EXAMINING THE *TALEVSKI* DECISION: PRESERVING JUSTICE FOR NURSING HOME RESIDENTS

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A growing proportion of the U.S. population—"the gray wave"—has reached or will soon reach "older adult" status. Accordingly, an increasing number of adults will require placement in a long-term care facility, which residents and their families rely on to provide high-quality care. Unfortunately, long-term care quality has declined due to staffing levels and increased private equity ownership. COVID-19 further exacerbated the problem and caused an even sharper decline in care quality. Poor care quality is directly linked to nursing home resident harm, including neglect, unnecessary psychotropic drug administration, and other forms of abuse—sometimes resulting in death.

*Consequently, in the wake of COVID-19 and the continuous decline in care quality, nursing home litigation involving negligence and wrongful death has been on the rise. Section 1396r of the Federal Nursing Home Reform Act outlines requirements for care provision in nursing homes. Some recent nursing home resident claims have argued that nursing homes' failure to adhere to § 1396r violates the residents' rights under the U.S. Constitution. However, pre-*Talevski*, the circuits were split in their interpretations of § 1396r's language. Courts have interpreted the language of § 1396r as either benefitting the nursing home residents—thus granting them a private right of action—or benefitting the nursing home facilities—thus denying the residents a private right of action.*

In May 2022, to address the circuit split, the U.S. Supreme Court granted certiorari to Health & Hospital Corp. of Marion County v. Talevski*, a case involving an older adult nursing home resident who allegedly experienced neglect and abuse while under the care of his nursing home facility, eventually dying as a result. Talevski*

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argued that the nursing home failed to adhere to § 1396r's mandated requirements for nursing home care provision—a constitutional rights violation. The Supreme Court ruled 7–2 in favor of Talevski, finding that § 1396r created a private right of action for Talevski under 42 U.S.C. § 1986. This decision will have significant and potentially long-lasting consequences for the long-term care industry and its participants. However, the Court's decision was not unanimous, and the dissent in Talevski *suggests the ruling is not immune to future legal opposition.*

This Note will discuss the legality behind Talevski *and similar litigation. It will also discuss the impact of the Supreme Court's recent decision on nursing home residents' ability to hold their facilities accountable under § 1396r of the Federal Nursing Home Reform Act. This Note will then argue that the Court's finding that § 1396r creates a private right of action is proper, as it provides nursing home residents some method for legal remedy and maintains nursing home accountability. Finally, this Note will provide alternative solutions to protect nursing home residents should the Supreme Court eventually reverse its decision.*

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INTRODUCTION

Aging is inevitable, and as people age, they gradually lose the ability to care for themselves. Family members often lack the necessary resources or skills to address the needs of older adults who require special care.[1] Effectively, for some, the only option is to delegate that care to a nursing home facility.[2] Nursing homes are residential care facilities for older adults or disabled individuals who require more assistance than they can receive at home.[3] Relationships of trust form when a nursing home becomes responsible for the care of an older adult—residents and family members rely on these facilities to provide the high-quality care they cannot.[4]

The Federal Nursing Home Reform Act ("FNHRA"), specifically § 1396r, regulates the quality of care nursing home facilities provide to their residents.[5] Unfortunately, despite this regulation, care quality varies widely from facility to facility nationwide due to multiple factors.[6] For one, staffing levels significantly impact facility care quality, as does facility ownership—e.g., to cut costs, private equity-owned facilities more consistently provide lower-quality care to their residents.[7] COVID-19 exacerbated the negative impact of these factors on long-term care quality.[8] Poor quality care causes substantial harm to nursing home residents—resulting in more frequent neglect and sometimes death—and when this happens, the residents and their loved ones understandably want to hold the facilities accountable.[9] As a consequence, nursing home litigation is on the rise.[10]

Interpretation questions surrounding § 1396r of FNHRA resulted in a split within and across circuit courts regarding whether the Statute's language refers to the nursing home residents or the facilities.[11] To resolve the split, the U.S. Supreme

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1. *E.g.*, *Nursing Home Abuse Statistics*, NURSING HOME ABUSE GUIDE, https://www.nursinghomeabuseguide.org/nursing-home-abuse-statistics/ [https://perma.cc/YK8P-M7T5] (last visited Oct. 10, 2023).
2. Jeff Hoyt, *What is a Nursing Home?*, SENIORLIVING (Aug. 21, 2023), https://www.seniorliving.org/nursing-homes/ [https://perma.cc/BQ24-AFZG].
3. *Id.*
4. *See, e.g.*, *id.*
5. *See, e.g.*, Grammer *ex rel.* Estate of Daniels v. John J. Kane Reg'l Ctrs.-Glen Hazel, 570 F.3d 520, 523–24 (3d Cir. 2009).
6. *See, e.g.*, *U.S: Concerns of Neglect in Nursing Homes*, HUMAN RIGHTS WATCH (Mar. 25, 2021, 12:01 AM) [hereinafter *Concerns of Neglect*], https://www.hrw.org/news/2021/03/25/us-concerns-neglect-nursing-homes#:~:text=Human%20Rights%20Watch%20interviews%20with,medications%20among%20nursing%20home%20residents [https://perma.cc/437V-FBPP].
7. *See* discussion *infra* Section I.D.
8. *See infra* Section I.C.
9. *See infra* Section II.A.
10. *See infra* Section I.B.
11. *See* discussion *infra* Section II.C.

Court granted certiorari to *Health & Hospital Corp. of Marion County v. Talevski* in May 2022;[12] oral arguments occurred in November 2022.[13] *Talevski* is an example of rising nursing home litigation in the wake of COVID-19,[14] and it exemplifies the continuous decline in long-term care quality[15] that causes harm or loss of life for countless older Americans.[16] The case raised the issue of whether nursing home residents can seek relief in federal court when nursing homes participating in Medicaid provide substandard care in violation of FNHRA requirements.[17] And while the Court ultimately ruled in favor of Talevski in June 2023, the decision was not unanimous.[18] The dissenting opinions of Justices Thomas and Alito, along with numerous pre-decision amicus briefs in support of the opposing party,[19] suggest that nursing home residents' rights to private action under FNHRA may be vulnerable to future legal challenges.

This Note will address the Court's recent *Talevski* decision and its impact on nursing home residents' ability to hold their facilities accountable for FNHRA violations, including those that result in negligence and wrongful death.[20] Part I outlines the steady decline of long-term care quality and its origins.[21] Part II provides an overview of legal areas relevant to *Talevski* and similar types of litigation, including an analysis of the two primary interpretations on which courts historically relied in FNHRA violation claims[22] and a discussion of the primary arguments involved in the *Talevski* case.[23] Part III argues in favor of the Court's finding for Talevski.[24] Finally, Part IV provides recommendations for future safeguards for nursing home residents and other Medicaid recipients should the Court overrule or abrogate *Talevski*.[25]

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12. 142 S. Ct. 2673, 2673 (2022) (mem.).

13. *See, e.g.*, Robin Rudowitz & Laurie Sobel, *What is at Stake for Medicaid in Supreme Court Case* Health & Hospital Corp. v. Talevski*?*, KFF (Oct. 28, 2022), https://www.kff.org/policy-watch/what-is-at-stake-for-medicaid-in-supreme-court-case-health-hospital-corp-v-talevski/ [https://perma.cc/F9DK-P8SY].

14. Kathleen Steele Gaivin, *COVID-19 lawsuits growing "in spades" against long-term care providers*, MCKNIGHTS SENIOR LIVING (Apr. 13, 2022), https://www.mcknightsseniorliving.com/home/news/business-daily-news/covid-19-lawsuit-growing-against-long-term-care-providers/ [https://perma.cc/2ZP7-KFVK].

15. Tara Sklar, *Implementation and Enforcement of Quality and Safety in Long-Term Care*, *in* COVID-19 POLICY PLAYBOOK: LEGAL RECOMMENDATIONS FOR A SAFER, MORE EQUITABLE FUTURE 143 (Scott Burris et al., eds., 2020) (ebook).

16. *Id.*

17. *See* Rudowitz & Sobel, *supra* note 13.

18. *See* Health & Hosp. Corp. of Marion Cnty. v. Talevski, 599 U.S. 166, 192–235(2023).

19. For a further discussion of briefs in support of Health and Hospital Corporation of Marion County, see discussion *infra* Section II.C.4.

20. *See generally* discussion *infra* Parts I–IV.

21. *See* discussion *infra* Part I.

22. *See* discussion *infra* Part II.

23. *See* discussion *infra* Part II..

24. *See* discussion *infra* Part III.

25. *See* discussion *infra* Part IV.

I. POOR LONG-TERM CARE QUALITY

Long-term care[26] quality has been of longstanding concern to policymakers, medical professionals, and consumers.[27] Poor long-term care quality directly impacts the likelihood of elder abuse and neglect in nursing homes.[28] More than 40% of nursing home residents have reported abuse; more than 90% report personal experiences of neglect or witnessing neglect of another resident.[29] These instances of neglect include leaving residents with mobility issues in their rooms for hours at a time, not changing residents' clothes or bedding regularly, failing to give residents enough food or water, and not adequately treating residents' injuries or illnesses.[30] As a result, residents' family members have witnessed harmful signs of neglect in their loved ones, such as bedsores, weight loss, malnourishment, dehydration, and increased depression.[31]

The following are three sobering examples of nationwide nursing home resident neglect.

A. Experiences of Three Nursing Home Residents

1. Ms. Daniels—Pennsylvania

Melvinteen Daniels, a mother of eight,[32] resided at the John J. Kane Regional Center, an Allegheny County-operated long-term care facility in Pennsylvania.[33] In 2005,[34] because of the Kane Center's alleged failure to provide proper care, she succumbed to neglect-related malnourishment and a blood infection.[35] Her skin sustained a stage four pressure ulcer[36] approximately 11 inches

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26. This Note will use the terms "long-term care" and "nursing home care" interchangeably.

27. *See* NURSING STAFF IN HOSPITALS AND NURSING HOMES: IS IT ADEQUATE? 128–68 (Gooloo S. Wunderlich et al., eds., 1996).

28. *See, e.g.*, Lee Friedman et al., *Association Between Type of Residence and Clinical Signs of Neglect in Older Adults*, 65 GERONTOLOGY 30, 31 (2019) ("Neglect in an institutional setting, in the form of substandard care, directly relates to quality-of-care issues.").

29. *Nursing Home Abuse Statistics*, *supra* note 1.

30. *Id.*

31. *See, e.g.*, *Concerns of Neglect*, *supra* note 6.

