No. 20-1664

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

GORGI TALEVSKI, by next friend IVANKA TALEVSKI,

Plaintiff-Appellant,

v.

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

Defendants-Appellees.

On Appeal from the United States District Court
for the Northern District of Indiana,
Civ. Action No. 2:19-cv-00013, Hon. James T. Moody

BRIEF FOR AARP, AARP FOUNDATION, CALIFORNIA ADVOCATES FOR NURSING HOME REFORM, CENTER FOR MEDICARE ADVOCACY, LONG TERM CARE COMMUNITY COALITION, AND THE NATIONAL CONSUMER VOICE FOR QUALITY LONG-TERM CARE AS AMICI CURIAE SUPPORTING PLAINTIFF-APPELLANT

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APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

Appellate Court No: 20-1664

Short Caption: Talevski v. Health and Hosp. Corp. of Marion Cnty. Corp., et al

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party, amicus curiae, intervenor or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

The Court prefers that the disclosure statements be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in the front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

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(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P. 26.1 by completing item #3):

AARP, AARP Foundation, California Advocates for Nursing Home Reform, The Center for Medicare Advocacy,

The National Consumer Voice for Quality Long-Term Care, and Long-Term Care Community Coalition

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

AARP Foundation

(3) If the party, amicus or intervenor is a corporation:

i) Identify all its parent corporations, if any; and

None

ii) list any publicly held company that owns 10% or more of the party's, amicus' or intervenor's stock:

None

(4) Provide information required by FRAP 26.1(b) – Organizational Victims in Criminal Cases:

None

(5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:

None

Attorney's Signature: /s/ Maame Gyamfi Date: August 7, 2020

Attorney's Printed Name: Maame Gyamfi

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☑ **No** ☐

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None

Attorney's Signature: /s/ William Alvarado Rivera Date: August 7, 2020

Attorney's Printed Name: William Alvarado Rivera

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☐ **No** ☑

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STATEMENT OF INTEREST[1]

AARP is the nation's largest nonprofit, nonpartisan organization dedicated to empowering Americans 50 and older to choose how they live as they age. With nearly 38 million members and offices in every state, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, AARP works to strengthen communities and advocate for what matters most to families, with a focus on health security, financial stability, and personal fulfillment. AARP's charitable affiliate, AARP Foundation, works to end senior poverty by helping vulnerable older adults build economic opportunities and social connectedness.

Among other areas, AARP and AARP Foundation fight to protect the right of nursing facility residents to obtain judicial redress when they have been victims of abuse and neglect, and frequently appear as friends of the court on issues affecting nursing facility residents. *See, e.g.*, Brief for AARP and AARP Foundation as Amici Curiae Supporting Appellees, *GGNSC Louisville Creek v. Bramer*, 932 F.3d 480 (6th Cir. 2019) (No. 18-6059), 2018 WL 6841557; Brief for

[1] Amici curiae certify that no party or party's counsel authored this brief in whole or in part, or contributed money intended to fund its preparation or submission. Amici curiae also certify that no person, other than themselves, their respective members, and their undersigned counsel, contributed money intended to prepare or submit this brief. FED. R. APP. P. 29(a)(4).

Both Appellant and Appellees have consented to the filing of this brief. FED. R. APP. P. 29(a)(2).

AARP and AARP Foundation as Amici Curiae Supporting Appellant, *Northport Health Serv. v. Posey*, 930 F.3d 1027 (8th Cir. 2019) (No. 18-2459), 2018 WL 5087545.

California Advocates for Nursing Home Reform (CANHR) is a non-profit organization that represents the interests of approximately 100,000 California nursing home residents and their families. Since 1983, CANHR has been advocating for the rights of long-term care residents. CANHR and its 3,000 members have a substantial interest in ensuring that quality care be provided to persons living in nursing facilities. CANHR's efforts include aiding residents and their families in obtaining legal services for long-term care issues; working to impose tougher sanctions on nursing homes that abuse or neglect residents; providing consumers, attorneys, and social workers with accurate information on long-term care; and continually working to determine the root causes of poor care and developing legislation and policies to address them.

