NO. 21-806

In The Supreme Court of the United States

HEALTH AND HOSPITAL CORPORATION OF MARION COUNTY, ET. AL., PETITIONERS
v.
IVANKA TALEVSKI, PERSONAL REPRESENTATIVE OF THE ESTATE OF GORGI TALEVSKI, DECEASED

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF OF AMICI CURIAE AARP, AARP FOUNDATION, CALIFORNIA ADVOCATES FOR NURSING HOME REFORM, THE CENTER FOR MEDICARE ADVOCACY, JUSTICE IN AGING, LONG TERM CARE COMMUNITY COALITION, AND THE NATIONAL CONSUMER VOICE FOR QUALITY LONG-TERM CARE IN SUPPORT OF RESPONDENT AND URGING AFFIRMANCE

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STATEMENT OF INTEREST*

AARP is the nation's largest nonprofit, nonpartisan organization dedicated to empowering Americans 50 and older to choose how they live as they age. With nearly 38 million members and offices in every state, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, AARP works to strengthen communities and advocate for what matters most to families, with a focus on health security, financial stability, and personal fulfillment. AARP's charitable affiliate, AARP Foundation, works to end senior poverty by helping vulnerable older adults build economic opportunity. Among other areas, AARP and AARP Foundation fight to protect the right of nursing facility residents to obtain judicial redress when they have been victims of abuse and neglect, and frequently appear as friends of the court on issues that impact nursing facility residents.

California Advocates for Nursing Home Reform (CANHR) is a nonprofit organization that represents the interests of approximately 100,000 California nursing home residents and their families. Since 1983, CANHR has been advocating for the

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* In accordance with Supreme Court Rule 37.6, Amici state that: (1) no counsel to a party authored this brief, in whole or in part; and (2) no person or entity, other than Amici, their members, and their counsel have made a monetary contribution to the preparation or submission of this brief. The parties have filed letters granting blanket consent to the filing of amicus briefs.

rights of long-term care residents. CANHR and its 3,000 members have a substantial interest in ensuring that quality care be provided to persons living in nursing facilities. CANHR's efforts include aiding residents and their families in obtaining legal services for long-term care issues and working to impose tougher sanctions on nursing homes that abuse or neglect residents. They also include providing consumers, attorneys, and social workers with accurate information on long-term care and continually working to determine the root causes of poor care and developing legislation and policies to address them.

The Center for Medicare Advocacy (the Center) is a national, nonprofit law organization that works to advance access to comprehensive Medicare coverage, health equity, and quality health care for older people and people with disabilities. Founded in 1986, the Center focuses on the needs of people with longer-term and chronic conditions. The organization's work includes legal assistance, advocacy, education, analysis, and policy initiatives. It advocates on behalf of beneficiaries in administrative and legislative forums, and serves as legal counsel in litigation of importance to Medicare beneficiaries and others seeking health care coverage.

Justice in Aging is a national nonprofit legal advocacy organization that fights senior poverty through law. Justice in Aging was founded in 1972 (originally under the name "National Senior Citizens Law Center") and maintains offices in Washington, D.C., and Los Angeles and Oakland, California.

Justice in Aging advocates for affordable health care and economic security for older adults with limited resources, focusing especially on populations that have traditionally lacked legal protection. Justice in Aging's work includes substantial advocacy on behalf of nursing facility residents, including federal administrative and legislative advocacy.

The Long Term Care Community Coalition (LTCCC) is a nonprofit organization dedicated to improving quality of care, quality of life, and dignity for elderly and people with disabilities in nursing homes, assisted living, and other residential settings. LTCCC focuses on systemic advocacy, researching relevant national and state policies, laws, and regulations to identify relevant issues and develop meaningful recommendations to improve quality, efficiency, and accountability. Along with providing a foundation for advocacy, LTCCC uses this research and the resulting recommendations to educate policymakers, consumers, and the general public. Consumer, family, and LTC Ombudsman empowerment are fundamental to its mission.

