district courts in this circuit. *Fiers,* 132 F. Supp. 3d at 1119; *Schwerdtfeger,* 2014 WL 1884471, at *6; *Terry,* No. 1:10-cv-00607-DML-JMS, slip op. at 16.

Plaintiff urges this court to dismiss the holdings of its sister district courts, and instead to embrace the holdings of other circuits where a private right of action has been read into the FNHRA. *See, e.g., Grammer v. John J. Kane Reg'l. Ctrs.,* 570 F.3d 520 (3d Cir. 2009); *see also Anderson v. Ghaly*, 930 F.3d 1066, 1075 (9th Cir. 2019). However, the court finds the reasoning employed by the district courts in *Fiels, Terry,* and *Schwerdtfeger* (especially when viewed in the context of *Bruggeman*) to be sound predictors of how the Seventh Circuit might rule on the issue. Accordingly, the court rejects plaintiff's argument that this court should adopt the non-binding precedent of other circuits.

IV. CONCLUSION

For the foregoing reasons, the court concludes that the FNHRA does not confer federal rights and,

accordingly, cannot support a cause of action under Section 1983. Therefore, defendants' motion to dismiss (DE # 14) is GRANTED and this case is DISMISSED.

SO ORDERED.

Date: March 26, 2020

s/James T. Moody
JUDGE JAMES T. MOODY
UNITED STATES DISTRICT COURT

APPENDIX C

APPENDIX C

United States Court of Appeals
For the Seventh Circuit
Chicago, Illinois

August 25, 2021

Before

MICHAEL S. KANNE, *Circuit Judge*

DIANE P. WOOD, *Circuit Judge*

MICHAEL Y. SCUDDER, *Circuit Judge*

No. 20-1664

GORGI TALEVSKI, by next friend IVANKA TALEVSKI, *Plaintiff-Appellant,* *v.* HEALTH AND HOSPITAL CORPORATION OF MARION COUNTY, *et al.,* *Defendants-Appellees*.	Appeal from the United States District Court for the Northern District of Indiana, Hammond Division Nos. 2:19 CV 13 James T. Moody, *Judge*.

ORDER

Defendants-appellees filed a petition for rehearing and rehearing *en banc* on August 10, 2021.

No judge[1] in regular active service has requested a vote on the petition for rehearing en banc, and all members of the original panel have voted to deny panel rehearing. The petition for rehearing en banc is therefore DENIED.

[1] Judge Candace Jackson-Akiwumi did not participate in the consideration of this matter.

APPENDIX D

APPENDIX D

42 U.S.C.A. § 1396r

§ 1396r. Requirements for nursing facilities

(c) Requirements relating to residents' rights

(1) General rights

(A) Specified rights

A nursing facility must protect and promote the rights of each resident, including each of the following rights:

(i) Free choice

The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

(ii) Free from restraints

The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed--

(I) to ensure the physical safety of the resident or other residents, and

(II) only upon the written order of a physician that specifies the duration and circumstances

under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

(iii) Privacy

The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.

(iv) Confidentiality

The right to confidentiality of personal and clinical records and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

(v) Accommodation of needs

The right--

(I) to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and

(II) to receive notice before the room or roommate of the resident in the facility is changed.

(vi) Grievances

The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(vii) Participation in resident and family groups

The right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

(viii) Participation in other activities

The right of the resident to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(ix) Examination of survey results

The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State with respect to the facility and any plan of correction in effect with respect to the facility.

(x) Refusal of certain transfers

The right to refuse a transfer to another room within the facility, if a purpose of the transfer is to relocate the resident from a portion of the facility that is not a skilled nursing facility (for

purposes of subchapter XVIII) to a portion of the facility that is such a skilled nursing facility.

(xi) Other rights

Any other right established by the Secretary.

Clause (iii) shall not be construed as requiring the provision of a private room. A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to medical assistance under this subchapter or a State's entitlement to Federal medical assistance under this subchapter with respect to services furnished to such a resident.

(B) Notice of rights

A nursing facility must--

(i) inform each resident, orally and in writing at the time of admission to the facility, of the resident's legal rights during the stay at the facility and of the requirements and procedures for establishing eligibility for medical assistance under this subchapter, including the right to request an assessment under section 1396r-5(c)(1)(B) of this title;

(ii) make available to each resident, upon reasonable request, a written statement of such rights (which statement is updated upon changes

in such rights) including the notice (if any) of the State developed under subsection (e)(6);

(iii) inform each resident who is entitled to medical assistance under this subchapter—

(I) at the time of admission to the facility or, if later, at the time the resident becomes eligible for such assistance, of the items and services (including those specified under section 1396a(a)(28)(B) of this title) that are included in nursing facility services under the State plan and for which the resident may not be charged (except as permitted in section 1396*o* of this title), and of those other items and services that the facility offers and for which the resident may be charged and the amount of the charges for such items and services, and

(II) of changes in the items and services described in subclause (I) and of changes in the charges imposed for items and services described in that subclause; and

(iv) inform each other resident, in writing before or at the time of admission and periodically during the resident's stay, of services available in the facility and of related charges for such services, including any charges for services not covered under subchapter XVIII or by the facility's basic per diem charge.

The written description of legal rights under this subparagraph shall include a description of the protection of personal funds under paragraph (6) and a statement that a resident may file a

complaint with a State survey and certification agency respecting resident abuse and neglect and misappropriation of resident property in the facility.

(C) Rights of incompetent residents

In the case of a resident adjudged incompetent under the laws of a State, the rights of the resident under this subchapter shall devolve upon, and, to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the resident's behalf.

(D) Use of psychopharmacologic drugs

Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written plan of care described in paragraph (2)) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually an independent, external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs.

* * *

(2) Transfer and discharge rights

(A) In general

A nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless--

(i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;

(ii) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) the safety of individuals in the facility is endangered;

(iv) the health of individuals in the facility would otherwise be endangered;

(v) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under this subchapter or subchapter XVIII on the resident's behalf) for a stay at the facility; or

(vi) the facility ceases to operate.