The Center for Medicare Advocacy (Center) is a national, private, non-profit law organization, founded in 1986, that provides education, analysis, advocacy, and legal assistance nationwide, primarily to assist the elderly and people with disabilities to obtain necessary healthcare, therapy, and Medicare. The Center focuses on the needs of Medicare beneficiaries, people with chronic conditions, and those in need of long-term care, and provides nationwide training regarding

Medicare and healthcare rights. It advocates on behalf of beneficiaries in administrative and legislative forums, and serves as legal counsel in litigation of importance to Medicare beneficiaries and others seeking healthcare coverage.

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

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

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

Amici are organizations that represent the interests of older adults and nursing facility residents. We file this brief because the Court's decision about whether a nursing facility resident can enforce their rights under the Federal Nursing Home Reform Act will dramatically affect their safety in state-run nursing facilities and their ability to hold violators accountable in court.

SUMMARY OF ARGUMENT

Congress passed the landmark Nursing Home Reform Act (NHRA) in 1987 after an Institute of Medicine study found that in too many nursing facilities, residents were being abused and neglected, and receiving "very inadequate – sometimes shockingly deficient – care."[2]

The NHRA changed the federal government's approach to protecting residents and ensuring that they receive high quality care. Among other things, the law mandates minimum standards of care that nursing facilities must meet to receive federal reimbursement. It also defines and guarantees the Residents' Bill of Rights, a comprehensive set of resident rights that nursing facilities must protect and promote. Among these rights are the right to be free of abuse and neglect, the

[2] Committee on Nursing Home Regulation, Institute of Medicine, *Improving the Quality of Care in Nursing Homes*, 2 (1989).

right to be free of illegal discharges, and the right to be free of chemical restraints administered for staff's convenience.

These legal rights are a matter of life and death for nursing facility residents. Even today, residents still experience abuse, neglect, and dangerously poor care in many facilities. On top of that, the COVID-19 pandemic has left residents more vulnerable and socially isolated because visitation restrictions have limited their contact with advocates and loved ones. They are now at their facilities' mercy without access to advocates who usually play a key role in protecting them. Given these conditions, the NHRA's enumerated rights are an essential defense to combat abuse, neglect, and poor care.

That said, the mere existence of these rights is not enough. For these rights to have meaning, facilities that violate them must be held accountable. Regulatory enforcement alone does not suffice. While regulatory enforcement determines facilities' compliance with standards, it does not vindicate residents' individual entitlement to high quality care. In addition, even if regulatory enforcement worked perfectly, which it does not, it still would not compensate residents for harm.

Thus, residents must be able to go to court and enforce their rights against state-run facilities themselves. Congress created these rights for the residents' protection, including the specific rights at issue here. It intended for residents and

regulators to both be able to enforce these essential rights. Accordingly, a decision in favor of Appellant fulfills Congress's promise and recognizes the importance of private rights of action to hold state-run facilities accountable for harm.

This Court should join the Third and Ninth Circuits in holding that residents can bring an action under Section 1983 of the Civil Rights Act against a state-run facility to enforce violations of their NHRA rights. Amici request that this Court reverse the lower court's decision and remand the case for further proceedings.

ARGUMENT

I. Nursing Facility Residents Must Be Able To Enforce Their Rights Under The Federal Nursing Home Reform Act To Combat Abuse, Neglect, and Substandard Care In State-Run Nursing Facilities and Hold Facilities Accountable.

The NHRA changed the landscape for nursing facility residents by, among other things, defining and guaranteeing their legal rights. Yet if this Court finds that residents cannot enforce those rights, they will lose a powerful weapon for their protection. This puts them at risk of harm and even death, as abuse, neglect, and poor care are rampant in many facilities.