The National Consumer Voice for Quality Long-Term Care (Consumer Voice) was formed as NCCNHR (the National Citizens' Coalition for Nursing Home Reform) in 1975 due to public concern for substandard care in nursing facilities. The Consumer Voice has since become the leading national voice representing consumers in issues relating to long-term care and is the primary source of information and tools for consumers, families, caregivers, ombudsmen, and other advocates to help ensure quality care for all

residents. Consumer Voice is dedicated to advocating for quality care, quality of life, and protection of rights for all individuals receiving long-term services and supports.

Amici are organizations that represent the interests of older adults and nursing facility residents. We file this brief because the Court's decision about whether nursing facility residents can enforce their rights under the Federal Nursing Home Reform Act will impact their safety in government-operated nursing facilities and their ability to vindicate violations of their rights.

SUMMARY OF ARGUMENT

Congress passed the landmark Federal Nursing Home Reform Act (FNHRA) in 1987 after an Institute of Medicine (IOM) study found that, in too many nursing facilities, residents were being abused and neglected, and receiving "very inadequate—sometimes shockingly deficient—care." Comm. on Nursing Home Regul., Inst. of Med., *Improving the Quality of Care in Nursing Homes* 2 (1986) [*IOM Study*].

FNHRA changed the federal government's approach to protecting residents and improving their care. Among other things, the law mandates minimum standards of care that nursing facilities must meet to receive federal reimbursement. It also defines and guarantees the Residents' Bill of Rights, a comprehensive set of resident rights that nursing facilities must protect and promote. Among these

rights are the right to be free of abuse and neglect, the right to be free of chemical restraints administered for the staff's convenience, and the right to be free of illegal involuntary discharges.

These legal rights are a matter of life and death for nursing facility residents. Even today, residents experience abuse, neglect, and dangerously poor care in many facilities. This abuse includes being chemically restrained for the staff's convenience or illegally discharged into unsafe situations without notice. Given these dire conditions, residents must be able to enforce their FNRHA rights to protect themselves from persistent harm.

Regulatory enforcement alone cannot do the job. Regulatory enforcement determines facilities' compliance with standards. It does not vindicate a resident's individual entitlement to quality care or violations of their rights. In addition, regulatory enforcement has failed to stop many pervasive harms, including illegal discharges and chemical restraints. Moreover, even if regulatory enforcement functioned perfectly, which it does not, it still would not compensate residents for harms that result from facilities' violating their rights.

Thus, residents must be able to go to court to enforce their rights themselves. A decision affirming their ability to enforce their rights under Section 1983 will give residents the mechanism they need to hold government-run facilities accountable for violating their rights. For these reasons, Amici respectfully request that the Seventh Circuit decision be affirmed.

ARGUMENT

I. Nursing Facility Residents Must Be Able To Enforce Their Rights Under The Federal Nursing Home Reform Act To Protect Themselves From Abuse And Neglect In Government-operated Nursing Facilities.

The Seventh Circuit properly applied the Supreme Court test set forth in *Blessing v. Freestone* and *Gonzaga University v. Doe* to determine that nursing facility residents can enforce their FNHRA rights to be free of illegal chemical restraints and discharges through a Section 1983 action against a government-run nursing facility. *See Talevski v. Health & Hosp. Corp. of Marion Cty.*, 6 F.4th 713, 718-21, 726 (7th Cir. 2020) (interpreting *Blessing v. Freestone*, 520 U.S. 329 (1997), and *Gonzaga University v. Doe*, 536 U.S. 273 (2002)). FNHRA changed the landscape for nursing facility residents by, among other things, defining and guaranteeing their legal rights. Yet, if this Court finds that residents cannot enforce those rights, they will lose a powerful shield that they need to guard their own safety and protect other residents from future harm. This loss could put them at risk of harm and even death because abuse, neglect, and poor care are rampant in many facilities.

In short, Section 1983 gives nursing facility residents and their families a mechanism to enforce their rights against abuse and neglect in government-run facilities. Regulatory enforcement has been

inadequate to protect them. Therefore, residents must be able to enforce their own rights.