32. Nursing Home Law Center Staff, *Appellate Court Decision Expands Nursing Home Patient Rights*, NURSING HOME L. NEWS (Jul. 9, 2009), https://www.nursinghomelawcenter.org/news/nursing-home-abuse/appellate-court-decision-expands-nursing-home-patient-rights/ [https://perma.cc/JN4C-D24U].

33. Grammer *ex rel.* Estate of Daniels v. John J. Kane Reg'l Ctrs.-Glen Hazel, 570 F.3d 520, 522 (3d Cir. 2009).

34. *Greenwood Cemetery: Melvinteen Daniels*, PEOPLELEGACY, https://peoplelegacy.com/melvinteen_daniels-1B1Q1H [https://perma.cc/8DDC-BRJV] (last visited Oct. 10, 2023) (Greenwood Cemetery is located in Allegheny County, Pennsylvania).

35. Nursing Home Law Center Staff, *supra* note 32.

36. Pressure ulcers are more commonly known as bed sores or pressure sores. They occur when individuals sit or lie in one position for too long, and their body weight, pressed against the surface of a bed or chair, cuts off circulation. These sores get worse without treatment, and "stages" of pressure sores depend on their size and depth. Stage four

wide.[37] After Ms. Daniels's death, her daughter, Sarah Grammer, filed a claim against the Kane Center.[38]

2. Mr. Shanklin—Washington

In 2014, John Shanklin suffered a stroke that left him weak on one side of his body, confining him to a wheelchair and placing him at high risk for falls.[39] Because his wife, Mildred, could not provide him with the 24-hour care he needed, she placed him at Coulee Medical Center, a nursing home in Washington State.[40] Despite Mr. Shanklin being a known fall risk,[41] the nursing home allegedly did not provide adequate supervision or develop a care plan to prevent him from falling; consequently, he fell four times within four months.[42] Three days after his final fall, Mr. Shanklin died, and Mildred filed suit against Coulee Medical Center.[43]

3. Mr. Talevski—Indiana

In 2016, when she could no longer provide care, Ivanka Talevski placed her husband, Gorgi Talevski, an older adult man with progressive dementia, at Valparaiso Care and Rehabilitation ("VCR"). VCR is a state-run nursing facility that Health & Hospital Corporation ("HHC") manages.[44] The Talevski family home was near VCR, so it was their preferred facility.[45] Soon after his admission to VCR, Mr. Talevski experienced a noticeable decline in his cognitive and physical functions, including losing the ability to speak and feed himself.[46] As Mr. Talevski's dementia worsened, according to HHC, he became violent and sexually inappropriate towards VCR staff.[47] The staff chemically restrained him with powerful, unnecessary

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pressure sores are "deep and big. Skin has turned black and shows signs of infection—red edges, pus, odor, heat, and/or drainage . . . tendons, muscles, and bone [may be visible]." Web MD Editorial Contributors, *What Are the Stages of Pressure Sores?*, WEBMD (Dec. 20, 2022), https://www.webmd.com/skin-problems-and-treatments/pressure-sores-4-stages/ [https://perma.cc/MS5G-H5BK].

37. Michelle Chen, *No Country for Old People*, IN THESE TIMES (Oct. 31, 2011), https://inthesetimes.com/article/no-country-for-old-people [https://perma.cc/VT5V-ZFML].

38. *Grammer*, 570 F.3d at 522.

39. Shanklin v. Coulee Med. Ctr., No. 2:17-CV-377-RMP, 2019 WL 1601360, at *1 (E.D. Wash. Apr. 15, 2019).

40. *Id.*

41. One in five falls results in serious injury, such as wrist, arm, ankle, and hip fractures. Falls are also the leading cause of traumatic brain injury and can result in death, particularly among older adults. *See Older Adult Fall Prevention*, CTRS. FOR DISEASE CONTROL & PREVENTION (Aug. 6, 2021), https://www.cdc.gov/falls/facts.html [https://perma.cc/73R6-YV4Q].

42. *Shanklin*, 2019 WL 1601360, at *1.

43. *Id.*

44. *See* Michelle Briney & Stephen Ponticiello, Health and Hospital Corporation of Marion County, Indiana v. Talevski, LEGAL INFO. INST., https://www.law.cornell.edu/supct/cert/21-806 [https://perma.cc/T7ZP-UDLQ] (last visited Dec. 6, 2022).

45. *Id.*

46. *Id.*

47. Farah Yousry, *Supreme Court to Hear Nursing Home Case That Could Affect Millions*, KFF HEALTH NEWS (Nov. 7, 2022), https://kffhealthnews.org/news/article/supreme-court-to-hear-nursing-home-case-that-could-affect-millions/#:~:text=A%

psychotropic medications to keep him unconscious without his or his family's consent.[48]

His family claimed HHC did not appropriately manage his dementia and transferred him without permission to different facilities hours away from the family's home, which accelerated his decline.[49] His transfers sometimes left him without personal necessities, such as dentures.[50] In an interview, Mr. Talevski's daughter stated: "[My father] went from being able to walk and talk . . . to not being able to move . . . . [The nursing facility] treated my dad like trash, like a dog."[51] Mr. Talevski died in October 2021 at age 85 in a different nursing home far from his loved ones after HHC transferred him from his preferred facility against his family's will.[52] His wife filed suit against HHC on his behalf, alleging violations of his rights under FNHRA.[53]

B. Nursing Home Litigation

The incidence of nursing home litigation involving negligence and wrongful death due to inadequate care—like Ms. Daniels's, Mr. Shanklin's, and Mr. Talevski's—is rising.[54] Long-term care is one of the fastest-growing areas of healthcare litigation.[55] This growth has accelerated in the wake of COVID-19.[56] Nursing home residents across the United States are suing their facilities in increasing numbers over alleged COVID-19-related negligence and wrongful deaths.[57] However, the onset of COVID-19 merely shed light on a problem that existed long before the outbreak: chronically inadequate nursing home care

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20ruling%20in%20favor%20of,the%20National%20Health%20Law%20Program [https://perma.cc/44DF-KXMC].

48. Amy Lavalley, *Case Over Care at Nursing Home Heading to US Supreme Court*, CHI. TRIB. (Nov. 8, 2022), https://www.proquest.com/docview/2732975973/3E829F5AE43A43DFPQ/1?accountid=8360 [https://perma.cc/YD9Y-BPQZ].

49. Yousry, *supra* note 47.

50. *See* Talevski *ex rel.* Talevski v. Health & Hosp. Corp. of Marion Cnty., 6 F.4th 713, 716 (7th Cir. 2021), *aff'd*, Health & Hosp. Corp. of Marion Cnty. v. Talevski, 599 U.S. 166 (2023).

51. Yousry, *supra* note 47.

52. Lavalley, *supra* note 48.

53. *Talevski*, 6 F.4th at 716.

54. David George Stevenson & David M. Studdert, *The Rise of Nursing Home Litigation: Findings from a National Survey of Attorneys*, SSRN (May 5, 2003), https://ssrn.com/abstract=399602 [https://perma.cc/4QK3-X22Y]. For example, the number of nursing home lawsuits in the U.S. nearly doubled from 1997 to 2001. *See* Christopher E. Johnson et al., *Predicting Lawsuits Against Nursing Homes in the United States, 1997–2001*, 39 HEALTH SERV. RES. 1713, 1724 (2004), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361094/ [https://perma.cc/3ZMH-443Z] (demonstrating the increasing rate of nursing home lawsuits).

55. *A Look at Long-Term Care Litigation and Liability Risks*, EXCELAS (Mar. 20, 2019), https://excelas1.com/a-look-at-long-term-care-litigation-and-liability-risks/ [https://perma.cc/VC83-XH9W].

56. Gaivin, *supra* note 14.

57. *Id.* ("[W]e are seeing the threat and looming cases filed in spades across the country against nursing homes for COVID-19-related deaths and injuries.").

quality.[58] The COVID-19 response, staffing, and nursing home facility ownership are recent factors contributing to this care deficit.

C. Impact of COVID-19 on the Long-Term Care Industry

The onset of COVID-19 in 2020 compounded an already severe problem, leading to an even sharper decline in nursing home care quality.[59] Since January 2020, 400,000 long-term care staff have resigned, citing pandemic exhaustion—as well as the low pay and lack of advancement opportunities that existed even pre-COVID-19.[60] Further, front-line healthcare workers had to accept COVID-19-related risks to work inside nursing facilities, leading to an even more significant hindrance to adequate staffing.[61] As of January 2022, COVID-19 had killed over 200,000 nursing home residents and staff.[62] COVID-19-related risks and burnout compelled many competent nurses and other nursing home workers to leave the industry, leaving a short supply of qualified candidates.[63] This has resulted in lower-quality care for nursing home residents.[64]

Additionally, because nursing home facility workers are persistently underpaid, they frequently work in multiple nursing facilities to make ends meet.[65] Thus, "multi-facility" workers infected with COVID-19 inadvertently spread the virus to different patients and facilities throughout their communities.[66] Further, 64% of nursing home staff do not have paid sick leave, cannot afford to miss work due to illness, and come to work sick.[67] This consequence was detrimental during COVID-19, as infected staff became the central drivers of COVID-19 infection in nursing homes.[68] As a result, 39% of the nearly 270,000 reported COVID-19-related

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58. Sklar, *supra* note 15.

59. *See, e.g.*, Chris Kirkham & Benjamin Lesser, *Special Report: Pandemic exposes systemic staffing problems at U.S. nursing homes*, REUTERS (June 10, 2020, 4:31 AM), https://www.reuters.com/article/us-health-coronavirus-nursinghomes-speci/special-report-pandemic-exposes-systemic-staffing-problems-at-u-s-nursing-homes-idUSKBN23H1L9/ [https://perma.cc/7JF2-E3LS].

60. Alexandra Moe, *The Crisis Facing Nursing Homes, Assisted Living and Home Care for America's Elderly*, POLITICO (July 28, 2022, 4:30AM), https://www.politico.com/news/magazine/2022/07/28/elder-care-worker-shortage-immigration-crisis-00047454 [https://perma.cc/8GA9-272G].

61. *Id.*

62. Yousry, *supra* note 47. Of note, this statistic refers to nursing home residents and staff only. The total number of deaths from COVID-19 within the *general* U.S. population as of June 2023 is 1,127,152. *WHO (COVID-19) Homepage*, WORLD HEALTH ORG., https://covid19.who.int/region/amro/country/us/ [https://perma.cc/L3XN-6A82] (last visited Oct. 10, 2023).