In each of the cases described in clauses (i) through (iv), the basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in clauses (i) and (ii), the documentation must be made by the resident's physician, and in the case described in clause (iv) the documentation must be made by a physician. For purposes of clause (v), in the case of a resident who becomes eligible for assistance under this subchapter after admission to the facility, only charges which may be imposed under this subchapter shall be considered to be allowable.

(B) Pre-transfer and pre-discharge notice

(i) In general

Before effecting a transfer or discharge of a resident, a nursing facility must--

(I) notify the resident (and, if known, an immediate family member of the resident or legal representative) of the transfer or discharge and the reasons therefor,

(II) record the reasons in the resident's clinical record (including any documentation required under subparagraph (A)), and

(III) include in the notice the items described in clause (iii).

(ii) Timing of notice

The notice under clause (i)(I) must be made at least 30 days in advance of the resident's transfer or discharge except--

(I) in a case described in clause (iii) or (iv) of subparagraph (A);

(II) in a case described in clause (ii) of subparagraph (A), where the resident's health improves sufficiently to allow a more immediate transfer or discharge;

(III) in a case described in clause (i) of subparagraph (A), where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs; or

(IV) in a case where a resident has not resided in the facility for 30 days.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as is practicable.

(iii) Items included in notice

Each notice under clause (i) must include--

(I) for transfers or discharges effected on or after October 1, 1989, notice of the resident's right to appeal the transfer or discharge under the State process established under subsection (e)(3);

(II) the name, mailing address, and telephone number of the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 in accordance with section 712 of the Act);

(III) in the case of residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals established under subtitle C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000; and

(IV) in the case of mentally ill residents (as defined in subsection (e)(7)(G)(i)), the mailing address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

(C) Orientation

A nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(D) Notice on bed-hold policy and readmission

(i) Notice before transfer

Before a resident of a nursing facility is transferred for hospitalization or therapeutic leave, a nursing facility must provide written information to the resident and an immediate family member or legal representative concerning--

(I) the provisions of the State plan under this subchapter regarding the period (if any) during which the resident will be permitted under the State plan to return and resume residence in the facility, and

(II) the policies of the facility regarding such a period, which policies must be consistent with clause (iii).

(ii) Notice upon transfer

At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility must provide written notice to the resident and an immediate family member or legal representative of the duration of any period described in clause (i).

(iii) Permitting resident to return

A nursing facility must establish and follow a written policy under which a resident--

(I) who is eligible for medical assistance for nursing facility services under a State plan,

(II) who is transferred from the facility for hospitalization or therapeutic leave, and

(III) whose hospitalization or therapeutic leave exceeds a period paid for under the State plan for the holding of a bed in the facility for the resident,

will be permitted to be readmitted to the facility immediately upon the first availability of a bed in a semiprivate room in the facility if, at the time of readmission, the resident requires the services provided by the facility.

(E) Information respecting advance directives

A nursing facility must comply with the requirement of section 1396a(w) of this title (relating to maintaining written policies and procedures respecting advance directives).

(F) Continuing rights in case of voluntary withdrawal from participation

(i) In general

In the case of a nursing facility that voluntarily withdraws from participation in a State plan under this subchapter but continues to provide services of the type provided by nursing facilities--

(I) the facility's voluntary withdrawal from participation is not an acceptable basis for the transfer or discharge of residents of the facility who were residing in the facility on the day before the effective date of the withdrawal (including those residents who were not entitled to medical assistance as of such day);

(II) the provisions of this section continue to apply to such residents until the date of their discharge from the facility; and

(III) in the case of each individual who begins residence in the facility after the effective date of such withdrawal, the facility shall provide notice orally and in a prominent manner in writing on a separate page at the time the individual begins residence of the information described in clause (ii) and shall obtain from each such individual at such time an acknowledgment of receipt of such information that is in writing, signed by the individual, and separate from other documents signed by such individual.

Nothing in this subparagraph shall be construed as affecting any requirement of a participation agreement that a nursing facility provide advance notice to the State or the Secretary, or both, of its intention to terminate the agreement.

(ii) Information for new residents

The information described in this clause for a resident is the following:

(I) The facility is not participating in the program under this subchapter with respect to that resident.

(II) The facility may transfer or discharge the resident from the facility at such time as the resident is unable to pay the charges of the facility, even though the resident may have become eligible for medical assistance for nursing facility services under this subchapter.

(iii) Continuation of payments and oversight authority

Notwithstanding any other provision of this subchapter, with respect to the residents described in clause (i)(I), a participation agreement of a facility described in clause (i) is deemed to continue in effect under such plan after the effective date of the facility's voluntary withdrawal from participation under the State plan for purposes of--

(I) receiving payments under the State plan for nursing facility services provided to such residents;

(II) maintaining compliance with all applicable requirements of this subchapter; and

(III) continuing to apply the survey, certification, and enforcement authority provided under subsections (g) and (h) (including involuntary termination of a participation agreement deemed continued under this clause).

(iv) No application to new residents

This paragraph (other than subclause (III) of clause (i)) shall not apply to an individual who begins residence in a facility on or after the effective date of the withdrawal from participation under this subparagraph.

* * *

(e) State requirements relating to nursing facility requirements

As a condition of approval of its plan under this subchapter, a State must provide for the following:

(3) State appeals process for transfers and discharges

The State, for transfers and discharges from nursing facilities effected on or after October 1, 1989, must provide for a fair mechanism, meeting the guidelines established under subsection (f)(3), for hearing appeals on transfers and discharges of residents of such facilities; but the failure of the Secretary to establish such guidelines under such subsection shall not relieve any State of its responsibility under this paragraph.

* * *

(g) Survey and certification process

(1) State and Federal responsibility

(A) In general

Under each State plan under this subchapter, the State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of nursing facilities (other than facilities of the State) with the requirements of subsections (b), (c), and (d). The

Secretary shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of State nursing facilities with the requirements of such subsections.

(B) Educational program

Each State shall conduct periodic educational programs for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies under this section.

(C) Investigation of allegations of resident neglect and abuse and misappropriation of resident property

The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility in providing services to such a resident. The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident

property in a facility, the State shall notify the appropriate licensure authority. A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.

(D) Removal of name from nurse aide registry

(i) In general

In the case of a finding of neglect under subparagraph (C), the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that--

(I) the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect; and

(II) the neglect involved in the original finding was a singular occurrence.