A. Congress established FNHRA's Residents' Bill of Rights to define and guarantee the legal rights of nursing facility residents and protect them from abuse and neglect.

The passage of FNHRA was a historic moment for nursing facility residents. After decades of residents being provided unsafe and abusive care, Congress passed FNHRA to protect residents by (1) defining and guaranteeing their legal rights, (2) establishing minimum health and safety standards that nursing facilities must meet to receive federal reimbursement, and (3) redesigning the regulatory inspection and enforcement process to focus on quality assurance. 42 U.S.C. §§ 1395i-3, 1396r.

A key impetus for the law was to combat the abuse and neglect of residents that was occurring in many nursing facilities. *IOM Report* at 2-3; *see also* Jeffrey A. Pitman & Katherine E. Metzger, *Nursing Home Abuse and Neglect and the Nursing Home Reform Act: An Overview*, 14 NAELA J. 137, 138 (2018) (explaining that decades of reports of abuse and neglect led up to the passage of FNHRA) [*Nursing Home Abuse*]. Studies, testimony, and news reports from the 1970s and 1980s showed that this abuse and neglect was leading residents to "premature death, permanent injury, increased disability, and unnecessary fear and suffering." *Id.* at 3; *see also*

Kaiser Fam. Found., *Nursing Home Reform: Then and Now* (Nov. 29, 2007), https://www.kff.org/medicare/video/nursing-home-reform-then-and-now/ (highlighting news reports documenting the harm to residents). Residents also were receiving "grossly inadequate care" that threatened their lives. *IOM Report* at 3. And they could not presumptively rely on federal and state regulators to protect them because government regulation of nursing facilities was inadequate, inconsistent, and often ineffective. *Id.* at 6-7, 15.

Consumer advocates, including residents and their families, sounded the alarm. *Id.* at 7. This began years of negotiations between consumer advocates, the nursing facility industry, Congress, and the federal government to change federal rules to protect residents and improve government oversight. *Id.* at 6-7; *see also* Joshua M. Wiener et al., *Nursing Home Care Quality: Twenty Years After The Omnibus Budget Reconciliation Act of 1987*, Kaiser Fam. Found., 3-5 (Dec. 2007) (describing the interactions among Congress, the Executive Branch, and consumer advocates). Finally, in 1983, Congress and the federal government requested that the IOM appoint a committee to study nursing facility issues and recommend changes to the law and policies. *IOM Report* at 2.

The IOM's Committee on Nursing Home Regulation issued its report in 1986. *Id.* at ii. It found that in too many nursing facilities, residents were being abused and neglected, and receiving deficient care. *Id.* at 2. It also found that government

regulation was inadequate. *Id.* at 15. It recommended significant reforms to ensure residents' safety and care, protect their legal rights, and improve government oversight. *Id*. at 12, 25-44.

Congress passed the reforms as part of the Nursing Home Reform Act in the Omnibus Budget Reconciliation Act of 1987. *Nursing Home Abuse*, *supra*, at 138. Among other things, the law defines the legal rights of nursing facility residents. H.R. Rep. No. 100-391(II) at 868-70 (1987). It also requires nursing facilities to protect and promote those legal rights. *Id.* at 868.

The legal rights, also called the Residents' Bill of Rights, include:

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

- 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;

- The right to be fully informed in advance about care and treatment and about any changes in care and treatment that may affect a resident's well-being, and to participate in planning care and treatment or changes to care and treatment;

- The right to participate in resident groups;

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

- The right to privacy about accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups; and

- The right to not be discharged or transferred from the facility except in very narrow circumstances that must be fully documented in the resident's medical record.

42 U.S.C. §§ 1395i-3(c)(1)(A), (2) and 1396r(c)(1)(A), (2).

Thus, after recognizing that residents were suffering widespread harm, Congress enacted the

FNHRA rights to protect residents and obligated nursing facilities to uphold them. These rights are an essential defense to combat the harm that can occur in nursing facilities.