63. Moe, *supra* note 60.

64. *Id.*

65. Sklar, *supra* note 15.

66. *Id.*

67. *See, e.g.*, *High Staff Turnover: A Job Quality Crisis in Nursing Homes*, THE NAT'L CONSUMER VOICE FOR QUALITY LONG-TERM CARE 7 (Sept. 8, 2022) [hereinafter *High Staff Turnover*], https://theconsumervoice.org/uploads/files/issues/High_Staff_Turnover-A_Job_Quality_Crisis_in_Nursing_Homes.pdf/ [https://perma.cc/94VQ-ERRS].

68. *Id.*

deaths in the United States as of December 2020 were among nursing home residents and staff.[69]

D. Inadequate Staffing Levels

Nursing home staffing issues are a primary contributor to the decline in nursing home care quality.[70] Nursing homes that rely on Medicaid reimbursement have long struggled with financial security, partly due to the fact that Medicaid payment rates are significantly lower than those of private payors or Medicare.[71] This financial insecurity equates to low job quality for nursing home staff—poor pay, substandard or no benefits, high workloads, lack of training, poor management, and few opportunities for career advancement.[72] These factors negatively impact nursing home professional staff recruitment and capacity;[73] attracting and retaining high-quality staff is a formidable challenge.[74] In January 2022, the Center for Medicare and Medicaid Services ("CMS") found staff turnover rates in nursing home facilities to be at an all-time high of 52%.[75] In other words, an average nursing home facility replaces over half its care staff every year.[76] More than 30% of these facilities replace 60% or more of their staff annually.[77] These numbers arguably reflect a crisis in nursing home staffing and job quality.[78]

Low wages substantially impede nursing homes' abilities to hire and maintain workers. The national median annual income for nursing aides, who

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69. Halley Bondy, *39% of Covid-19 Deaths Have Occurred in Nursing Homes—Many Could Have Been Prevented: Report*, MSNBC (Dec. 8, 2020, 11:29 AM), https://www.msnbc.com/know-your-value/39-covid-19-deaths-have-occurred-nursing-homes-many-could-n1250374 [https://perma.cc/8KHT-RBK6]. Note that this statistic refers to the COVID-19-related death tally in 2020; the current number of COVID-19 deaths has more than doubled since that time. *See WHO (COVID-19) Homepage*, *supra* note 62.

70. *See, e.g.*, Emma Bardin, *Report: Nursing Home Quality and Care Declining, Action and Research Needed*, MEDCITYNEWS (May 4, 2022, 12:52 PM), https://medcitynews.com/2022/05/report-nursing-home-quality-of-care-declining-action-and-research-needed/ [https://perma.cc/X2WU-6393]; *High Staff Turnover*, *supra* note 67 at 6–9; Jaqueline Lantsman, Milena Berhane, & James Hernandez, *To Achieve Equitable Quality of Care in Nursing Homes, Address Key Workforce Challenges*, HEALTHAFFAIRS (Feb. 17, 2021), https://www.healthaffairs.org/do/10.1377/forefront.20210210.904101/ [https://perma.cc/2GKV-N8TC].

71. Lantsman et al., *supra* note 70.

72. *See, e.g.*, *High Staff Turnover*, *supra* note 67, at 6–9; Lantsman et al., *supra* note 70.

73. Lantsman et al., *supra* note 70.

74. Sarah M. Hall & Eleanor T. Chung, *Is Private Equity Really the Boogeyman in Nursing Home Quality of Care?*, WESTLAW TODAY (May 2, 2022), https://today.westlaw.com/Document/I34e27207ca5c11ec9f24ec7b211d8087/View/FullText.html?transitionType=Default&contextData=(sc.Default)&firstPage=true/ [https://perma.cc/G8EA-JDLC].

75. *High Staff Turnover*, *supra* note 67, at 1.

76. *Id.*

77. *Id.* at 2.

78. *Id.*

comprise 36% of nursing home caregiver staff, is approximately $22,000.[79] Further, nurses working in nursing homes make almost 10% less than nurses working in hospitals.[80] These low wages stem from Medicaid funding, which accounts for 70% of long-term care financing.[81] Medicaid does not consider labor market conditions when limiting costs, which translates to inadequate, stagnant wages for workers, resulting in rampant job dissatisfaction and absenteeism.[82]

Absenteeism among nursing home staff is considerable.[83] Nursing aides, representing 36% of caregiver staff in nursing homes, provide roughly 80% of resident care.[84] A typical workload for a nurse aide is 12 residents, for whom the aide must care simultaneously for long hours each shift;[85] the recommended caseload is 6 residents per aide.[86] One in ten nursing aides in the United States has a caseload of 19 or more residents.[87] Thus, robust nurse aide staffing is needed to deliver an adequate quality of care to residents,[88] making absenteeism a substantial concern. The average daily nurse aide absenteeism rate is almost 10%, higher than any other industry.[89] Together, widespread absenteeism and elevated turnover rates establish a continuous need for higher staffing levels than most nursing homes provide.[90]

Ultimately, high turnover, absenteeism, and overall poor staffing conditions harm nursing home residents.[91] For example, overwhelming workloads due to understaffing result in residents waiting an excessive time for essential care—or going without any care.[92] This means they do not receive adequate care, let alone high-quality care.[93] These conditions also make adhering to federal and state guidelines more difficult. For example, between 2013 and 2017, 82% of all nursing homes had deficient infection control and prevention, including a lack of regular

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79. Lantsman et al., *supra* note 70. This is below the poverty threshold for a family of four ($26,500). *2021 Poverty Guidelines*, OFF. OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION (Feb. 1, 2021), https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references/2021-poverty-guidelines [https://perma.cc/SMY7-RUUH].

80. *High Staff Turnover*, *supra* note 67, at 6.

81. Lantsman et al., *supra* note 70.

82. *Id.*

83. *Id.*

84. *Id.*

85. *Id.*

86. *High Staff Turnover*, *supra* note 67, at 7.

87. *Id.*

88. Lantsman et al., *supra* note 70.

89. *Id.*

90. *Id.*

91. *See, e.g.*, *High Staff Turnover*, *supra* note 67, at 2–6.

92. *See, e.g.*, Lantsman et al., *supra* note 70 (stating that increased nursing home "staffing resulted in an increased frequency of care provided to residents and reduced the missed or delayed care episodes").

93. *See, e.g.*, *High Staff Turnover*, *supra* note 67, at 1.

handwashing, leading to increased risk of disease among residents and staff.[94] Further, nursing home turnover rates correlate with resident abuse citation rates.[95] Facilities with turnover rates between 50% and 59% are more than twice as likely to receive citations for abuse than facilities with rates between 30% and 39%.[96] Similarly, as staffing hours decrease, the likelihood of nursing homes receiving citations for resident abuse increases.[97] High turnover means that caregivers do not receive sufficient training and are often unfamiliar with individual residents' care needs, negatively impacting resident safety, care quality, and quality of life.[98]

E. Private Equity Facilities

There is a significant disparity in care quality between publicly-owned and private-equity-owned nursing homes.[99] Private equity firms take on debt to buy nursing homes, then put that debt on the newly acquired nursing home's books, allowing for maximum profit.[100] Private equity ownership of nursing homes increased dramatically between 2000 and 2018, growing from $5 billion to over $100 billion.[101] This growth is concerning—in a 2021 National Bureau of Economic Research study, the authors found that the mortality rate of private-equity-owned nursing home residents was 10% higher than of residents of non-private-equity facilities.[102] This translates to roughly 1,000 resident deaths a year.[103]

Why this disparity? One reason is that private equity firms often reduce their nursing homes' staffing—arguably the most significant factor in care quality—to cut costs.[104] When private equity companies purchase non-private-equity nursing homes, this results in an average reduction in staffing by 1.4%.[105] In addition to lowering staff numbers, private equity firms also cut their workers' hours.[106] This means that front-line staff, such as nurses and nursing aides, have fewer hours per

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94. *See Fact Sheet: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes*, THE WHITE HOUSE (Feb. 28, 2022) [hereinafter *Fact Sheet: Protecting Seniors*], https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by improving-safety-and-quality-of-care-in-the-nations-nursing-homes/ [https://perma.cc/PA6D-YVK4].

95. *See, e.g.*, *High Staff Turnover*, *supra* note 67, at 2–3.

96. *Id.*

97. *Id.*

98. *Id.*

99. *See* Dylan Scott, *Private equity ownership is killing people at nursing homes*, VOX (Feb. 22, 2021, 4:30 PM), https://www.vox.com/policy-and-politics/22295461/nursing-home-deaths-private-equity-firms/ [https://perma.cc/JZK8-Z864].

100. *Id.*

101. *Id.*

102. Atul Gupta et al., *Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes* 1 (Nat'l Bureau of Econ. Rsch., Working Paper No. 28474, 2021).

103. Scott, *supra* note 99.

104. *Id.*

105. Aine Doris, *When Private Equity Takes Over Nursing Homes, Mortality Rates Jump*, CHI. BOOTH REV. (May 18, 2021), https://www.chicagobooth.edu/review/when-private-equity-takes-over-nursing-homes-mortality-rates-jump/ [https://perma.cc/L6V4-Q2QV].

106. *Id.*

day to provide essential services to patients.[107] Those services include bed turning, infection prevention, and other non-invasive services critical to positive health outcomes and high care quality.[108]

Additionally, as a possible attempt to compensate for cutting staff hours, private-equity-owned nursing home residents are 50% more likely to be on antipsychotics than non-private-equity nursing home residents.[109] This places residents at greater risk for harm, as antipsychotics are linked to higher mortality rates in older adults.[110] Antipsychotic drugs are even more hazardous for older adults with dementia, doubling their chances of death from heart problems, infections, falls, and other conditions.[111] But in many cases, facilities administer these drugs without obtaining informed consent from residents or their families[112] and without a legitimate reason.[113] Understaffed facilities have often used sedatives as "chemical straitjackets" so they don't have to hire more staff to handle residents.[114]

Further, private equity firms tend to prioritize profit over patient care.[115] These firms often own other companies and can pay themselves with their nursing homes' money.[116] For example, a private equity firm that owns a nursing home could pay monitoring fees to a medical alert company that the firm also owns, resulting in greater profits.[117] The firms spend more money in this manner than they do on things related to patient care.[118] The private equity firms also reduce the taxpayer money allotted to each nursing home resident.[119] Combined with reducing nursing staff availability, these methods "suggest a systemic shift in operating costs away from patient care"[120] that results in poorer care quality for nursing home residents.