(ii) Timing of determination

In no case shall a determination on a petition submitted under clause (i) be made prior to the expiration of the 1-year period beginning on the date on which the name of the petitioner was added to the registry under subparagraph (C).

(E) Construction

The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(2) Surveys

(A) Annual standard survey

(i) In general

Each nursing facility shall be subject to a standard survey, to be conducted without any prior notice to the facility. Any individual who notifies (or causes to be notified) a nursing facility of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title. The Secretary shall review each State's procedures for scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(ii) Contents

Each standard survey shall include, for a case-mix stratified sample of residents--

(I) a survey of the quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment,

(II) written plans of care provided under subsection (b)(2) and an audit of the residents' assessments under subsection (b)(3) to determine the accuracy of such assessments and the adequacy of such plans of care, and

(III) a review of compliance with residents' rights under subsection (c).

(iii) Frequency

(I) In general

Each nursing facility shall be subject to a standard survey not later than 15 months after the date of the previous standard survey conducted under this subparagraph. The statewide average interval between standard surveys of a nursing facility shall not exceed 12 months.

(II) Special surveys

If not otherwise conducted under subclause (I), a standard survey (or an abbreviated standard survey) may be conducted within 2 months of any change of ownership, administration, management of a nursing facility, or director of nursing in order to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

* * *

(h) Enforcement process

(1) In general

If a State finds, on the basis of a standard, extended, or partial extended survey under subsection (g)(2) or otherwise, that a nursing facility no longer meets a

requirement of subsection (b), (c), or (d), and further finds that the facility's deficiencies—

(A) immediately jeopardize the health or safety of its residents, the State shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii), or terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in paragraph (2); or

(B) do not immediately jeopardize the health or safety of its residents, the State may--

(i) terminate the facility's participation under the State plan,

(ii) provide for one or more of the remedies described in paragraph (2), or

(iii) do both.

Nothing in this paragraph shall be construed as restricting the remedies available to a State to remedy a nursing facility's deficiencies. If a State finds that a nursing facility meets the requirements of subsections (b), (c), and (d), but, as of a previous period, did not meet such requirements, the State may provide for a civil money penalty under paragraph (2)(A)(ii) for the days in which it finds that the facility was not in compliance with such requirements.

(2) Specified remedies

(A) Listing

Except as provided in subparagraph (B)(ii), each State shall establish by law (whether statute or regulation) at least the following remedies:

(i) Denial of payment under the State plan with respect to any individual admitted to the nursing facility involved after such notice to the public and to the facility as may be provided for by the State.

(ii) A civil money penalty assessed and collected, with interest, for each day in which the facility is or was out of compliance with a requirement of subsection (b), (c), or (d). Funds collected by a State as a result of imposition of such a penalty (or as a result of the imposition by the State of a civil money penalty for activities described in subsections (b)(3)(B)(ii)(I), (b)(3)(B)(ii)(II), or (g)(2)(A)(i)) shall be applied to the protection of the health or property of residents of nursing facilities that the State or the Secretary finds deficient, including payment for the costs of relocation of residents to other facilities, maintenance of operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for personal funds lost.

(iii) The appointment of temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while--

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the State has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

(iv) The authority, in the case of an emergency, to close the facility, to transfer residents in that facility to other facilities, or both.

The State also shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the State may provide for other specified remedies, such as directed plans of correction.

(B) Deadline and guidance

(i) Except as provided in clause (ii), as a condition for approval of a State plan for calendar quarters beginning on or after October 1, 1989, each State shall establish the remedies described in clauses (i) through (iv) of subparagraph (A) by not later than October 1, 1989. The Secretary shall

provide, through regulations by not later than October 1, 1988, guidance to States in establishing such remedies; but the failure of the Secretary to provide such guidance shall not relieve a State of the responsibility for establishing such remedies.

(ii) A State may establish alternative remedies (other than termination of participation) other than those described in clauses (i) through (iv) of subparagraph (A), if the State demonstrates to the Secretary's satisfaction that the alternative remedies are as effective in deterring noncompliance and correcting deficiencies as those described in subparagraph (A).

(C) Assuring prompt compliance

If a nursing facility has not complied with any of the requirements of subsections (b), (c), and (d), within 3 months after the date the facility is found to be out of compliance with such requirements, the State shall impose the remedy described in subparagraph (A)(i) for all individuals who are admitted to the facility after such date.

(D) Repeated noncompliance

In the case of a nursing facility which, on 3 consecutive standard surveys conducted under subsection (g)(2), has been found to have provided substandard quality of care, the State shall (regardless of what other remedies are provided)--

(i) impose the remedy described in subparagraph (A)(i), and

(ii) monitor the facility under subsection (g)(4)(B),

until the facility has demonstrated, to the satisfaction of the State, that it is in compliance with the requirements of subsections (b), (c), and (d), and that it will remain in compliance with such requirements.

(E) Funding

The reasonable expenditures of a State to provide for temporary management and other expenses associated with implementing the remedies described in clauses (iii) and (iv) of subparagraph (A) shall be considered, for purposes of section 1396b(a)(7) of this title, to be necessary for the proper and efficient administration of the State plan.

(F) Incentives for high quality care

In addition to the remedies specified in this paragraph, a State may establish a program to reward, through public recognition, incentive payments, or both, nursing facilities that provide the highest quality care to residents who are entitled to medical assistance under this subchapter. For purposes of section 1396b(a)(7) of this title, proper expenses incurred by a State in carrying out such a program shall be considered to be expenses necessary for the proper and efficient administration of the State plan under this subchapter.

(3) Secretarial authority

(A) For State nursing facilities

With respect to a State nursing facility, the Secretary shall have the authority and duties of a State under this subsection, including the

authority to impose remedies described in clauses (i), (ii), and (iii) of paragraph (2)(A).

(B) Other nursing facilities

With respect to any other nursing facility in a State, if the Secretary finds that a nursing facility no longer meets a requirement of subsection (b), (c), (d), or (e), and further finds that the facility's deficiencies—

(i) immediately jeopardize the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (C)(iii), or terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in subparagraph (C); or

(ii) do not immediately jeopardize the health or safety of its residents, the Secretary may impose any of the remedies described in subparagraph (C).

Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy a nursing facility's deficiencies. If the Secretary finds that a nursing facility meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (C)(ii) for the days on which he finds that the facility was not in compliance with such requirements.

(C) Specified remedies

The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

(i) Denial of payment

The Secretary may deny any further payments to the State for medical assistance furnished by the facility to all individuals in the facility or to individuals admitted to the facility after the effective date of the finding.

(ii) Authority with respect to civil money penalties

(I) In general

Subject to subclause (II), the Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(II) Reduction of civil money penalties in certain circumstances

Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

(III) Prohibitions on reduction for certain deficiencies

(aa) Repeat deficiencies

The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

(bb) Certain other deficiencies

The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

(IV) Collection of civil money penalties

In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that--

(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day

of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary

(including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).

(iii) Appointment of temporary management

In consultation with the State, the Secretary may appoint temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while--

(I) there is an orderly closure of the facility; or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the Secretary has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

The Secretary shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe

fines for repeated or uncorrected deficiencies. In addition, the Secretary may provide for other specified remedies, such as directed plans of correction.

(D) Continuation of payments pending remediation

The Secretary may continue payments, over a period of not longer than 6 months after the effective date of the findings, under this subchapter with respect to a nursing facility not in compliance with a requirement of subsection (b), (c), or (d), if--

(i) the State survey agency finds that it is more appropriate to take alternative action to assure compliance of the facility with the requirements than to terminate the certification of the facility, and

(ii) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action.

The Secretary shall establish guidelines for approval of corrective actions requested by States under this subparagraph.

(4) Effective period of denial payment

A finding to deny payment under this subsection shall terminate when the State or Secretary (or both, as the case may be) finds that the facility is in substantial compliance with all the requirements of subsections (b), (c), and (d).

(5) Immediate termination of participation for facility where State or Secretary finds noncompliance and immediate jeopardy

If either the State or the Secretary finds that a nursing facility has not met a requirement of subsection (b), (c), or (d), and finds that the failure immediately jeopardizes the health or safety of its residents, the State or the Secretary, respectively[5] shall notify the other of such finding, and the State or the Secretary, respectively, shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii) or (3)(C)(iii), or terminate the facility's participation under the State plan. If the facility's participation in the State plan is terminated by either the State or the Secretary, the State shall provide for the safe and orderly transfer of the residents eligible under the State plan consistent with the requirements of subsection (c)(2).

(6) Special rules where State and Secretary do not agree on finding of noncompliance

(A) State finding of noncompliance and no secretarial finding of noncompliance

If the Secretary finds that a nursing facility has met all the requirements of subsections (b), (c), and (d), but a State finds that the facility has not met such requirements and the failure does not immediately jeopardize the health or safety of its residents, the State's findings shall control and the remedies imposed by the State shall be applied.

(B) Secretarial finding of noncompliance and no State finding of noncompliance

If the Secretary finds that a nursing facility has not met all the requirements of subsections (b), (c), and (d), and that the failure does not immediately jeopardize the health or safety of its residents, but the State has not made such a finding, the Secretary--

(i) may impose any remedies specified in paragraph (3)(C) with respect to the facility, and

(ii) shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D).

(7) Special rules for timing of termination of participation where remedies overlap

If both the Secretary and the State find that a nursing facility has not met all the requirements of subsections (b), (c), and (d), and neither finds that the failure immediately jeopardizes the health or safety of its residents--

(A)(i) if both find that the facility's participation under the State plan should be terminated, the State's timing of any termination shall control so long as the termination date does not occur later than 6 months after the date of the finding to terminate;

(ii) if the Secretary, but not the State, finds that the facility's participation under the State plan should be terminated, the Secretary shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D); or

(iii) if the State, but not the Secretary, finds that the facility's participation under the State plan

should be terminated, the State's decision to terminate, and timing of such termination, shall control; and

(B)(i) if the Secretary or the State, but not both, establishes one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, such additional or alternative remedies shall also be applied, or

(ii) if both the Secretary and the State establish one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, only the additional or alternative remedies of the Secretary shall apply.

(8) Construction

The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), (ii)(IV), 6 (iii), and (iv) of paragraph (2)(A) may be imposed during the pendency of any hearing. The provisions of this subsection shall apply to a nursing facility (or portion thereof) notwithstanding that the facility (or portion thereof) also is a skilled nursing facility for purposes of subchapter XVIII.

(9) Sharing of information

Notwithstanding any other provision of law, all information concerning nursing facilities required by this section to be filed with the Secretary or a State agency shall be made available by such

facilities to Federal or State employees for purposes consistent with the effective administration of programs established under this subchapter and subchapter XVIII, including investigations by State medicaid fraud control units.

APPENDIX E

Appendix E

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF INDIANA
HAMMOND DIVISION

GORGI TALEVSKI, by Next Friend Ivanka Talevski,	)	
Plaintiff,	)	
v.	)	
THE HEALTH AND HOSPITAL CORPORATION CORPORATION OF MARION COUNTY, AMERICAN AMERICAN SENIOR COMMUNITIES, LLC, and VALPARAISO CARE AND REHABILITATION,	)	CASE NO. 2:19-cv-0013-
Defendants.	)	

COMPLAINT AND DEMAND FOR JURY TRIAL

Plaintiff Gorgi Talevski, by Next Friend Ivanka Talevski, and by counsel, files his Complaint and Demand for Jury Trial against Defendants The

Health and Hospital Corporation of Marion County ("HHC"), American Senior Communities, LLC ("ASC"), and Valparaiso Care and Rehabilitation ("VCR") depriving and/or conspiring to deprive Plaintiff of rights secured under the Omnibus Budget Reconciliation Act of 1987 ("OBRA"), the Federal Nursing Home Reform Act ("FNHRA"), 42 U.S.C. § 1396, *et seq.*, the Federal Nursing Home Regulations found in 42 C.F.R. Sec. 483, and the Constitution of the United States of America, under color of state law, pursuant to 42 U.S.C. § 1983.