In short, Section 1983 gives residents and their families a mechanism to enforce their rights against state-run facilities. *See* 42 U.S.C. § 1983. This private right of action would be pivotal to residents under any condition, but is even more critical because regulatory enforcement is inadequate to protect them. Thus,

residents must enforce their rights themselves through private actions that hold facilities accountable and deter future misconduct.

A. Nursing facility residents must be able to enforce their NHRA rights under Section 1983 because the NHRA provides for such enforcement and regulatory enforcement is inadequate to enforce their rights.

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

These regulatory obligations and sanctions, however, do not erase the fact that Congress bestowed NHRA rights on residents so they could enforce these rights themselves. Nor do they obviate the need for residents to enforce their rights. Simply put, regulatory enforcement on its own cannot vindicate residents' rights. For one thing, regulatory enforcement and private litigation serve different functions. The purpose of the regulatory survey and enforcement processes is to determine facilities' compliance with standards. It is not to vindicate each resident's individual entitlement to compliance with their rights and high quality of care.

The purpose of private litigation, on the other hand, is to vindicate and enforce a resident's rights. Even if regulatory enforcement adequately remedied the facility problems that harm residents, regulators would not be able to compensate injured residents. In the end, residents would still need to bring their own actions to be made whole. Private litigation would also help other residents because it would drive facilities into compliance and deter future misconduct.

Indeed, Congress intended that residents bring private actions to enforce their NHRA rights. It drafted the NHRA to provide that the regulatory remedies were in addition to remedies available to individuals under federal and state law. 42 U.S.C. §§ 1395i-3(h)(5), 1396r(h)(8). In doing so, it recognized that residents must have every mechanism available to them to enforce their rights, especially when the facilities' conduct causes death or harm to a vulnerable person. These mechanisms include pursuing Section 1983 actions against state-run facilities.

In a good scenario, regulatory enforcement and private litigation would complement each other. This point notwithstanding, private enforcement of NHRA rights is also essential because regulatory enforcement has failed to adequately protect residents and bring about change.

After all, despite the law's mandate that nursing facilities promote and protect residents' rights and meet minimum standards of care, many facilities flout that mandate and harm residents. In 2016, over one in five U.S. nursing facilities

received a deficiency for causing actual harm or jeopardy to residents. *See* Charlene Harrington et al., *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2016*, Kaiser Family Found. (Apr. 3, 2018), https://www.kff.org/45f0273/.

The inadequacies of regulatory oversight of nursing facilities are well documented. For example, in June 2019, the Government Accountability Office (GAO) published a report detailing the need for CMS to improve its oversight of facilities to protect nursing facility residents from abuse and neglect. U.S. Gov't Accountability Office, GAO-19-433, *Nursing Homes- Improved Oversight Needed to Better Protect Residents from Abuse*(June 2019), https://www.gao.gov/assets/700/699721.pdf.

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

Six months later, the GAO reported that CMS had yet to enforce several of its recommendations about oversight gaps in abuse reporting requirements for nursing facilities. U.S. Gov't Accountability Office, GAO-20-259T, *Better Oversight Needed to Protect Residents From Abuse* (Nov. 14, 2019), 6, 7, 8, https://www.gao.gov/assets/710/702638.pdf.

The Office of Inspector General (OIG) of the U.S. Department of Health and Human Services has also issued several reports over the years highlighting CMS's lack of adequate oversight. For example, in June 2019, the Inspector General issued a report documenting the failure of nursing facilities to report incidents of potential abuse or neglect of residents to their state survey agency in 2016. Office of Inspector General, U.S. Dep't. of Health and Human Serv., No. A-10-16-00509, *Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated* (June 2019), https://oig.hhs.gov/oas/reports/region1/11600509.pdf.