In a February 2022 statement, the Biden Administration commented on private-equity-run nursing homes, pointing out that private equity ownership leads

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107. *Id.*
108. *Id.*
109. *Id.*
110. *Id.*
111. Katie Thomas et. al., *Phony Diagnoses Hide High Rates of Drugging at Nursing Homes*, N.Y. TIMES, https://www.nytimes.com/2021/09/11/health/nursing-homes-schizophrenia-antipsychotics.html [https://perma.cc/2GVK-ER6G] (Oct. 15, 2021).
112. *Concerns of Neglect*, *supra* note 6.
113. In these cases, antipsychotic prescriptions are often based on invalid diagnoses. *See id.*; *see also* T. Joseph Mattingly II, *A Review Exploring the Relationship Between Nursing Home Staffing and Antipsychotic Medication Use*, 4 NEUROLOGY & THERAPY 169, 170 (2015) ("In 2006, despite black box warnings, most [antipsychotic use] in [nursing homes] was for patients lacking an approved indication while only approximately 21% of adult patients prescribed [antipsychotics] had diagnoses of schizophrenia or bipolar disorder.").
114. *See* Thomas et al., *supra* note 111 ("Studies have found that the worse a home's staffing situation, the greater its use of antipsychotic drugs. That suggests that some homes are using the powerful drugs to subdue patients and avoid having to hire extra staff.").
115. *See* Scott, *supra* note 99.
116. *Id.*
117. *Id.*
118. *Id.*
119. *Fact Sheet: Protecting Seniors*, *supra* note 94.
120. Scott, *supra* note 99 (quoting Gupta et al., *supra* note 102).

to worse resident outcomes.[121] The Administration highlighted research showing that the private equity firms' tactic of cutting expenses has come at the cost of nursing home resident health and safety, including during the COVID-19 pandemic.[122] Additional statistics further supported these findings—residents in private-equity-run nursing homes were about 11% more likely to have a preventable emergency department visit and almost 9% more likely to experience a preventable hospitalization,[123] probable indicators of poor care quality. In response, the Administration announced steps by the Department of Health and Human Services through CMS to "improve the quality and safety of nursing homes [and] protect vulnerable residents . . . ."[124] These steps include examining the role of private equity firms in the nursing home sector and informing the public when these entities "are not serving their residents' best interests."[125]

II. LEGAL OVERVIEW

A. Justice for Nursing Home Residents

For most older adults on a fixed income, Medicaid makes nursing homes the most affordable long-term care option. But this may come at an immeasurable cost: human lives.[126] An increasing number of older Americans—the "gray wave"—are enrolling in long-term care.[127] Unfortunately, there is no guarantee that the long-term care system can deliver the quality of care that older adults require and deserve at their most vulnerable stage of life.[128] Thus, when the system cannot or does not provide adequate quality of care and causes harm to its older adult residents, their ability to seek justice by holding offending facilities accountable is of crucial importance.

1. Arbitration Clauses

Arbitration clauses in nursing home contracts impact residents' ability to seek relief for dissatisfaction or negligence.[129] In response to increasing consumer lawsuits, many nursing home facilities began to include pre-dispute arbitration clauses in their admission contracts in the 1990s and 2000s.[130] Nursing home residents waive their Seventh Amendment right to a public civil jury trial by signing a contract with an arbitration clause, agreeing instead to arbitration in a less public setting.[131] Arbitration clauses benefit the long-term care industry but not nursing home residents. Under these contracts, nursing homes usually get to choose the

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121. *Fact Sheet: Protecting Seniors*, *supra* note 94.
122. *Id.*
123. *Id.*
124. *Id.*
125. *Id.*
126. Chen, *supra* note 37.
127. *Id.*
128. *Id.*
129. William F. Smith III & Robert L. Schenk II, *A Brief History of Mandatory Arbitration Clauses in Nursing Homes and the Current State of Law*, THE CONSUMER VOICE 1–2, https://theconsumervoice.org/uploads/files/general/Arbitration_Clauses_in_Nursing_Home_Admission_Contracts.pdf [https://perma.cc/2K46-9RQS] (last visited Oct. 10, 2023).
130. *Id.*
131. *Id.* at 3.

arbitrator, avoid informing the public of their misdeeds, and pay less in damages.[132] Meanwhile, residents have almost no right to appeal a decision, and when they do, they tend to receive less impactful remedies.[133]

2. Relief Through the Federal Courts

The rise of nursing home litigation demonstrates that greater numbers of nursing home residents and their families want to hold nursing homes accountable for injuries and deaths stemming largely from neglect. One avenue for seeking relief in some jurisdictions[134] has been FNHRA enforcement.[135] Section 1396r outlines requirements for the care of nursing home residents.[136] Claims alleging § 1396r violations depend substantially on whether courts interpret the statute's language as benefiting nursing home residents or as benefiting facilities.

In May 2022, the Court granted certiorari to the *Talevski* case,[137] and it heard oral arguments in November 2022.[138] In June 2023, the Court ruled 7–2 in favor of Talevski, a landmark decision with far-reaching consequences.[139] The Court's holding sets a precedent allowing nursing home residents to hold long-term facilities accountable for FNHRA violations, likely for years to come. However, the fact that the Court's ruling was not unanimous alludes to the potential for future legal battles over this issue. But reversing *Talevski* could deprive millions of vulnerable Americans of their power to hold state-run, Medicaid-funded nursing homes accountable when they do not provide their residents with the services and benefits the law mandates.[140]

B. The Federal Nursing Home Reform Act

Concerned about the effectiveness of government regulation in maintaining nursing home residents' safety, in 1982, Congress asked the Health Care Financing Administration[141] to evaluate the regulation of nursing homes participating in Medicaid.[142] The agency concluded that existing regulations were unsatisfactory because too many marginal or substandard nursing homes remained in operation.[143]

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132. *See id.* at 2.

133. *See id.* at 3–4.

134. Pre-*Talevski*, courts were split in their interpretation of 42 U.S.C. § 1396r regarding whether its language benefits nursing home residents or the nursing homes themselves. *See infra* Figure 1.

135. *See, e.g.*, Grammer *ex rel.* Estate of Daniels v. John J. Kane Reg'l Ctrs.-Glen Hazel, 570 F.3d 520, 527 (3d Cir. 2009).

136. *Id.*

137. Health & Hosp. Corp. of Marion Cnty. v. Talevski, 142 S. Ct. 2673, 2673 (2022) (mem.).

138. Rudowitz & Sobel, *supra* note 13.

139. *Talevski*, 143 S. Ct. at 1462.

140. Yousry, *supra* note 47.

141. The Healthcare Financing Administration is the predecessor to the Centers for Medicare and Medicaid Services ("CMS"). Anderson v. Ghaly, 930 F.3d 1066, 1070 (9th Cir. 2019).

142. *See id.*

143. *Id.* (quoting COMM. ON NURSING HOME REGUL., INST. OF MED., IMPROVING THE QUALITY OF CARE IN NURSING HOMES 2 (1986)).

In 1986, another Congress-sanctioned review of nursing home conditions by the Institute of Medicine revealed that residents were receiving "shockingly deficient care that [was] likely to hasten the deterioration of their physical, mental, and emotional health."[144] The report also found "neglect and abuse leading to premature death, permanent injury, increased disability, and unnecessary fear and suffering on the part of residents."[145]

Based on these findings, Congress amended the Medicare and Medicaid Act in 1987 to improve the quality of care for nursing home residents in Medicaid-eligible facilities.[146] The resulting amendments, known as the Federal Nursing Home Reform Act, imposed multiple prerequisites for Medicaid reimbursement, providing enhanced supervision and assessment of nursing homes under Medicaid.[147] Per FNHRA, nursing homes must obtain certification and undergo regular inspection for recertification; to pass inspection, a nursing home must meet defined standards of care.[148] Specifically, nursing homes must (1) provide care for their residents in a way that promotes quality of life; (2) maintain maximal physical, mental, and psychosocial health through activities and services; and (3) conduct comprehensive functional ability assessments.[149] Per FNHRA, nursing home residents are also entitled to freedom from physical or mental abuse, involuntary seclusion, corporal punishment, and medically unnecessary chemical or physical restraints imposed solely for discipline or convenience.[150]

FNHRA's standard of care requirements, codified at 42 U.S.C. § 1396r,[151] include § 1396r(b), which outlines requirements for services nursing facilities must provide to their residents.[152] These requirements consist of categories addressing quality-of-life enhancement, such as consistency and accuracy of resident

144. Jane Hartsock, Gabriel Bosslet, & Jamie Levine Daniel, *Op/Ed: Marion County Health Agency's SCOTUS Case Could End Protections for Most Vulnerable*, INDYSTAR (Nov. 6, 2022, 4:01 AM), https://www.indystar.com/story/opinion/2022/11/06/marion-county-health-agency-supreme-court-protections-scotus/69621191007/ [https://perma.cc/KF4E-K96R] (quoting COMM. ON NURSING HOME REGUL., INST. OF MED., IMPROVING THE QUALITY OF CARE IN NURSING HOMES 2 (1986)).

145. *Id.*

146. *Anderson*, 930 F.3d at 1070. While Medicaid provides coverage for nursing homes and other long-term care options for those who qualify, Medicare does not provide this coverage. *See How Can I Pay for Nursing Home Care*, MEDICARE, https://www.medicare.gov/what-medicare-covers/what-part-a-covers/how-can-i-pay-for-nursing-home-care#:~:text=Medicare%20and%20most%20health%20insurance,re%20in%20the%20nursing%20home./ [https://perma.cc/L3NX-JESV].

147. *See generally* 42 U.S.C. § 1396.

148. Duncan v. Johnson-Mathers Health Care, Inc., No. 5:09–CV–00417–KKC, 2010 WL 3000718, at *4 (E.D. Ky. July 28, 2010).

149. Grammer *ex rel.* Estate of Daniels v. John J. Kane Reg'l Ctrs.-Glen Hazel, 570 F.3d 520, 529 (3d Cir. 2009) (citing 42 U.S.C. §§ 1396r(b)(l)–(3)).

150. *Id.*

151. *Anderson*, 930 F.3d at 1070.