I. Parties, Jurisdiction and Venue

1. Plaintiff Gorgi Talevski ("Mr. Talevski") is an adult individual residing at Signature of Bremen located at 316 Woodies Lane in Bremen, Marshall County, Indiana, within the geographical boundaries of the Northern District of Indiana. At all times relevant to this action, Mr. Talevski has resided within the geographic boundaries of the Northern District.

2. Ivanka Talevski ("Mrs. Talevski") is the Plaintiff's wife and attorney in fact, and at all times relevant to this action, has resided at 429 Hampshire Court, Valparaiso, Porter County, Indiana, within the geographical boundaries of the Northern District of Indiana.

3. Valparaiso Care and Rehabilitation ("VCR") is a long-term care, skilled nursing facility, located in Valparaiso, Porter County, Indiana, within the geographical boundaries of the Northern District of Indiana.

4. The Health and Hospital Corporation of Marion County ("HHC") is a municipal corporation, owned by Marion County, Indiana, and headquartered in Indianapolis, Indiana. At all times relevant to this action, HHC has owned VCR, as well as approximately 77 other nursing homes throughout Indiana.

5. American Senior Communities ("ASC") is a privately held nursing home management company headquartered in Indianapolis, Indiana. At all times relevant to this case, ASC has been under contract with HHC to manage and operate VCR, as well as all of HHC's other nursing homes throughout the state.

6. This case presents an issue of federal law, and therefore, subject matter jurisdiction is proper in this Court, pursuant to 28 U.S.C. § 1331, .

7. All acts and events relating to this action having occurred within the geographical boundaries on the Northern District of Indiana, venue is proper in this Court.

II. Factual Allegations

8. Mr. Talevski suffers from dementia. His family cared for him until it became clear that he needed full-time care to ensure his safety.

9. In January 2016, when Mr. Talevski's family could no longer care for him, he became a patient at VCR, a nursing facility located in his hometown Valparaiso, Indiana. At the time that he entered VCR, Mr. Talevski was able to able to walk, talk, feed himself, socialize, and recognize his family.

10. While Mr. Talevski was a resident at VCR, his wife and two daughters were frequently called to the

facility to help staff with Mr. Talevski. Mrs. Talevski and her daughters observed that VCR's dementia unit was often understaffed. Additionally, the staff that was present appeared to be poorly trained in dealing with dementia patients. On a number of occasions, Mr. Talevski's family found that he had soiled himself, and had a severe rash on his buttocks.

11. As Mr. Talevski's time at VCR passed, he began losing his ability to communicate in English. Instead, he could communicate only in his native Macedonian. VCR never provided or used any language translation services or other means to communicate with Mr. Talevski. Consequently VCR staff had great difficulty caring for Mr. Talevski.

12. In late August 2016, Mr. Talevski suddenly and dramatically decompensated. He stopped eating on his own, requiring his wife and daugthers to go to VCR to feed him. One one occasion, Mr. Talevski could not even get up out of bed at all.

13. When Mr. Talevski's confronted VCR staff about why Mr. Talevski's condition was deteriorating so drastically, they were told that it was the progression of his disease.

14. On or about September 2016, Mr. Talevski's daughter asked VCR staff for a list of all the medications that Mr. Talevski was being given. The list revealed that Mr. Talevski was on ten different medications, six of which were psychotropic medications.

15. Mr. Talevski's daughter strongly suspected that her father was being chemically restrained, a suspicion she confirmed with outside medical providers, and Mr. Talevski's family sought outside

medical care from a specialist to remove these medications from her father's regime.

16. During the week of September 27, 2016, the Indiana State Department of Health ("ISDH") conducted its annual survey of VCR. During that time, survey nurses were available for residents or family members to speak with. Mr. Talevski's family filed a formal compliant with ISDH regarding the over-prescribing of psychiatric drugs to chemically restrain Mr. Talevski.

17. As Mr. Talevski's medication was tapered down, per the orders of his own neurologist, Mr. Talevski began to recover, and started to feed himself once agian.

18. In late November, VCR started to send Mr. Talevski out to Doctors NeuroPsychiatric Hospital ("NeuroPsych") in Bremen, Indiana, which is an hour and half away from Valparaiso. VCR's reason for this action was alleged inappropriate behavior towards female residents and staff.

19. Initially, Mr. Talevski was sent to NeuroPsych from November 23 through December 15, 2016. Only four days after his return from NeuroPsych, Mr. Talevski was sent to the facility for a second time, from December 19 through December 29. The day after his return Talevski was sent to NeuroPsych for a third time.

20. NeuroPsych intended to return Mr. Talevski to VCR on January 9, 2017. However, VCR refused to accept Mr. Talevski back. Instead, VCR tried to force his transfer to an all-male dementia facility in Indianapolis.

21. The last time Mr. Talevski was sent to NeuroPsych, he was sent without his dentures. VCR never provided NeuroPsych with Mr. Talevski's dentures, leaving him, essentially, toothless in Bremen.

22. When VCR refused to allow Mr. Talevski to return, his family filed a Petition for Review of Involuntary Transfer through the ISDH.

23. Although the staff at NeuroPsych attempted to find another facility for Mr. Talevski, they were unable to find another appropriate facility in Northwest Indiana. NeuroPsych was able to find a suitable facility in Bremen, although that facility was a ninety-minute drive from Mr. Talevski's family in Valparaiso.

24. The family agreed to Mr. Talevski's temporary transfer there pending the outcome of the ISDH hearing.

25. Because Mr. Talevski had not had his dentures at NeuroPsych, when he was transferred to Bremen, the staff there was unable to fit new dentures because his gums had receded to far. As of the date of filing, Mr. Talevski is still without his dentures.

26. On January 19, 2017, an ISDH Administrative Law Judge ("ALJ") held a nearly six-hour-long hearing following which the ALJ effectively denied VCR's attempt to "patient dump" Mr. Talevski, ruling "the decision to transfer [Mr. Talevski] from Valparaiso Care and Rehabilitation should NOT be affirmed." The order was issued February 28, 2017.

27. Based on the ALJ's order, the family attempted to have Mr. Talevski returned to VCR.

However, VCR simply ignored the order and refused to readmit Mr. Talevski.

28. As a result, Mr. Talevski unnecessarily spent more than a month and a half at NeuroPsych, at a cost of nearly $30,000, all of which was paid for by Medicare.