Take, for example, the right to be free of chemical restraints provided for facility staff's convenience or as a punishment, which is one of the rights at issue here. The inappropriate use of chemical restraints is life-threatening resident abuse that has plagued the nursing facility industry for years. *See e.g.*, Office of Inspector General, U.S. Dept. of Health & Human Servs., OEI-07-08-00150, *Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents* (May 2011), https://oig.hhs.gov/oei/reports/oei-07-08-00150.pdf (raising quality and safety concerns about the high use of antipsychotic drugs with nursing facility residents who have dementia and who did not have an appropriate diagnosis) [OIG Antipsychotic Drug Report].

Chemically restraining a resident illegally generally involves facility staff administering antipsychotic drugs to sedate a resident without medical justification. The U.S. Food and Drug Administration has approved antipsychotic drugs for the treatment of psychotic conditions such as schizophrenia and bipolar disorder. Food & Drug Admin., U.S. Dept. of Health & Human Servs., *ZYPREXA Label* (2009), https://www.accessdata.fda.gov/drugsatfda_docs/label/2014/020592s062021086s040021253s048lbl.pdf.

It has also issued its most dire warning — a black box warning — on these drugs because they increase the risk of death when used with elderly patients with dementia. *Id.* About half of nursing facility residents have dementia. Nat'l Ctr. For Health Stat., Ctrs. For Disease Control & Prev., *Long-term Care Providers and Service Users in the United States, 2015-2016*, 23, https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf. [Nat'l Ctr. Health Stat.].

Facilities that administer antipsychotic drugs as chemical restraints do so to make the staff's jobs easier. Sedated residents require fewer staff interactions. Human Rights Watch, *"They Want Docile": How Nursing Facilities in the United States Overmedicate People With Dementia* (Feb. 5, 2018), https://www.hrw.org/report/2018/02/05/they-want-docile/how-nursing-homes-united-states-overmedicate-people-dementia# [*HRW Study*]. But these drugs take a dangerous toll on the residents. Along with increasing their risk of death, these drugs can cause respiratory infections, confusion, falls, stroke, and severe cardiovascular and nervous system complications. OIG Antipsychotic Drug Report at 23-25.

In a 2018 report, *"They Want Docile": How Nursing Homes in the United States Overmedicate People with Dementia*, Human Rights Watch documented the high prevalence of nursing facilities' inappropriate use of antipsychotic drugs as chemical restraints. *HRW Study*. Human Rights Watch estimated that, every week, nursing facilities administer antipsychotic drugs without an

appropriate diagnosis to more than 179,000 people, mostly those living with dementia. *Id.*

Residents and their family members reported that the facilities gave residents drugs without their knowledge, without explaining the risks, or over their objections. *Id.* Residents described the trauma of losing their ability to stay awake, think, and communicate. *Id.* Their families described the pain of witnessing their loved one wither away. *Id.* Staff admitted that they did not always inform residents that they were giving them antipsychotic drugs. *Id.* While most staff said that they administered the drugs appropriately, other staff admitted to giving residents these drugs for their own convenience. *Id.* Some doctors would prescribe drugs at the staff's request, without first evaluating or even seeing the patients. *Id.*

This egregious conduct is pervasive and persistent. In July 2020, the House Ways and Means Majority Committee released a report showing that the inappropriate use of antipsychotic drugs remains unaddressed in nursing facilities. U.S. House of Reps., Report of the Majority Committee on Ways and Means, *Under-enforced and Over-prescribed: The Antipsychotic Drug Epidemic Ravaging America's Nursing Homes* (July 2020), https://waysand means. house.gov/sites/democrats.waysandmeans.house.gov/ files/documents/WMD%20Nursing%20Home%20 Report_Final.pdf.

It found that around 20 percent of all residents in the U.S. – about 298,650 people every week –

received some form of antipsychotic medication in the fourth quarter of 2019, even though only about two percent had qualifying conditions for such drugs. *Id.* at 6. Most residents did not even have diagnosis that would be appropriate for the administered drugs. *Id.*

FNHRA prohibits this abuse by guaranteeing residents the right to avoid restraints of all kinds imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. 42 U.S.C. §§ 1395i-3(c)(1)(A)(ii), 1396r(c)(1)(A)(ii). This right is clear and unambiguous. Congress' intent with this right is also clear: it wanted to stop residents from being inappropriately chemically restrained.