152. 42 U.S.C. §§ 1396r(b)(1)–(8).

assessment; staff training adequacy; and staff qualification and competency, among other factors.[153]

1. FNHRA and Private Rights of Action

When analyzing FNHRA violations, a court will first determine if there is Supreme Court precedent evaluating whether private rights of action exist for violations of other laws enacted under Congress's Spending Clause power.[154] When Congress enacts a statutory provision pursuant to its spending power, the provision offers no basis for 42 U.S.C. § 1983 enforcement unless Congress clearly demonstrates an unambiguous intent to confer individual rights of action.[155] Thus, because FNHRA passed pursuant to Congress's spending power, a court must determine whether Congress clearly manifested an unequivocal intent to create an individual right.[156] If a claimant establishes the existence of a private right of action, it is presumed to be enforceable under § 1983.[157] Section 1983 imposes liability against anyone who deprives a person of privileges, rights, or immunities protected by the Constitution and federal laws.[158] Section 1983 does not itself create substantive individual rights but instead provides methods for vindicating federal rights conferred elsewhere.[159]

To create an enforceable right under § 1983, the text of a federal statute must be expressed "in terms of the persons benefitted."[160] Under *Blessing v. Freestone*,[161] courts consider three factors when determining whether a federal statute confers an individual right: (1) Congress must have intended the provision at issue to benefit the claimant; (2) the asserted right must be clear so as not to "strain judicial competence" in its enforcement; and (3) the provision conferring the right must be phrased in mandatory terms.[162]

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153. 42 U.S.C. § 1396r(b) Specifically, these requirements address (1) Quality of life–nursing facilities must care for their residents in a way that promotes enhanced quality of life for each resident; (2) Resident assessment–nursing facilities must complete assessments of each resident's functional capacity that are comprehensive, accurate, and standardized; (3) Qualified care providers–qualified persons must provide services according to written plans of care for each resident; (4) Required training of nursing aides–nursing aides must complete a training and competency evaluation approved by the state; and (5) Competency–nursing facilities cannot permit and individual to serve as a nurse aide or provide any services for which the individual has not shown competency. *Id.*

154. Duncan v. Johnson-Mathers Health Care, Inc., No. 5:09–CV–00417–KKC, 2010 WL 3000718, at *5 (E.D. Ky. July 28, 2010).

155. Gonzaga Univ. v. Doe, 536 U.S. 273, 280 (2002).

156. *Id.*

157. *Id.* at 284.

158. Maine v. Thiboutot, 448 U.S. 1, 4–6 (1980).

159. NINTH CIR. OFF. OF STAFF ATT'YS, SECTION 1983 OUTLINE 1 (2022), https://cdn.ca9.uscourts.gov/datastore/uploads/guides/section_1983/Section%201983%20Outline%202018%20-%20WESTLAW.pdf [https://perma.cc/C2MQ-AMVL] (quoting Graham v. Connor, 490 U.S. 386, 393–94 (1989)).

160. *Gonzaga*, 536 U.S. at 274.

161. 520 U.S. 329, 340–43 (1997) ("[T]o seek redress through § 1983, however, a plaintiff must assert the violation of a federal *right*, not merely a violation of federal *law*.").

162. 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).

The Supreme Court further clarified the three *Blessing* factors in *Gonzaga University v. Doe,* stating that only an "unambiguously conferred [individual] right" as demonstrated through "rights-creating language" can support a § 1983 action.[163] Additionally, for a successful § 1983 claim to create a private right of action, a provision's language must clearly grant an individual entitlement and have an "unmistakable focus" on the beneficiaries.[164] Hence, for a court to find for a claimant in an action against a nursing home involving § 1983 enforcement of § 1396r, the provisions in question must contain rights-creating language imparting individual rights to, and unmistakably focusing on, the nursing home residents.

However, even if the intent of a federal statute is to benefit a particular class of individuals, this does not guarantee a federal right.[165] Because § 1983 only grants private causes of action for the deprivation of rights, not general interests, a class's inclusion in a federal statute's "general zone of interest" alone is insufficient.[166]

C. Interpreting Resident Rights

Pre-*Talevski*, courts were split within and across circuits in their interpretations of whether § 1396r creates a private right of action for nursing home residents that is enforceable under § 1983.[167] Figure 1 below provides examples of circuit-specific cases finding for and against individual nursing home resident rights under § 1983.

Figure 1. Pre-Talevski Circuits Finding for and Against Nursing Home Resident Rights of Action Under § 1983 for FNHRA Violations

Circuit	Case	Year	Conclusion: Are there enforceable individual nursing home resident rights under § 1983?
1	*Rolland v. Romney*	2003	Yes[168]
2	*Concourse Rehabilitation & Nursing Center Inc. v. Whalen*	2001	Yes[169]

163. *Gonzaga*, 536 U.S. at 283, 290.

164. *Id.* at 284 (quoting Cannon v. Univ. of Chi., 441 U.S. 677, 691 (1979)).

165. *Gonzaga*, 536 U.S. at 283.

166. Talevski *ex rel.* Talevski v. Health & Hosp. Corp. of Marion Cnty., No. 2:19 CV 13, 2020 WL 1472132, at *2 (N.D. Ind. Mar. 26, 2020), *rev'd,* 6 F.4th 713 (7th Cir. 2021), *aff'd,* Health & Hosp. Corp. of Marion Cnty. v. Talevski, 599 U.S. 166 (2023) (citing *Gonzaga*, 536 U.S. at 283).

167. Shanklin v. Coulee Med. Ctr., No: 2:17-CV-377-RMP, 2019 WL 1601360, at *4 (E.D. Wash. Apr. 15, 2019).

168. 318 F.3d 42, 56 (1st Cir. 2003).

169. 249 F.3d 136, 144 (2d Cir. 2001) (stating that § 1396r(b)(4)(A) "is obviously intended to benefit Medicaid beneficiaries").

	Baum v. North Dutchess Hospital	2011	No[170]
3	*Grammer v. John J. Kane Regional Centers-Glen Hazel*	2009	Yes[171]
4	*Kalen v. Health Center Commission of Orange County, Virginia*	2016	No[172]
5	*Steward v. Abbott*	2016	Yes[173]
6	*Duncan v. Johnson-Mathers Health Care, Inc.*	2010	No[174]
	Brown v. Sun Healthcare Group, Inc.	2007	No[175]
7	*Talevski ex rel. Talevski v. Health & Hospital Corporation of Marion County*	2021; 2020	Yes (Court of Appeals); No (District Court)[176]
8	*Liptak v. County*	2016	No[177]
9	*Shanklin v. Coulee Medical Center*	2019	No[178]
	Anderson v. Ghaly	2019	Yes[179]
10	*Price v. Price*	2018	No[180]

170. 764 F. Supp. 2d 410, 428 (N.D.N.Y. 2011).
171. 570 F.3d 520, 522, 532 (3d Cir. 2009).
172. 198 F. Supp. 3d 636, 642–43, 647 (W.D. Va. 2016).
173. 189 F. Supp. 3d 620, 638 (W.D. Tex. 2016).
174. No. 5:09–CV–00417–KKC, 2010 WL 3000718, at *10 (E.D. Ky. July 28, 2010).
175. 476 F. Supp. 2d 848, 851 (E.D. Tenn. 2007).
176. Talevski *ex rel.* Talveski v. Health & Hosp. Corp. of Marion Cnty., 6 F.4th 713, 726 (7th Cir. 2021), *aff'd,* Health & Hosp. Corp. of Marion Cnty. v. Talevski, 599 U.S. 166 (2023) (concerning provisions of 42 U.S.C. § 1396r).
177. Civ. No. 16–225 ADM/JSM, 2016 WL 5349429, at *6 (D. Minn. Sept. 23, 2016).
178. No. 2:17-CV-377-RMP, 2019 WL 1601360, at *5 (E.D. Wash. Apr. 15, 2019).
179. 930 F.3d 1066, 1081 (9th Cir. 2019).
180. No. 18-cv-00029-CMA-SKC, 2018 WL 4620362, at *5 (D. Colo. Sept. 26, 2018).

	Hawkins v. County of Bent, Colorado	2011	No[181]
11	*McCarthy v. 207 Marshall Drive Operations, LLC*	2015	No[182]
D.C.	TBD**	—	—

****This circuit has no court decisions that address nursing home resident FNHRA-based rights of private action under § 1983.**

Courts across the country have generally interpreted whether § 1396r creates a private right of action for nursing home residents in one of two ways. The first interpretation is that § 1396r creates a private right of action under § 1983 because it is phrased in terms of the "persons benefitted," i.e., the nursing home residents.[183] The second interpretation is that no such right of action exists because the focus in § 1396r(b) is on the "persons regulated," i.e., the nursing homes.[184]

1. Interpretation One: Enforceable Nursing Home Resident Rights

Courts employing the first interpretation have concluded that the language of § 1396r creates enforceable nursing home resident rights under § 1983 because the Statute was intended for Medicaid beneficiaries and nursing home residents, not nursing home facilities. In other words, § 1396r's phrasing focuses on "the persons benefitted."[185] The Third Circuit, which decided Ms. Daniels's case,[186] falls into this category.[187]

After Ms. Daniels's death, her daughter alleged that the Kane Center deprived Ms. Daniels of her civil rights by breaching its duty to ensure quality care under FNHRA.[188] The complaint focused on many aspects of FNHRA, including several § 1396r provisions.[189] Two provisions were at issue. First, "[a] nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident,"[190] and second,"[a] nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental and psychosocial well-being of

181. 800 F. Supp. 2d 1162, 1168–69 (D. Colo. 2011).

182. No: 6:15–cv–2121–Orl–18TBS, 2015 WL 9701089, at *2 (M.D. Fla. Dec. 24, 2015).

183. *See, e.g.*, Grammer *ex rel.* Estate of Daniels v. John J. Kane Reg'l Ctrs.-Glen Hazel, 570 F.3d 520, 527 (3d Cir. 2009).

184. *See, e.g.*, *Hawkins*, 800 F. Supp. 2d at 1167.

185. *See, e.g.*, *Grammer*, 570 F.3d at 529–30.

186. *Infra* Subsection I.A.1.

187. *See, e.g.*, *Grammer*, 570 F.3d at 527.

188. *Id.* at 522; *see also* Nursing Home Law Center Staff, *supra* note 32 ("The administrator of Ms. Daniels's estate brought a claim under Section 1983 for wrongful death and survival, alleging that the Kane Center deprived Ms. Daniels of her civil rights for failing to ensure quality care under the [FNHRA].").

189. *Grammer*, 570 F.3d at 524–25.

190. 42 U.S.C. § 1396r(b)(l)(A).

each resident in accordance with a written plan of care which describes the medical, nursing and psychosocial needs of the resident and how such needs will be met."[191]

The Third Circuit held that the § 1396r provisions Ms. Daniels's daughter sought to enforce under § 1983 contain language that reflects Congress's intent to create individual rights.[192] The court based its reasoning on FNHRA's frequent use of the word "residents" and concluded that FNHRA's provisions are clearly "phrased in terms of the persons benefitted."[193] Further, the court indicated that because the provisions state that "a nursing home *must care* for its residents" in a manner that promotes maintenance or enhancement of the quality of life for every resident, the mandatory nature of the provisions is evident.[194]

The court also further discussed FNHRA's language: "A nursing facility *must provide* services and activities to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident."[195] The court reasoned that these provisions, along with the others under which the plaintiff brought claims, bear similarity to the phrase "a state plan of medical assistance *must provide*," which the court previously found to be "rights-creating."[196]

2. Interpretation Two: Unenforceable Nursing Home Resident Rights

The second and (before *Talevski*) majority interpretation[197] was that the language of § 1396r focuses on the nursing facilities ("persons regulated"), not the nursing facility residents ("persons benefitted"), making § 1396r unenforceable under § 1983.[198] Mr. Shanklin's case illustrates the Ninth Circuit interpreting § 1396r in this way.[199]

Mr. Shanklin's wife contended that Coulee Medical Center disregarded several § 1396r mandates that require facilities to provide high-quality, individualized, and up-to-date care to each resident.[200] The court held that § 1396r

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191. 42 U.S.C. § 1396r(b)(2)(A).