29. Mr. Talevski's family complained to the ISDH regarding VCR's refusal to abide by the ALJ's order. The ISDH sent in another nurse investigator to address all the complaints against the nursing home.

30. In May 2017, the ISDH issued their finding in an 81 page document.

31. After "dumping" Mr. Talevski at NeuroPsych in January, following the May ISDH report, ASC contacted Mrs. Talevski to discuss evaluating Mr. Talevski for return to VCR.

32. After meeting with VCR staff in June 2017, and after reading the 81 page report, Mr. Talevski's family was very concerned about possible retribution against Mr. Talevski if he was to be returned. Additionally, Mr. Talevski was by now acclimated to his new surrounding at the Bremen nursing home.

33. As a result, Mr. Talevski's family opted to leave Mr. Talevski in the Breman facility.

34. As a result, Mr. Talevsji's family is required to make a three-hour round-trip to visit Mr. Talevski, which they do on a regular basis.

III. Legal Allegations

Count One: Deprivation of Rights Under Color of State Law (42 U.S.C. § 1983)

35. Plaintiff restates each and every allegation in paragraphs one (1) through thirty-four (34) as though fully set forth herein.

36. Defendant HHC is a corporation owned by Marion County, Indiana, and is therefore "person . . . under color of any statute, ordinance, regulation, custom, or usage, of [the State of Indiana," as that term is used in 42 U.S.C. § 1983.

37. Defendant VCR is wholly-owned by HHC and is therefore a "person . . . under color of any statute, ordinance, regulation, custom, or usage, of [the State of Indiana," as that term is used in 42 U.S.C. § 1983.

38. Defendant ASC manages VCR as an agent of HHC, and is therefore "person . . . under color of any statute, ordinance, regulation, custom, or usage, of [the State of Indiana," as that term is used in 42 U.S.C. § 1983.

39. The 1987 Omnibus Budget Reconciliation Act ("OBRA"), the Federal Nursing Home Reform Act ("FNHRA"), which was contained within the 1987 OBRA, and the implementing regulations therefore, found at 42 C.F.R. § 483, *et seq*., clearly and unambiguously create rights enforceable pursuant to 42 U.S.C. § 1983.

40. The Defendants' actions, individually and/or collectively, and in derogation of the above statute and regulations, have deprived Mr. Talevski of those rights by:

a. maintaining a policy, practice or custom of allowing the use illegal chemical restraints on Mr. Talevski and other VCF patients;

b. maintaining a policy, practice or custom that denied Mr. Talevski, via his legal representatives, to file grievance free of reprisal as required by law;

c. maintaining a policy, practice or custom that deprived Mr. Talevski and other VCR residents, to remain at the nursing facility and not to be transferred or discharged without due process;

d. denying Mr. Talevski due process by failing to provide proper and timely notification of any transfer or discharge from the nursing facility;

e. by maintaining a policy, practice, or custom, that failed to care for Mr. Talveski in such a manner and in such an environment as to promote maintenance or enhancement of the quality of life of each resident;

f. by maintaining a policy, practice, or custom that failed to provide Mr. Tavelsi with nursing and related services and specialized rehabilitative services to attain or maintain his highest practicable physical, mental, and psychosocial well-being; that is, by repeatedly and regularly failing to have sufficient staff to care for Mr. Tavelski;

g. failing to provide Mr. Talevski with medically-related social services, including but not limited to translation services, to attain or maintain his highest practicable physical, mental, and psychosocial well-being; that is, by failing to provide an

effective means to communicate with Mr. Tavelski in his native language;

h. failing to provide Mr. Talevski with pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet his needs; that is, by over-prescribing the use of psychotropic drugs as chemical restraints;

i. failing to provide Mr. Talevski with an on-going program, directed by a qualified professional, of activities designed to meet his interests and the physical, mental, and psychosocial well-being;

j. by failing to provide Mr. Talevski with routine dental services (to the extent covered under the State plan) and emergency dental services to meet his needs; that is, by failing to provide him with his dentures when transferring him to NeuroPsych;

k. depriving Mr. Talevski of his right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat his medical symptoms; that is, by over-prescribing the use of psychotropic drugs to chemically restrain Mr. Talevski;

41. The Defendants' actions were intentional, willful, and in reckless disregard for Mr. Talevski's rights.

42. As a result of the Defendants' unlawful actions, Mr. Talevski suffered, and continues to suffer, damages, including but not limited to, legal expenses, physical and mental pain and suffering, emotional distress, humiliation, and embarrassment.

IV. Relief Requested

WHEREFORE, Plaintiff Gorgi Talevski, by Next Friend Ivanka Talevski, respectfully requests that the Court enter judgment in her favor, and against the Defendants, and provide the following relief:

43. Order the Defendants, jointly and severally, to pay him actual damages in an amount sufficient to compensate him for any actual out-of-pocket costs, including but not limited to any subrogation by any insurance company or government entity;

44. Order the Defendants, jointly and severally, to pay him compensatory damages for the physical and mental pain and suffering, emotional distress, humiliation, and embarrassment caused by Defendants' actions;

45. Order Defendant ASC to pay him punitive damages, for its willful, reckless and malicious actions;

46. Order the Defendants, jointly and severally, to pay pre- and post-judgment interest on all sums awarded

47. Order the Defendants, jointly and severally, to pay her reasonable attorney fees and costs of litigating this action; and

48. Order the Defendants, jointly and severally, to provide any and all other relief to which the Plaintiff may be entitled.

V. Demand for Jury Trial

Plaintiff Gorgi Talevski by Next Friend Ivanka Talevski, and by counsel, demands a trial by jury on all issues so triable.