In the end, a resident's ability to enforce this right can be a question of life and death. As discussed below in Section II, regulatory enforcement is not enough to protect residents from these harms. Residents must be able to enforce their rights themselves, including by bringing actions under Section 1983 against government-run facilities. Congress defined and guaranteed FNHRA rights to protect residents. Residents must be able to enforce these rights to give them full force.

B. Nursing facility residents face high rates of abuse, neglect, and poor care in many nursing facilities.

In 2022, more than 1.1 million nursing facility residents live in nearly 15,200 nursing facilities certified to participate in Medicaid and Medicare. Kaiser. Fam. Found., *Nursing Facilities,* https:// www.

kff.org/state-category/providers-service-use/nursing-facilities/.

Overall, these residents are in an extremely vulnerable position, which makes their FNHRA-mandated rights all the more important. Due to their residing in nursing facilities, they are largely isolated from their friends and family. Kjersti Lisbeth Braaten & Wenche Malmedal, *Preventing Physical Abuse of Nursing Home Residents- As Seen From the Nursing Staff's Perspective*, Nursing Open (vol. 4 2017), https://doi.org/10.1002/nop2.98. They depend on staff for their activities of daily living, such as eating, bathing, dressing, and toileting. Nat'l Ctr. Health Stat. at 24 (stating that 87 percent of nursing facility residents had functional impairments in three or more activities of daily living). They are also generally physically weak, and almost half have dementia. *Id.* at 23 (stating that 49% of residents have Alzheimer's or other dementia).

In addition, the chronic understaffing in many nursing facilities puts residents in harm's way. Charlene Harrington & Toby Edelman, *Failure to Meet Nurse Staffing Standards: A Litigation Case Study of a Large US Nursing Home Chain*, 55 Inquiry 1, 8 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6055099/. When nursing facility staffing is inadequate, residents are at heightened risk for painful pressure wounds, dangerous falls, weight loss, and hospitalizations. *Id.* The Centers for Medicare & Medicaid Services (CMS) has recognized that the daily staffing levels in a facility affects quality of care and outcomes. Pauline Karikari-Martin & Cameron

Ingram, *Centers for Medicare & Medicaid Services Staffing Study to Inform Minimum Staffing Requirements for Nursing Homes*, Ctrs. for Medicare & Medicaid Servs. (Aug. 22, 2022), https://www.cms.gov/blog/centers-medicare-medicaid-services-staffing-study-inform-minimum-staffing-requirements-nursing-homes.

Although some facilities are complying with FNHRA's mandate, others are flouting the law and violating residents' rights – with tragic consequences. A recent systemic review of nursing facilities found that 33.4% of residents reported being psychologically abused, 14.1% physically abused, and 11.6% neglected. Nat'l Ctr. On Elder Abuse, U.S. Department of Health and Human Services, Admin. For Comm. Living, *Research, Statistics, and Data*, https://ncea.acl.gov/What-We-Do/Research/Statistics-and-Data.aspx#prevalence (quoting Yongjie Yon et al., *The prevalence of elder abuse in institutional settings: a systematic review and meta-analysis*, European Jrnl. of Pub. Health, Vol. 29, 4 (Feb. 2019).) That same review suggested that around 64.2% of staff admitted to abusing a resident during that past year. *Id.*

The complex challenge of collecting accurate data on the prevalence of abuse in nursing facilities means that these numbers, though unacceptably high, are a mere fraction of a largely under-detected and under-reported problem. Daniel R. Levinson, Office of Inspector General, A-01-17-00504, *Early Alert: The Centers for Medicare & Medicaid Services has Inadequate Procedures to Ensure that Incidents of Potential Abuse or Neglect at Skilled Nursing*

Facilities are Identified and Reported in Accordance with Applicable Requirements, 5-7 (2017), https://oig.hhs.gov/oas/reports/region1/11700504.pdf; *see also* Karl Pillemer et al., *Elder Abuse: Global Situation, Risk Factors, and Prevention Strategies*, 56 The Gerontologist (Supp. 2) S194, S197 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5291158/pdf/gnw004.pdf (stating that projections of elder abuse in institutions underestimate the actual population prevalence).