192. *Grammer*, 570 F.3d at 532; *see also* Nursing Home Law Center Staff, *supra* note 32 (stating that "the court concluded that Congress used rights-creating language sufficient to unambiguously confer individually enforceable rights") (cleaned up).

193. *Grammer*, 570 F.3d at 529–30.

194. *Id.* at 529.

195. *Id.* (quoting 42 U.S.C. § 1396r(b)(2)(A)).

196. *Id.* at 529 (quoting Sabree *ex rel.* Sabree v. Richman, 367 F.3d 180, 190 (3d Cir. 2004).

197. Liptak *ex rel.* Estate of Rotter v. Ramsey Cnty., Civ. No. 16–225 ADM/JSM, 2016 WL 5349429, at *6 (D. Minn. Sept. 23, 2016).

198. *See, e.g.*, Hawkins v. Cnty. of Bent, Colo., 800 F. Supp. 2d 1162, 1167 (D. Colo. 2011).

199. *Supra* Subsection I.A.2.

200. Shanklin v. Coulee Med. Ctr., No. 2:17-CV-377-RMP, 2019 WL 1601360, at *4 (E.D. Wash. Apr. 15, 2019) (quoting 42 U.S.C. § 1396r(b)(1)(A)). Provisions in Ms. Shanklin's claim included mandates that: (1) "A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident;" (2) "A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care which— (A) describes the

is not enforceable under § 1983, reasoning that the provisions of § 1396r at issue were all phrased in terms of what the nursing facilities "must do," not in terms of protections that the patients "must receive."[201]

The court said the provisions at issue mention the benefits the nursing homes should provide the residents, but by making the facilities the subject of the provisions, Congress demonstrated it did not intend to confer individual rights with FNHRA's language.[202] The fact that FNHRA passed under Congress's spending power also conveyed Congress's lack of intention to confer individual rights.[203] Thus, the § 1396r provision offered no basis for § 1983 enforcement.[204]

The court concluded that the § 1396r provisions in question "were not phrased in terms of the persons benefitted" and therefore did not grant individual rights of action to nursing facility patients.[205] Further, the court declared that even if these provisions did include rights-creating language intended to benefit nursing facility residents, such as Mr. Shanklin, the language was too vague to allow enforcement under § 1983.[206]

3. The Talevski *Case*

The district court that heard Mr. Talevski's case is another example of a court that used the second interpretation—that the language of § 1396r does not create enforceable rights of action for nursing home residents because it is phrased in terms of the "person[s] regulated."[207] In 2020, Ms. Talevski sued HHC on behalf of her husband, seeking to enforce his FNHRA rights under § 1983.[208] She claimed HHC committed numerous violations of FNHRA § 1396r, including failing to "attain or maintain [plaintiff's] highest practicable physical, mental, and psychological well-being."[209]

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medical, nursing, and psychosocial needs of the resident and how such needs will be met . . . and (C) is periodically reviewed and revised by such team after each assessment;" and (3) "a nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity." *Id.*

201. *Id.*

202. *Id.*

203. *Id.*

204. *See* Gonzaga Univ. v. Doe, 536 U.S. 273, 280 (2002).

205. *Shanklin*, 2019 WL 1601360, at *4.

206. *Id.* at *5.

207. *See* Talevski *ex rel.* Talevski v. Health & Hosp. Corp. of Marion Cnty., No. 2:19 CV 13, 2020 WL 1472132, at *2 (N.D. Ind. Mar. 26, 2020), *rev'd*, 6 F.4th 713 (7th Cir. 2021), *aff'd*, Health & Hosp. Corp. of Marion Cnty. v. Talevski, 599 U.S. 166 (2023) (quoting Ind. Prot. & Advocacy Servs. v. Ind. Family & Soc. Servs. Admin., 603 F.3d 365, 377 (7th Cir. 2010) (citations omitted).

208. *Id.* at *1.

209. *Id.* Ms. Talevski also alleged HHC committed other FNHRA violations, including: the 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; and the refusal to fulfill an administrative law

The district court concluded that, although Congress seemingly intended for FNHRA to benefit nursing home residents by making certain federal funds contingent on statutory requirements, this was not enough to confer a private right of action to Talevski.[210] Relying on *Gonzaga*, the court reasoned that the provisions in question had no clear language establishing that nursing home residents fall out of FNHRA's "general zone of interest."[211] Rather, the court maintained that FNHRA's focus is on "the person regulated rather than the individuals protected," providing no evidence of intent "to confer rights on a particular class of persons."[212] Thus, Congress's intent to benefit nursing home residents evidenced in § 1396r and other FNHRA provisions was not enough to outweigh FNHRA's focus on "the person regulated," i.e., the nursing homes.[213]

Additionally, looking at the second *Blessing-Gonzaga* factor,[214] the district court declared that FNHRA's language—specifically that in § 1396r(b)—was too "vague and amorphous" to support a private right of action under FNHRA and that to enforce such a right would "strain judicial competence."[215] Considering the third *Blessing-Gonzaga* factor, the court opined that the mandatory nature of the statutory provisions in question was not significant enough to outweigh the other two factors' implication that inferring a private right of action from "vague [c]ongressional statements regarding indirect beneficiaries" would be injudicious.[216] Subsequently, the district court dismissed Talevski's action, finding that FNHRA does not impart a private right of action allowing relief under § 1983.[217]

Following the district court's verdict, Ms. Talevski filed an appeal, and in 2021, the Seventh Circuit reversed.[218] Although Talevski dropped the allegations involving § 1396r(b) provisions in the appeal, the claim involving another FNHRA

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judge's order to readmit him to [a nursing home]. Talevski *ex rel.* Talevski v. Health & Hosp. Corp. of Marion Cnty., 6 F.4th 713, 716 (7th Cir. 2021).

210. The district court used language from § 1396r(b), specifically, to make this argument (e.g., nursing homes must "attain or maintain [a resident's] highest practicable physical, mental, and psychological well-being"). *Talevski*, 2020 WL 1472132, at *2.

211. *Id.*

212. *Id.* (quoting Ind. Prot. & Advoc. Servs., 603 F.3d at 377) (cleaned up).

213. *Id.*

214. *Supra* Section II.B ("[C]ourts consider three factors when determining whether a federal statute confers an individual right: (1) Congress must have intended the provision at issue to benefit the claimant, (2) the asserted right must be clear so as not to "strain judicial competence" in its enforcement, and (3) the provision conferring the right must be phrased in mandatory terms.").

215. *Talevski*, 2020 WL 1472132, at *3. The district court again borrowed language specifically from § 1396r(b) to make its argument, stating that the terms in the allegations (e.g., "maintenance or enhancement of quality of life" and "highest practicable physical mental, and psychosocial well-being") were "indefinite" and "so vague and amorphous that enforcement would strain judicial competence." *Id.*

216. *Id.*

217. *Id.*

218. Talevski *ex rel.* Talevski v. Health & Hosp. Corp. of Marion Cnty., 6 F.4th 713, 726 (7th Cir. 2021), *aff'd*, Health & Hosp. Corp. of Marion Cnty. v. Talevski, 599 U.S. 166 (2023).

provision, § 1396r(c), remained.[219] In particular, the question before the court was whether FNHRA demonstrated the existence of two private rights of action: (1) the right to be free from chemical restraints used not for treatment but for discipline or convenience;[220] and (2) the right not to be transferred or discharged from a nursing home without satisfying specific criteria.[221]

The appellate court decided that Congress intended the § 1396r(c) provisions at issue to benefit nursing home residents.[222] Reasoning that § 1396r(c) expressly uses "the language of rights," the court indicated it did not "know how Congress could have been any clearer."[223] To illustrate, the court highlighted a phrase appearing directly after the heading of § 1396r(c)(1)(A): "[A] skilled nursing facility must protect and promote the rights of each resident, including each of the following *rights,*" with the provisions in question following.[224] The court argued that the provision and its "rights-creating language" showed Congress's "unmistakable focus" on the residents as beneficiaries by detailing "the *rights* of each resident" and appearing under the "specified rights" heading of § 1396r(c).[225] Thus, the provisions in question satisfied the first *Blessing-Gonzaga* factor.[226]

Further, the court determined that the § 1396r(c) provisions at issue also satisfied the second and third *Blessing-Gonzaga* factors regarding unambiguous and mandatory terminology.[227] According to the court, the provisions' frequent use of the terms "must" and "must not" indicate unambiguous obligations, and a "common-sense reading" of these provisions allowed no other interpretation. [228]

Given the foregoing, the court found that the § 1396r(c) provisions in Talevski's claim unequivocally grant private rights of action to nursing home residents.[229]

4. The Supreme Court and Talevski

HHC appealed the appellate court's decision, and the Supreme Court granted certiorari in May 2022.[230] In November 2022, the Court heard oral arguments.[231] HHC asserted that § 1983 does not grant a private right of action for legislation enacted under the Spending Clause (such as FNHRA) unless the

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219. *Id.* at 716. Section 1396r(c) addresses requirements related to residents' rights and lists specific rights with associated notice requirements. *Id.*

220. *Id.* at 715.

221. *Id.*

222. *Id.* at 718.

223. *Id.*

224. *Id.*

225. *Id.* (first quoting Cannon v. Univ. of Chi., 441 U.S. 677, 691 (1979); and then quoting Gonzaga Univ. v. Doe, 536 U.S. 273, 284 (2002)).

226. *See id.*

227. *Id.*

228. *Id.* at 719–20 ("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 resident.").

229. *Id.* at 720.

230. *See* Health & Hosp. Corp. of Marion Cnty. v. Talevski, 142 S. Ct. 2673 (2022) (mem.).