Respectfully submitted,

s/ Jay Meisenhelder
Jay Meisenhelder, Atty No. 19996-49
JAY MEISENHELDER EMPLOYMENT &
CIVIL RIGHTS LEGAL SERVICES, P.C.
650 North Girls School Road, Suite D40
Indianapolis, IN 46214
Office Telephone: 317/231-5193
Direct Telephone: 317/899-9220
Facsimile Number: 317/982-5463
Email Address: jaym@ecrls.com

s/ Susie Talevski
Susie Talevski, Atty. No. 23771-49 429
Hampshire Court
Valparaiso, IN 46385

APPENDIX F

APPENDIX F

CONFIDENTIAL

STATE OF INDIANA)		BEFORE AN
	) SS:	ADMNISTRATIVE
COUNTY OF MARION)		LAW JUDGE FOR THE INDIANA STATE DEPARTMENT OF HEALTH
		CAUSE NO. IVT-000350-17
PETITION FOR REVIEW OF		)
INVOLUNTARY TRANSFER OF G.T.,		)
RESIDENT, FROM VALPARAISO CARE		)
& REHAB		)
VALPARAISO, INDIANA 46383		)

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDED ORDER
PRELIMINARY COMMENTS

This matter was assigned to Scott Wallace, duly appointed Administrative Law Judge (ALJ) for the Indiana State Department of Health ("Department") on or about January 10, 2017. At issue is an appeal by Petitioner G.T. (alternately "G.T." and "Petitioner") of a Notice of Transfer made by the Facility on or about January 6, 2017, from Valparaiso Care and Rehabilitation, at 606 Wall Street, Valparaiso, IN 46383. Petitioner made a timely appeal by written submission in the form of a fax on or about January 9, 2017.

On or about January 13, 2017, the undersigned Administrative Law Judge scheduled a hearing for January 19, 2017.

Pursuant to Ind. Code § 4-21 et. Seq., the ALJ has considered the evidence herein from the entire record of this Cause, and developed the following Findings of Fact and Conclusions of Law. These Findings of Fact and Conclusions of Law are also based on the evidence and exhibits presented at the Informal Hearing and the transcript of that Hearing and the arguments of the parties.

+ + +

FINDINGS OF FACT

1. The Administrative Law Judge is designated to hear appeals on the involuntary interfacility transfer of a resident in a comprehensive care facility pursuant to 410 IAC 16.2-3.1-12 and 42 CFR 483.12.

2. This matter is properly before the ALJ pursuant to Ind. Code § 4-21.5, et seq., and that he has the authority to hear and rule upon all matters presented herein.

3. All Findings of Fact that can more properly be deemed Conclusions of Law are hereby deemed Conclusions of Law. All Conclusions of Law that can more properly be deemed Findings of Fact are hereby deemed Findings of Fact.

4. Petitioner has resided at the facility since January of 2016. At the time of hearing, Petitioner temporarily was inpatient at Bremen

Hospital. Petitioner had four other hospital stays during this time. He stayed at St. Catherine's Hospital March 3, 2016 through March 17, 2016 and July 21, 2016 through July 26, 2016. He stayed at Bremen Hospital November 23, 2016 through December 15, 2016 and December 19, 2016 through December 29, 2016.

5. According to Exhibit 6, Resident Face Sheet, Petitioner suffers from, among other things, unspecified dementia with behavioral disturbance, cognitive communication deficit, dementia in other diseases classified elsewhere with behavioral disturbance, and other sexual dysfunction not due to a substance or known physiological condition.

6. Petitioner no longer understands English. He communicates with his family in his native Macedonian language.

7. Petitioner has had a variety of incidents with other residents and staff. These incidents include physical harm to staff and sexual inappropriateness with female residents. These incidents are documented in Exhibit A, Resident Progress Notes.

8. Exhibit A, Resident Progress Notes, contains the entire list of incidents for Petitioner. These incidents include the following:

    a. On January 26, 2016, Petitioner was overly friendly with females touching their arms and

legs. Petitioner was redirected away from other female residents several times.

b. On January 28, 2016, Petitioner was kissing and touching residents that morning.
c. On February 10, 2016, Petitioner was inappropriately touching another female resident and trying to lure resident into his room.
d. On February 22, 2016, a CNA reported to the nurse that Petitioner was leading a female resident into his room numerous times and closing the door. It took three staff members to separate and redirect the two residents.
e. On February 29, 2016, Petitioner still continues to touch and rub on the arms and legs of female residents. Petitioner tries to take them to his room. He gets angry when staff tries to redirect him.
f. On July 2, 2016, as noted in the July 5, 2016 note, Petitioner pushed a CNA, pulled a knife on a nurse while making stabbing motions, and raised fists to staff.
g. Only July 3, 2016, Petitioner was redirected out of another resident's room. Petitioner raised his fist to the staff. Petitioner was rubbing the arms and face of female residents.
h. On July 21, 2016, Petitioner tried to stab a worker with a fork.
i. On July 27, 2016, Petitioner touched a female resident on the breast on top of the clothing. He slid his hand under the sleeve of same resident's shirt. Throughout the evening he had four more events of touching female residents on the hands or back, not of a sexual nature.

j. On July 27, 2016, Petitioner continued to inappropriately touch residents. This included kissing or grabbing other residents.
k. On November 23, 2016, Petitioner grabbed, twisted, and shoved a staff member onto a couch when the staff member tried to redirect his behavior.
l. On December 19, 2016, Petitioner was rubbing himself between his legs and put his arm around another female resident. Petitioner follows female residents around the dining room. Later, Petitioner was waving a broom stick around in the dining room. Petitioner was roaming and not easily redirected.
m. On December 30, 2016, Petitioner was touching female residents on the shoulder as he walked by them. He also attempted to pull another female resident onto his lap. When redirected, he grabbed her hand twisting and pulling; he reared back to hit her.

9. According to exhibit A, on March 4, 2016, the facility discussed with Petitioner's family the possibility of transferring Petitioner to an all male facility.

10. On January 6, 2017, Melissa Hershman received a general order from Dr. Mirochna that stated Petitioner was not to return to the facility. He requires an all male facility. On January 6, 2017, Dr. Mirochna wrote in the Resident Progress Notes that Petitioner poses a danger to other residents at the facility due to his increased physical and sexual behaviors toward women. Dr.

Mirochna stated, "I am in support of and recommend placement in another facility, preferably all male."

11. If transferred, Petitioner would go to Harcourt Terrace Nursing and Rehabilitation in Indianapolis, IN. The facility stated that it could only find two facilities, both in Indianapolis, that could accommodate Petitioner – that being an all male unit with dementia care.