Consequently, residents must use every tool of redress and deterrence available to protect themselves from harm. FNHRA mandates that nursing facilities protect and promote residents' rights. When government-run facilities violate these rights, residents must be able to sue under Section 1983 to hold the facilities accountable.

II. Nursing Facility Residents Must Be Able To Enforce Their FNHRA Rights Under Section 1983 Because The FNHRA Enforcement Scheme Is Inadequate To Protect Them.

Congress charged the CMS and the States with surveying and certifying nursing facility compliance with the NHRA. 42 U.S.C. §§ 1395i-3(h)(1), 1396r(h)(1). It also armed them with a range of sanctions and remedies to address identified deficiencies. 42 U.S.C. § 1396r(h). These remedies include partial and full denial of payment to the noncomplying facility, prohibitions on new admissions, and penalties. *Id.* However, these

regulatory obligations and sanctions do not obviate the need for residents to enforce the rights at issue here.

Simply put, regulatory enforcement is inadequate to hold a government-run nursing facility accountable for violating a resident's rights. Below are several reasons why regulatory enforcement alone cannot do the job.

A. Regulatory enforcement and private litigation do not serve the same purpose.

First, regulatory enforcement and private litigation serve different functions. The purpose of the regulatory survey-and-enforcement process is to determine and assess facilities' compliance with standards. The process depends on sampling a set of resident records during an annual review of each facility. Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health and Human Servs., *Long Term Survey Process Procedure Guide* 35 (2021), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/LTCSP-Procedure-Guide.pdf. The process does not involve a comprehensive review of rights violations for each resident. *Id.* The process is not designed to vindicate each resident's individual entitlement to the enforcement of their rights and high quality of care.

The purpose of private litigation, on the other hand, is to vindicate and enforce a resident's rights.

Even if regulatory enforcement adequately remedied the facility violations that harm residents, regulators would be unable to compensate injured residents. In the end, residents still need to bring their own actions to be made whole. Private litigation under Section 1983 also helps other residents because it drives facilities into compliance and deters future misconduct. This is particularly true because Section 1983 provides for injunctive relief. 42 U.S.C. § 1983. Thus, it is a tool for systemic change that helps other current and future residents.

B. Regulatory enforcement cannot quickly investigate and rectify rights violations.

Regulators do not survey nursing facilities often enough nor do they respond to resident complaints quickly enough to identify and then quickly remedy a violation of each resident's rights. State survey agencies, acting as CMS agents, are only required to survey each nursing facility once every 15 months. 42 U.S.C. §§ 1395i-3(g)(1)(A), (g)(2)(A)(iii)(I), 1396r(g)(1)(A), (g)(2)(A)(iii)(I).

In addition, although surveyors are supposed to investigate individual resident complaints timely to address substandard care and mitigate harm, even before the pandemic, many states had a backlog of nursing facility complaints that they failed to investigate timely or at all. *See, e.g.*, *Found. Aiding the Elderly v. Cal. Dep't of Pub. Health*, No. CPF-20-517278 (Cal. Super. Ct. Nov. 15, 2021) (granting writ of mandamus after finding that the California

Department of Public Health was gravely behind in reviewing and processing nursing facility complaints, including having 5,286 complaints open and 2,351 of those had been open more than a year for fiscal year 2018 to 2019); Rachel Stassen-Berger, *Lawmakers Outraged over Lack of Investigation in Nursing Home Complaints*, Twin Cities Pioneer Press (Feb. 17, 2017), https://www.twincities.com/2017/02/17/mn-nursing-home-complaints-go-uninvestigated-legislature/ (reporting on lawmakers' outrage after learning about the large numbers of nursing facility complaints that the Minnesota Health Department did not fully investigate.)