Looking at a sample of high-risk emergency room claims that hospitals submitted to CMS, the Inspector General estimated that there were 7831 cases of potential abuse or neglect of residents in 2016. *Id*. at 12. The Inspector General also found that facilities failed to report more than 84% of these incidents to the state survey agencies although the law requires such reports. The OIG report found

that CMS had unclear guidelines that contributed to nursing facilities failing to report abuse. *Id.*

Moreover, a Kaiser Family Foundation report also confirmed long-term problems with regulatory oversight not achieving lasting improvements. *See* Charlene Harrington, et al., *Key Issues in Long-Term Services and Supports Quality*, Kaiser Family Found. (October 2017), http://files.kff.org/attachment/Issue-Brief-Key-Issues-in-Long-Term-Services-and-Supports-Quality. While the report found that nursing facilities had improved quality of care in some areas, certain areas, such as inappropriate antipsychotic drug use, had worsened. *Id*. at 2.

Most importantly, the Kaiser report identified several shortcomings in regulatory oversight of long-term care. First, nursing facilities were not reporting some incidents of abuse and neglect to the appropriate law enforcement and regulatory authorities. *Id.* at 7. Second, some state survey agencies were not investigating complaints timely. Third, regulators rarely imposed fines and other penalties, meaning enforcement rarely occurred even for documented care problems. *Id.*

Compounding this is a recent federal policy that rolled back regulations and guidance developed over the past 30 years to implement and enforce the NHRA. In July 2017, CMS issued a directive entitled “Revision of Civil Money Penalty

(CMP) Policies and CMP Analytic Tool". Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health and Human Servs., *Revision of Civil Money Penalty (CMP) Policies and CMP Analytic Tool* (July 7, 2017), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-37.pdf.

That directive instructs State Survey Agency Directors and CMS Regional Offices to impose a "Per-Instance" civil monetary penalty (CMP) for past non-compliance instead of the per-day penalties that the NHRA requires. *Id*. at 2. Past noncompliance refers to violations of the NHRA that occurred since the last survey, but which have been corrected before the current survey started without regard to the seriousness of the violation or the actual harm that resulted.

The language in the CMS memo prohibits CMS Regional Offices from imposing and states from recommending, per-day CMPs for past noncompliance. *Id.* Per-day penalties incentivize nursing facilities to identify and self-correct violations at the earliest point, before they place residents at risk of harm. In contrast, per instance CMPs are a flat amount regardless of the severity or length of the harm. This change undermines enforcement of the NHRA.

All in all, because of lax regulatory enforcement, nursing facilities know that they are less likely to face stiff penalties for the most serious and persistent

violations. For some facilities, this eliminates the coercive incentive to meet NHRA mandates and reasonably mitigate the risk of harm to vulnerable residents. As a result, nursing facility residents must have every tool of deterrence and accountability available to them. This includes enforcing their NHRA rights under Section 1983 against state-run facilities.

B. Nursing facility residents must to be able to enforce their NHRA rights against state-run facilities to combat the high rates of abuse, neglect, and substandard care they experience in nursing facilities.

The NHRA defines and guarantees the legal rights of nursing facility residents. 42 U.S.C. §§ 1395i-3(c), 1396r(c). Among these rights are:

- The right to be free of chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms;
- The right to be free of physical or mental abuse;
- The right to not be subject to an illegal transfer or discharge;
- The right to voice grievances about treatment or care that is (or fails to be) furnished without discrimination or reprisal for voicing the grievances;
- The right to participate in the review of one's care plan, and to be fully informed in advance about any changes in care, treatment, or change in status in the facility;
- The right to participate in resident and family groups;

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

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

Id.

These rights are critical to residents because they are often victims of abuse, neglect, and substandard care in nursing facilities. Many factors lead residents to be vulnerable to these harms. To begin with, residents are separated from their social networks when they are in a facility. *See* Kjersti Lisbeth Braaten and Wenche Malmedal, *Preventing Physical Abuse of Nursing Home Residents- As Seen From the Nursing Staff's Perspective*, Nursing Open (vol. 4 2017), https://doi.org/10.1002/nop2.98. They also depend on others to perform activities of daily living such as eating, bathing, dressing, and toileting. *See id.* Moreover, many people have negative views of older people, such as believing that they are worthless, frail, and a burden on society. *See* Jennifer Beth Glick, *Protecting and Respecting Our Elders: Revising Mandatory Elder Abuse Reporting Statutes to Increase Efficiency and Preserve Autonomy*, 12 Va. J. of Soc. Pol'y & L. 714, 720 (2005).