12. As of the date of the hearing, the facility had not completed a relocation planning conference.

CONCLUSIONS OF LAW

1. This matter is properly before the ALJ herein, pursuant to Ind. Code § 4-21.5, and that the ALJ has the authority and jurisdiction to hear and rule upon all matters presented herein.

2. No known procedural defect occurred in the hearing process.

3. The AOPA, Ind. Code § 4-21.5, requires that this decision be rendered solely on the record before the ALJ. However, the ALJ may also utilize his experience, technical competence, and specialized knowledge in evaluating evidence.

4. All Conclusions of Law that can be deemed Findings of Fact are hereby deemed Findings of Fact. All Findings of Fact that can be deemed Conclusion of Law are hereby deemed Conclusions of Law.

5. The issue herein is whether Petitioner could be transferred to another facility because the safety of the individuals in the facility is endangered or the health of the individuals in the facility would otherwise be endangered. More specifically, the first issue is whether the facility followed the proper procedures as stated in the Indiana Administrative Code. And secondly, the issue is whether Petitioner's behavior rises to the level of endangering the safety or health of the individuals while weighing his behavior with his psychological and social health.

6. 410 IAC 16.2-3.1-12(4) states, "Health facilities must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless: (C) The safety of individuals is endangered; (D) The health of the individuals in the facility would otherwise be endangered[.]"

7. According to 410 IAC 16.2-3.1-12(4)(a), when a facility discharges a resident because the transfer is necessary for the resident's welfare and his needs cannot be met by the facility, the resident's clinical record must be documented. The documentation must be made by the resident's physician. It does not require the physician "order" the transfer, but rather than that the physician supports the transfer in the resident's clinical documented record.

8. According to 410 IAC 16.2-3.1-12(a)(18), Prior to any interfacility or involuntary intrafacility relocation, the facility shall prepare a relocation plan to prepare the resident for relocation and to provide continuity of care. In nonemergency relocations, the planning process shall include a relocation planning conference to which the resident, his or her legal representative, family members, and physician shall be invited. The planning conference may be waived by the resident or his or her legal representative. (19) At the planning conference, the resident's medical, psychosocial, and social needs with respect to the relocation shall be considered and a plan devised to meet these needs.

9. Because the Facility has not completed a relocation plan, it cannot transfer the Petitioner involuntarily. Even if the Representatives do not cooperate with the relocation process, the facility is required to first complete a relocation plan as described in 410 IAC 16.2-3.l-12(a)(l8). The law requires the facility to notify and invite the representative or the resident – not require them to be present. If the resident or representative refuses to cooperate or attend the meeting, the facility can still go along with the relocation plan meeting. But the facility has to complete that plan before an involuntary transfer is authorized. Even though the facility could complete a relocation plan meeting before it transferred the resident, the ALJ cannot authorize a transfer when all

the requirements for transfer have not been met.

10. 410 IAC 16.2-3.l-12(a)(18), specifically uses the words "In nonemergency relocations, the planning process shall include a relocation planning conference[.]" Thus, if the facility does not complete a relocation planning conference, it can only transfer the resident in an emergency. 410 IAC 16.2-1.1-24 defines emergency as, "a situation or physical condition that presents imminent danger of death or serious physical or mental harm to one (1) or more residents of a facility." Based on the facts presented, Petitioner's behavior does not rise to the level of imminent danger of death or serious physical or mental harm. Because the situation with Petitioner does not present imminent danger or death or serious physical or mental harm to a resident, it is not an emergency. Because it is not an emergency, the facility is required to complete a relocation planning conference.

11. The second issue is addressing the case on the specifics and whether it would otherwise be granted if a relocation planning conference was completed. The biggest problem with the transfer is that it transfers Petitioner to Indianapolis when his family lives in or around Valparaiso. It would likely be a hardship on any dementia patient to be relocated. New environments can be difficult for dementia patients, and it often takes time to adjust to new surroundings. This would be exacerbated

for Petitioner because he no longer speaks English and because his strong family network would be so far away. His family would likely ease a transition by both being a comforting force in his life and by being able to communicate with him. With his family being so far away, Petitioner would likely suffer more.

12. Even though it would likely be harmful to Petitioner to be transferred to a facility in Indianapolis, he is not absolved of all bad conduct. The facility still has a duty to its other residents to keep them safe and healthy. One problem is that Petitioner has had very little time to acclimate himself back to the facility after he returned from Bremen. From November 23, 2016 through the date of the hearing, Petitioner only spent five days at the facility. When he came back December 15, 2016, he did not have much time to readjust before he was sent back on December 19, 2016. The same is true when he came back on December 29, 2016. He was sent out the next day. This does not mean that the facility erred in sending him to the hospital. It just means that it is difficult to assess how he would adjust after several days, several weeks of a new environment.

13. Two of Petitioner's most concerning sexual events are on July 27, 2016 when he touched the breast of a female resident and on December 19, 2016 when he was rubbing himself inappropriately and following female

residents into their rooms. Both of those events took place after just having returned to the facility from the hospital stay. Because it can sometimes take quite a bit of time for a dementia patient to readjust to new surroundings, incidents like these are somewhat expected.

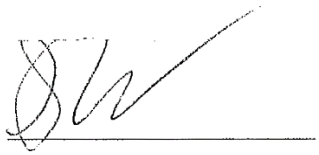
14. Also, the record is not clear that Petitioner needs to go to an all male facility. Dr. Mirochna noted that he recommends placement in another facility, preferably all male. He did not state that he needs to go to an all male facility. The facility should not have limited the search for a new facility to an all male facility.

15. Based on factors that a transfer to Indianapolis would be an extreme hardship for Petitioner, his most recent incidents occurred after just returning to the facility, and it's not clear that Petitioner must go to an all male facility, the transfer would not be granted if the relocation planning conference had been completed. However, these incidents would be reevaluated with any future incidents if they so arose.

RECOMMENDED ORDER

The decision to transfer G.T. from Valparaiso Care and Rehabilitation should NOT be affirmed.

So RECOMMENDED this 3rd day of February, 2017.



Scott Wallace
Administrative Law Judge

FINAL ORDER

APPROVED AND ORDERED THIS 28th day of February, 2017.

ERIC MILLER
CHIEF OF STAFF