231. Briney & Ponticiello, *supra* note 44.

legislation explicitly specifies a private right of action.[232] It also argued that even disregarding the previous argument, there is no private right of action under FNHRA because its language does not accord individual statutory rights.[233] HHC further implored the Court to overrule *Wilder v. Virginia Hospital Association*,[234] a case upholding a Medicaid-related private cause of action to enforce Spending Clause legislation under § 1983.[235]

Talevski counterargued that the plain text of § 1983 unequivocally establishes a private right of action when Spending Clause legislation serves to protect a federal right.[236] She also contended a reversal of *Wilder* would contradict over two decades of judicial and legislative precedent and that FNHRA's language unquestionably creates statutory federal rights.[237]

The Court was therefore tasked with resolving two primary issues: (1) whether the Court should reexamine its previous holding that Spending Clause legislation can create privately enforceable rights under § 1983, given significant contrary historical evidence;[238] and (2) whether FNHRA's transfer and medication rules grant private rights enforceable under § 1983.[239]

Perhaps unsurprisingly, prior to the Court's anticipated ruling in June 2023,[240] many were concerned about the outcome.[241] Various entities submitted amicus briefs in support of both sides.[242] For example, the state of Indiana, joined by several other states, filed a brief supporting HHC and arguing that private rights of action can disrupt state and federal grant program administration.[243] Furthermore, the American Health Care Association ("AHCA")[244] and the Indiana Health Care Association also filed an amicus brief suggesting that a private right of action against public actors under § 1983 would create incongruent treatment because private entities are not subject to damages for violations of regulations, but Medicaid-funded entities are.[245]

Multiple entities also filed briefs in support of Talevski,[246] including the National Health Law Program ("NHeLP") and other advocacy organizations; population groups—including the AARP, the American Cancer Society, and the

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232. *Id.*
233. *Id.*
234. 496 U.S. 498, 500 (1990).
235. *Id.*
236. Briney & Ponticiello, *supra* note 44.
237. *Id.*
238. *See id.* ("[O]verruling *Wilder* would overturn an understanding endorsed by all three branches of government that § 1983 applies to all federal laws.").
239. *Id.*
240. Rudowitz & Sobel, *supra* note 13.
241. *See id.*
242. *Id.*
243. *Id.*
244. The AHCA is a hospital and long-term care lobbyist group. *See Advocacy*, ACHA/NCAL (2023), https://www.ahcancal.org/Advocacy/Pages/default.aspx/ [https://perma.cc/WY5D-YFL5].
245. Rudowitz & Sobel, *supra* note 13.
246. *Id.*

Bazelon Center; provider groups—including public hospitals and community health centers; professors and other academics; and federal officials—including former and current members of Congress and former Department of Health and Human Services ("HHS") officers.[247] George Washington University and NHeLP compiled summaries of all these entities' briefs, synthesizing four central arguments: (1) overturning multiple decades of judicial precedent undermines Congress's intent that individuals have the ability to enforce their rights under federal programs in federal court; (2) making private rights of action unavailable puts millions of Americans at risk because limited capacity and funding preclude federal entities from providing adequate enforcement; (3) limiting an individual's ability to raise a claim in federal court could eliminate access to care for millions of Medicaid enrollees—not only older adults, but others who qualify such as children, those with chronic conditions or serious life-threatening diseases, and people with disabilities; and (4) many low-income Americans depend on other Spending Clause programs, not just Medicaid—the Court's holding would also affect their rights.[248]

III. THE CASE FOR FINDING IN FAVOR OF *TALEVSKI*

On June 8, 2023, the Supreme Court ruled in favor of Talevski.[249] Justice Ketanji Brown Jackson authored the majority opinion reaffirming that Spending Clause legislation "unambiguously confer[s] individually enforceable rights" that are "presumptively enforceable via § 1983"; to wit, FNHRA's transfer and medication rules grant a private right of action to Medicaid-beneficiary nursing home residents.[250] However, Justices Thomas and Alito penned dissenting opinions; notably, Justice Thomas's dissent advocated for the dissolution of rights under Congress's spending power because those rights "contradict the bedrock constitutional prohibition against federal commandeering of the States."[251] Further, although Justice Gorsuch joined the majority opinion, he also wrote a separate concurrence in which he referred to the anti-commandeering issues as "questions for another day."[252] Though the *Talevski* decision may serve as the controlling precedent for nursing home resident rights of private action for a time, Justice Thomas's and Justice Alito's dissenting opinions, Justice Gorsuch's qualified concurrence, and the numerous pre-decision amicus briefs supporting HHC may foreshadow the onset of future legal opposition and inquiry into this issue.

This Note argues that the majority's holding in *Talevski* was proper by highlighting the undesirable consequences that may have ensued had the Court

247. *Id.* These entities filed 25 amicus briefs as of September 2022 and include the "National Health Law Program (NHeLP), other advocacy organizations, professors and scholars, population groups (including AARP, American Cancer Society and Bazelon Center), provider groups (including public hospitals and community health centers), and federal officials (former HHS officials and former / current members of Congress)." *Id.*

248. *Id.*

249. Health & Hosp. Corp. of Marion Cnty. v. Talevski, 599 U.S. 166, 192 (2023).

250. *See id.* at 184 (cleaned up).

251. *Id.* at 196 (Thomas, J., dissenting).

252. *Id.* at 193 (Gorsuch, J., concurring).

found in favor of HHC: fewer options for legal remediation, less facility accountability, and violation of international human rights law.[253]

A. Legal Remedies, Nursing Home Accountability, and International Human Rights

Pre-*Talevski*, in some jurisdictions,[254] the enforcement of at least some FNHRA requirements could transpire through private litigation, and nursing home residents could sue their facilities for violating their rights under these requirements.[255] But had the Supreme Court found in favor of the HHC in this case, it could have essentially deprived millions of nursing home residents of legal safeguards intended to guarantee them sufficient care in their places of residence.[256]

If the Court had held that § 1396r does not establish a private right of action for nursing home residents, residents and family members who sustained harm from substandard care would have been left with only one option: filing a tort claim for negligence, malpractice, or wrongful death.[257] However, this is not a viable option for everyone. Over 80% of Americans who need legal help can't afford it[258]—and given that enrollment in Medicaid is contingent on income, nursing home residents are likely to fall into this category.[259] Only about 20% of low-income individuals who need legal help receive it—many law firms do not have the staff or funding for pro bono work, [260] and it may be difficult to find a pro bono attorney with experience or skill in this specific legal area.[261] Additionally, as discussed above, an increasing number of facilities are including arbitration clauses in their residency contracts, making it impossible for residents to file claims and providing minimal chance for remedy.[262]

Further, without the existence of individual rights of action for nursing home residents, the few remaining tools the federal government could use to

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253. *See* discussion *infra* Section III.A.

254. *See supra* Figure 1.

255. *See* Ian Millhiser, *The Nightmarish Supreme Court Case That Could Gut Medicaid, Explained*, VOX (Nov. 3, 2022, 8:30 AM), https://www.vox.com/policy-and-politics/2022/11/3/23435346/supreme-court-medicaid-health-hospital-corporation-indiana-talevski [https://perma.cc/X9H3-JWBU].

256. *See id.*

257. *Nursing Home Neglect: Nursing Home Negligence*, NURSING HOME ABUSE CENT., https://www.nursinghomeabusecenter.com/nursing-home-neglect/ [https://perma.cc/B2AR-VBM3] (last visited Mar. 11, 2023).

258. *The Unmet Need for Legal Aid*, LEGAL SERVS. CORP.(2023), https://www.lsc.gov/about-lsc/what-legal-aid/unmet-need-legal-aid [https://perma.cc/Y8KM-V874].

259. *Medicaid Eligibility*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/eligibility/index.html [https://perma.cc/587K-NU4U] (last visited Mar. 12, 2013).

260. *Pros and Cons of Law*, TOP ATTY'S NEARBY, https://topattorneysnearby.com/Pros%20and%20Cons%20of%20Legal%20Services [https://perma.cc/Y6RS-BSA] (last visited Mar. 12, 2023).

261. *See, e.g.*, Deane B. Brown, *The Challenge of Pro Bono Legal Service*, 48 ILL. STATE BAR ASS'N: BENCH & BAR 1, 2–3 (2017).

262. Smith & Schenk, *supra* note 129, at 2.

discipline facilities violating FNHRA would likely be ineffective.[263] One reason, as the amicus briefs supporting Talevski mention, is that the federal government has limited resources to investigate these violations.[264] Additionally, when the federal government becomes aware of a facility or state in violation of FNHRA, the primary remedy is to reduce or eliminate its Medicaid funds.[265] But that means if state-run facilities fail to provide legally required services to Medicaid beneficiary residents, as a consequence, those facilities receive less funding to provide health care to those very same individuals.[266] The federal government would be inadvertently punishing residents for facilities' misconduct.[267]

With little risk of litigative backlash and few effective governmental punitive measures, nursing home facilities' accountability for providing substandard care would be negligible. Essentially, there would be scant incentive for the facilities to put patients over profit. This is especially problematic in the case of private-equity-owned facilities, whose practices of cutting staff numbers and hours—among other medically necessary items—to maximize profits[268] would likely only increase in the face of scant accountability measures. With maximal staff workloads and fewer resources available, the likelihood of poor care quality would only further increase, as would resident neglect, abuse, injury, inappropriate psychotropic medication administration, and death.[269] But with no individual right of action for FNHRA § 1396r violations, it is probable that little could, or would, be done to hold these facilities accountable for inferior resident care and its devastating effects.

Under international human rights law, all individuals—nursing home residents included—have the fundamental right to the highest possible standard of health and to an effective remedy for violations of this right.[270] Given the lack of effective alternative legal avenues, had the Court found in favor of HHC, essentially eliminating the ability to file claims to enforce Medicaid law,[271] its decision would have stripped nursing home residents of their fundamental rights under international law.

IV. ALTERNATIVE SOLUTIONS

Justices Alito's and Justice Thomas's dissenting opinions, Justice Gorsuch's qualified concurrence, and the various pre-decision amicus briefs supporting HHC suggest that a reversal of the *Talevski* decision, though not inevitable, remains possible. In light of this possibility, to foster nursing home resident safety and quality of life, policymakers and caregivers must shift focus

263. Millhiser, *supra* note 255.
264. Rudowitz & Sobel, *supra* note 13; Millhiser, *supra* note 255.
265. Millhiser, *supra* note 255.
266. *Id.*
267. *Id.*
268. *See* discussion *supra* Section I.E.
269. *See* discussion *supra* Part I.
270. *See* OFF. OF THE U. N. HIGH COMM'R. FOR HUM. RTS., THE RIGHT TO HEALTH: FACT SHEET NO. 31, at 5 (June 1, 2008), https://www.ohchr.org/sites/default/files/Documents/Publications/Factsheet31.pdf [https://perma.cc/Z6CC-CFCP] (indicating all individuals have this right).
271. Millhiser, *supra* note 255.

towards prevention—i.e., the improvement of long-term care quality. If nursing home residents cannot hold long-term care facilities accountable through litigation, then policymakers must eliminate the circumstances that cause the need for private rights of action against FNHRA violators.