In contrast, residents can quickly identify violations because they are living in the facilities. They personally experience the daily events. They know about the rights violations at the facilities because it is their rights that are being violated. They also can uncover violations invisible to regulators.

For example, nursing facilities' illegally discharging or "dumping" residents without providing the required notice can go unnoticed by surveyors because it leaves no paper trail showing that the facility violated the law. Yet, this life-threatening resident abuse is pervasive and persistent.

In fact, for the past ten years, Long-Term Care Ombudsmen, advocates for nursing facility residents, received more complaints about facility-initiated discharges than any other complaint category. Nat'l Ombud. Rep. Sys., *Multi-year Trend Report* (March 9, 2022), https://ltcombudsman.org/omb_support/nors/

nors-data. In 2020, more than 8,000 of the 108,648 nursing facility complaints were about discharges. *Id.* Despite this fact, the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services has found that the government does not have strong safeguards to protect residents from illegal discharges. Office of Inspector General, U.S. Dept. of Health & Human Servs., OEI-01-18-00250, *Facility Initiated Discharges in Nursing Homes Require Further Attention*, (Nov. 2021), https://oig.hhs.gov/oei/reports/OEI-01-18-00250.pdf. [2021 OIG Facility Initiated Discharge Report].

Resident dumping takes place in many forms. Sometimes a facility will remove a resident without any notice and dump them in an unsafe environment such as a park, a shelter, or even the street. *See, e.g.*, Katie Engelhart, *Some nursing homes are illegally evicting elderly and disabled residents who can't afford to pay*, NBC News (Nov. 29, 2019), https://www.nbcnews.com/news/us-news/some-nursing-homes-are-illegally-evicting-elderly-disabled-residents-who-n1087341 (discussing 51-year-old resident with diabetes who was woken in the middle of the night and then dumped on the sidewalk in a wheelchair without his insulin or testing supplies).

Other times, a facility will send a resident to a hospital to receive temporary treatment, then refuse to accept the resident back. Matt Sedensky, *Nursing Homes Turn to Eviction To Drop Difficult Patients*, Assoc. Press (May 8, 2016), https://apnews.com/95c33403b5024b4380836d3ed3dfecb0/nursing-homes-turn-eviction-drop-difficult-patients (describing

resident who remained in hospital for seven months because the nursing facility refused to readmit him). Regardless of the form, illegally discharging a resident can be an unsafe and traumatic experience for the resident and their family. 2021 OIG Facility Initiated Discharge Report at 1.

This illegal conduct also obliterates the FNHRA transfer and discharge rights. FNHRA provides that residents have a right to remain in the facility unless the discharge is:

- necessary to meet the resident's welfare;
- appropriate because the resident's health has improved and they no longer require nursing facility care;
- needed to protect the health and safety of other residents or staff;
- required because the resident has failed, after reasonable notice, to pay the facility charge for an item or service provided at the resident's request; or
- appropriate because the facility closed.

42 U.S.C. §§ 1395i-3(c)(2), 1396r(c)(2).

A nursing facility must provide its residents with a thirty-day notice of transfer or discharge, except for in rare exceptions when the facility must provide a notice as many days as practicable before the

transfer or discharge. *Id.* The notice should include the reason, effective date, location to which the facility is transferring or discharging the resident, the right to appeal, and the name, address, and telephone number of the state Long-Term Care Ombudsman. *Id.* The facility should also provide a safe and orderly transfer or discharge with sufficient preparation and orientation. *Id.*

When facilities defy these procedures, residents can be left in perilous positions. Unfortunately, the pandemic exacerbated this long-standing problem. During the pandemic, many nursing facilities illegally discharged older residents and residents with disabilities against their wishes into homeless shelters, run-down motels, and other unsafe locations. *See, e.g.*, Jessica Silver-Greenberg & Amy Julia Harris, *'They Just Dumped Him Like Trash': Nursing Homes Evict Vulnerable Residents,* N.Y. Times (June 21, 2020), https://www.nytimes.com/2020/06/21/business/nursing-homes-evictions-discharges-coronavirus.html. Many of these residents were among those most susceptible to the virus. *Id.* According to 22 watchdogs in 16 states, as well as elder-care lawyers, social workers, and former nursing facility executives, nursing facilities across the country have discharged residents despite the residents' continuing need for care. *Id.* Some facilities reportedly discharged vulnerable residents so they could admit other residents who would make them more money. *Id.*

As evicting a resident does not leave a paper trail, state surveyors would have trouble identifying these violations without the residents alerting them.