In 2016, more than 1.3 million nursing facility residents lived in 15,600 nursing facilities certified to participate in the Medicaid and Medicare health

insurance programs. *See* Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health and Human Servs., *Nursing Home Data Compendium 2015-2016 Edition*, National Center for Health Statistics, 73-76 (Feb. 2019), https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf.

Most residents shared at least one characteristic that put them at risk of abuse, neglect, and poor care. Eighty-three percent were 65 or older. *Id.* at 76. Eighty-nine percent had functional impairments in three or more activities of daily living. *Id.* Forty-seven percent had Alzheimer's disease or other dementias. *Id.*

Finally, chronic understaffing in nursing facilities also puts residents in harm's way and prevents them from getting needed care. *See, e.g.*, Charlene Harrington and Toby Edelman, *Failure to Meet Nurse Staffing Standards: A Litigation Case Study of a Large US Nursing Home Chain*, The National Center for Biotechnology Information (July 20, 2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6055099/. As an example, when staffing is inadequate, residents can suffer painful pressure wounds, injuries from falls, weight loss, depression, hospitalizations, and even death. *Id.* CMS has recognized that daily staffing levels in a facility affects quality of care and outcomes. Ctrs. For Medicare & Medicaid Servs., U.S. Dep't of Health and Human Servs., QSO-18-17-NH, *Transition to Payroll-Based Journal (PBJ) Staffing Measures on the Nursing Home Compare tool on Medicare.gov and the Five Star*

Quality Rating System, 1 (Apr. 6, 2018), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO18-17-NH.pdf.

The problems of abuse, neglect, and poor care are prevalent in many nursing facilities. For instance, in 2014, 44% of nursing facility residents surveyed said that they had personally been abused, 95% said that they had been neglected or had witnessed neglect of another resident. *See* Richard Weinmeyer, *Statutes to Combat Elder Abuse in Nursing Homes*, 16 AMA J. of Ethics 359, 360 (2014), https://journalofethics.ama-assn.org/article/statutes-combat-elder-abuse-nursing-homes/2014-05. Government studies, such as the ones listed above, have also corroborated the abuse in facilities.

The complex challenge of collecting accurate data on the prevalence of abuse in nursing facilities means that these numbers, though unacceptably high, are a mere sampling of a largely under-detected and under-reported problem. *See* Office of Inspector General, U.S. Dep't of Health and Human Servs., A-01-17-00504, *Early Alert: The Centers for Medicare & Medicaid Services Has Inadequate Procedures to Ensure that Incidents of Potential Abuse or Neglect at Skilled Nursing Facilities are Identified and Reported in Accordance with Applicable Requirements*, 5-7 (Aug. 24, 2017), https://oig.hhs.gov/oas/reports/region1/11700504.asp.

Indeed, the COVID-19 pandemic has also exposed the dangerous consequences of poor care, abuse, and neglect, while revealing residents' increased vulnerability to facility actions. *See, e.g.*, Xenia Shih Bion, *Why Nursing Homes Became Such Covid-19 Hot Spots*, CFCH Blog (July 13, 2020), https://www.chcf.org/blog/why-nursing-homes-become-covid-19-hot-spots/.

Being in a nursing facility is already socially isolating. Now, due to visitation restrictions, the crisis has left residents with limited or no access to family, friends, or the Long-Term Care Ombudsman. These people often serve as advocates for the resident, so their absence leaves a huge gap in monitoring the facility's treatment of residents. State survey teams are also not monitoring compliance as frequently as before because CMS cut back on those functions to focus on infection control. *See* Ctrs. for Medicare & Medicaid Servs., *Coronavirus: Updates for State Surveyors and Accrediting Organizations* (May 1, 2020), https://www.cms.gov/medicare/quality-safety-oversight-general-information/coronavirus.