A. Incentivize and Standardize High-Quality Long-Term Care

Currently, a disconnect exists between public funding distribution and quality of care.[272] In traditional fee-for-service ("FFS") reimbursement methods under Medicaid, CMS,[273] through the state, directly pays nursing home facilities for each covered service a resident Medicaid beneficiary receives.[274] Federal rules do not stipulate how or how much states should pay nursing facilities, but instead stipulate that state Medicaid payment policies "should promote efficiency, economy, quality, access, and safeguard against unnecessary utilization."[275] States have broad discretion in interpreting these criteria, but generally the amounts states pay are mainly based on costs and resource use reported by providers.[276] This traditional FFS payment approach provides strong incentives for increasing the number of patients served but weak incentives to improve care quality.[277] To illustrate, a facility could maximize its Medicaid resident population but minimize its staff numbers and hours. This would likely decrease overall care quality,[278] but a facility might find that the resultant increased profit margin from Medicaid payments outweighs this risk and proceed with taking on additional residents regardless of staffing.

To reduce this type of misconduct and standardize Medicaid funding distribution across states and facilities, Congress should implement federal legislation for stronger, more specific rules regulating state disbursement of Medicaid payments. Additionally, CMS should not provide funding based solely on costs and resource use—this encourages facilities to place too much emphasis on profits over patients. Instead, the basis for payment disbursement should predominately be patient outcomes. To do this, as an example, CMS could implement strong oversight of nationwide standardized facility quality and safety surveys with the aim of monitoring resident well-being.[279] It could also increase the number and frequency of these surveys,[280] rewarding facilities who perform well with additional funding. Incentivizing positive patient outcomes over "efficiency, economy . . . and safeguard[ing] against unnecessary utilization"[281] could help shift

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272. Jenna Libersky et al., *Value-Based Payment in Nursing Facilities: Options and Lessons for States and Managed Care Plans*, INTEGRATED CARE RES. CTR. 1, 1 (Nov. 2017), https://www.integratedcareresourcecenter.com/pdfs/ICRC_VBP_in_Nursing_Facilities_November_2017.pdf [https://perma.cc/RB6X-8AVM].

273. Centers for Medicare and Medicaid Services.

274. *Nursing Facilities*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N (2023), https://www.macpac.gov/subtopic/nursing-facilities/ [https://perma.cc/M39A-Q4WR].

275. *Id.*

276. Libersky et al., *supra* note 272, at 1.

277. *Id.*

278. *Concerns of Neglect*, *supra* note 6.

279. *See, e.g.*, *id.*

280. *Id.*

281. *Nursing Facilities*, *supra* note 274 (citing 42 U.S.C. § 1902 (a)(30)(A)).

facilities' focus towards prioritizing high-quality care, instead of overlooking it in favor of profit.

B. Increase and Standardize Minimum Staffing Levels

Staffing levels arguably have one of the most significant impacts on long-term care quality, which directly affects the health and well-being of the residents.[282] Staffing shortages hinder the ability of nurses and aides to provide residents with adequate and consistent care, including assistance with eating, drinking, hygiene, and emotional support.[283]As previously discussed, even prior to COVID-19, insufficient nursing home staffing has been a longstanding problem, and it is associated with higher instances of nursing home resident abuse, neglect, and inappropriate psychotropic drug administration.[284] CMS indicates that long-term care facilities must have sufficient staff to provide "the highest practicable physical, mental, and psychosocial well-being of each resident"; however, the agency has never set official minimum staffing requirements.[285] It instead leaves this determination up to the facilities themselves.[286] This subjective requirement means that facilities' minimum staffing levels can vary widely, resulting in dangerously low staffing levels—and poor care quality—at some facilities, particularly those that are private-equity-owned.[287]

To improve national long-term care quality and consistency across facilities, federal legislators and CMS should officially establish specific federal minimum nurse staffing levels or ratios to allow for the provision of resident care sufficiently compliant with federal regulations.[288] CMS should also encourage or incentivize nursing homes to provide paid sick and family leave, affordable healthcare coverage, and adequate training to promote staff competency.[289] Further, CMS should advance the provision of a living wage to facility employees and consider labor market conditions when determining facility funding. These factors could help increase nursing home facility staff satisfaction, attract more capable staff members, and reduce the frequency of staff turnover and absenteeism, facilitating higher resident care quality.

C. Eliminate Arbitration Clauses

Arbitration clauses in nursing home facility contracts deprive residents and family members of the right to a civil trial against the facility in the event of abuse or neglect.[290] In essence, these agreements allow nursing home facilities to escape

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282. *See, e.g.*, *Concerns of Neglect*, *supra* note 6.
283. *Id.*
284. *See, e.g.*, *id.*
285. *Id.*
286. *Id.*
287. *See, e.g.*, *id.*; Scott, *supra* note 99.
288. *Concerns of Neglect*, *supra* note 6.
289. *Id.* (The administrator of a small not-for-profit nursing home in a western state said her facility avoided staffing shortages by providing hazard pay, benefits, and a base pay above the state's minimum wage as incentives for staff).
290. *Nursing Homes*, FAIR ARB. NOW (Aug. 31, 2015, 6:41 PM), https://fairarbitrationnow.org/nursing-home-arbitration/ [https://perma.cc/AME7-UEYL].

accountability for their misconduct.[291] While arbitration itself is not inherently bad, some nursing home facilities exploit residents' situations to get them to sign pre-dispute arbitration agreements.[292] For example, these contracts are signed at the time of admission, which is often a time of crisis for individuals and their families—the potential resident is likely in an impaired condition, there may be severely limited nursing home options, and the resident and family members are likely unaware of the disputes that would be bound by an arbitration clause in the future.[293] Further, these clauses are frequently placed in fine print, which could easily go unnoticed by the resident and family when they are experiencing stress, fear, or confusion.[294]

In 2016, CMS placed an outright ban on nursing home facility use of binding pre-dispute arbitration,[295] finding "significant evidence that pre-dispute arbitration agreements have a deleterious impact on the quality of care for . . . patients."[296] But in July 2019, at the behest of the nursing home industry, the Trump Administration overturned this rule.[297] Should *Talevski* be reversed, it will be imperative that CMS reinstate the arbitration ban. Otherwise, increased use of arbitration agreements in nursing home contracts[298] will all but guarantee that residents and families have no way to hold facilities accountable for harmful misconduct.

D. Regulate Private Equity Ownership

To increase care quality and resident well-being across nursing home facilities nationally, curtailing private equity-ownership practices in nursing homes is essential. These facilities are a consistent source of harm for nursing home residents—there is substantial evidence[299] that "private equity-owned nursing homes have lower staffing levels, lower quality ratings, more violations of federal standards, and poorer health outcomes for residents".[300] Private-equity-owned facilities have driven overall quality of care lower than facilities under any other kind of ownership.[301]

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291. *Id.* (referring to these as "forced arbitration agreements").

292. *Id.*

293. Charlie Sabatino, *Our New Nursing Home Arbitration Mandate: Educate, Educate, Educate*, AM. BAR ASS'N (July–Aug. 2019), https://www.americanbar.org/groups/law_aging/publications/bifocal/vol-40/volume-40-issue-6/cms-final-rule-on-nursing-home-arbitration-clause/ [https://perma.cc/5XF7-RDX8].

294. *Id.*

295. *Id.*

296. *Nursing Homes*, *supra* note 290.

297. *Id.*; Sabatino, *supra* note 293.

298. *See* discussion *supra* Section II.A.

299. AMERICANS FOR FINANCIAL REFORM, FACT SHEET: STOP PRIVATE EQUITY-OWNED NURSING HOMES FROM EXTRACTING PROFITS AT THE EXPENSE OF CARE (2021), https://ourfinancialsecurity.org/wp-content/uploads/2021/10/AFR-Stop-PE-Nursing-Home-Extraction-FS-2021-1.pdf [https://perma.cc/6XC7-JQHZ] (including "[a] mountain of academic studies, government reports, and media exposés").

300. *Id.*

301. *See id.*

Congress should develop and pass strong legislation to limit private equity's life-threatening mercenary practices.[302] If the Supreme Court ever reconsiders its *Talevski* decision, it will be even more important to regulate private equity ownership to prevent the types of harm that would give rise to residents' need for private rights of action.

CONCLUSION

This Note discussed the Supreme Court's decision in *Talevski* and its impact on nursing home residents' ability to hold their facilities accountable for FNHRA violations. With a growing proportion of the population reaching "older adult" status, an increasing number of people will likely require nursing home placement when they are no longer able to take care of themselves. It is important to prevent these facilities from harming their residents by delivering inadequate care and to provide nursing home residents with sufficient avenues for legal remedy should their facilities fail them.

This Note described the continuous decline of long-term care quality and some of the primary reasons behind this decline, including staffing levels, COVID-19, and private equity ownership. It then provided an overview of the legal areas relevant to *Talevski*—the content and reasoning of FNHRA overall and FNHRA § 1396r specifically; the role of § 1986 in FNHRA violation claims; the circuit split involving two primary interpretations on which pre-*Talevski* courts relied in federal nursing home regulation violation claims; and a discussion of the primary arguments on both sides of *Talevski*. The Note argued in favor of the Supreme Court's finding that § 1396r creates private rights of action for FNHRA violation claims, as this maintains nursing home residents' options for legal remedy and provides a method to hold nursing homes accountable for misconduct.

This Note also provided several recommendations to safeguard nursing home residents and improve nursing home care quality in the event the Supreme Court ever reverses its recent decision. First, CMS should base funding distribution on positive patient outcomes rather than efficiency to increase the likelihood of better care quality. Second, CMS should provide mandatory minimum staff-to-resident ratios or staff numbers, and staff members should receive benefits to increase staff satisfaction and attract more competent workers, thus increasing overall quality of care. Third, eliminating arbitration clauses is crucial to allow residents other avenues for legal remedy against nursing homes in violation of FNHRA. Fourth, stronger regulation of private equity nursing home ownership would help to increase care quality and prevent the types of incidents that give nursing home residents and families a reason to sue the facilities in the first place.

Even if *Talevski's* precedent endures—and Medicaid beneficiaries retain their federal right to hold their facilities accountable—these recommendations, if implemented, would still provide great benefit to nursing home residents.[303]

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302. *Id.*

303. And other Medicaid beneficiaries.

Regardless of the Supreme Court's decision, providing high-quality care to older adults and protecting one of the fastest growing and most vulnerable groups of our population should be of utmost importance.