In fact, the OIG found that the scope of facility-initiated discharges in nursing facilities remains unknown. 2021 OIG Facility Initiated Discharge Report at 1.

C. Government oversight of nursing facilities is inadequate.

A final reason that regulatory enforcement is insufficient to enforce FNHRA rights is because of the inadequacy of government oversight of nursing facilities. In June 2019, the Government Accountability Office (GAO) published a report detailing the need for CMS to improve its oversight of facilities to protect nursing facility residents from abuse and neglect. U.S. Gov't Accountability Off., GAO-19-433, *Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse* (2019), https://www.gao.gov/assets/700/699721.pdf.

The GAO found that although abuse deficiencies cited in nursing facilities doubled from 2013 to 2017, less than 8% of the reported deficiencies had any enforcement actions implemented against the nursing facility. *Id.* at 14, 17-18. It also found that CMS had several gaps in its oversight. *Id.* at 35. For example, CMS could not readily access data on the type of abuse or perpetrator. *Id.* CMS also had not provided guidance on information that facilities should include in facility-reported incidents. *Id.* Finally, CMS had several gaps in its referral process that could result in delayed and missed referrals to law enforcement and other entities. *Id.*

In a separate report, the GAO found that infection-control deficiencies in nursing facilities were "widespread" and "persistent," even before more than 150,000 nursing facility residents died from COVID-19. U.S. Gov't Accountability Off., GAO-20-576R, *Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic* (2020), https://www.gao.gov/assets/gao-20-576r.pdf; AARP, *AARP Nursing Home COVID-19 Dashboard Fact Sheets* (Sept. 15, 2022), https://www.aarp.org/ppi/issues/caregiving/info-2020/nursing-home-covid-states.html (showing 154,068 nursing facility residents died of COVID-19 since January 2020).

The GAO found that eighty-two percent of nursing facilities surveyed between 2013 and 2017 were cited for an infection-prevention-and-control deficiency in one or more years. *Id.* at 4. Surveyors cited half of the facilities for the same deficiency in multiple inspections over the five-year period. *Id.* The magnitude and persistence of these dangerous conditions show the failure of enforcement and oversight to remedy the situation, which arguably contributed to COVID-19 ravaging nursing facility residents.

The OIG has also issued several reports over the years highlighting CMS's lack of adequate oversight. For example, in June 2019, the Inspector General issued a report documenting the failure of nursing facilities to report incidents of potential abuse or neglect of residents to their state survey agency as required. Office of Inspector General, U.S. Dept. of

Health & Human Servs., No. A-10-16-00509, *Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated* (2019), https://oig.hhs.gov/oas/reports/region1/11600509.pdf.

Looking at a sample of high-risk emergency room claims that hospitals submitted to CMS, the OIG estimated that in 2016, one in five high-risk hospital emergency room Medicare claims for treatment were the result of potential abuse or neglect in nursing facilities. *Id.* at 1, 8. It also found that facilities failed to report more than 84% of these incidents to the state survey agencies although the law requires such reports. *Id.* at 12. It further found that CMS had unclear guidelines that contributed to nursing facilities failing to report abuse. *Id.*

So regulatory enforcement alone cannot hold government-run facilities accountable for violating residents' rights. In the end, the prevalence and severity of abuse and neglect in nursing facilities and the continued failure of state and federal governments to effectively hold them accountable create a continued need for residents to use every tool of redress and deterrence available to protect themselves from harm and vindicate their rights. These tools include pursuing a private right of action under Section 1983 against government-run facilities.

CONCLUSION

For the reasons stated above, the decision below should be affirmed.

Respectfully submitted,

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