Along with that, those who live in institutional settings are at higher risk of contracting COVID-19. *See* Ctrs. for Disease Control & Prevention, *Coronavirus Disease, Nursing Homes or Long-Term Care Facilities* (updated June 25, 2020), https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-in-nursing-homes.html. In fact, forty-one percent of pandemic deaths have been

residents of nursing facilities. *See* NY Times, *More Than 40% of U.S. Coronavirus Deaths Are Linked to Nursing Homes* (July 30, 2020), https://www.nytimes.com/interactive/2020/us/coronavirus-nursing-homes.html.

During this time of great uncertainty and increased isolation, residents depend even more on the facilities. While some facilities are complying with the NHRA's mandate, others are flouting the law and violating residents' rights – with tragic consequences.

For example, during the pandemic, many nursing facilities are illegally discharging or "dumping" older residents and residents with disabilities against their wishes into homeless shelters, rundown motels, and other unsafe locations. *See* Jessica Silver-Greenberg & Amy Julia Harris, *'They Just Dumped Him Like Trash': Nursing Homes Evict Vulnerable Residents,* New York Times(June 21, 2020), https://www.nytimes.com/2020/06/21/business/nursing-homes-evictions-discharges-coronavirus.html. Many of these residents are among those most susceptible to the virus. *Id.* Many are being discharged despite continuing to need nursing facility level of care. *Id.* According to 22 watchdogs in 16 states, as well as elder-care lawyers, social workers, and former nursing facility executives, this conduct is happening across the country. *Id.* Some facilities reportedly are discharging vulnerable residents so they can admit other residents who will make them more money. *Id.*

These actions obliterate these residents' transfer and discharge rights. Even in the pandemic, these residents still have a right to remain in the facility unless the discharge:

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

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

Unless the resident's situation falls into a rare COVID-19 exception, the residents must also receive thirty-day notice of transfer or discharge which includes the reason, effective date, location to which the facility is transferring or discharging the resident, the right to appeal, and the name, address, and telephone number of the state Long-Term Care Ombudsman. *Id.* The facility must also provide a safe and orderly transfer or discharge with sufficient preparation and orientation. *Id.*

If the NHRA is not enforced by the regulators and private rights of action are precluded against government-run facilities, these facilities could dump the most vulnerable residents into shelters or to the streets with impunity and

without ever being held accountable for any resulting harm. Given the poor regulatory enforcement, incentives for self-policing and self-correction would be entirely eliminated if residents cannot bring actions to secure compliance with the NHRA.

Another example of the importance of residents enforcing their NHRA rights is the pervasive problem of nursing facilities chemically restraining residents without medical justification. Like illegal discharges, the illegal use of chemical restraints has plagued the nursing facility industry for years.

In a 2018 report, "'*They Want Docile': How Nursing Homes in the United States Overmedicate People with Dementia*," human rights organization Human Rights Watch documented nursing facilities' inappropriate use of antipsychotic drugs in older people with dementia as well as their administration of the drugs without informed consent. Human Rights Watch, "*They Want Docile" How Nursing Facilities in the United States Overmedicate People With Dementia*, (Feb. 5, 2018), https://www.hrw.org/report/2018/02/05/they-want-docile/how-nursing-homes-united-states-overmedicate-people-dementia# [hereinafter HRW Study].

This conduct is life-threatening abuse. The U.S. Food and Drug Administration (FDA) has approved antipsychotic drugs for the treatment of psychotic conditions such as schizophrenia and bipolar disorder. *Id.; See, e.g.*,

Zyprexa Label, U.S. Food and Drug Administration, https://www.accessdata.fda.gov/drugsatfda_docs/label/2010/020592s052,021086s031,021253s037lbl.pdf. It has also has issued its most dire warning—known as a black box warning— on these drugs because of the risk of death. Studies show that on average, these drugs at least double the risk of death when used with elderly patients with dementia. *See* HRW Study. Facilities that administer chemical restraints do so for staff convenience to sedate residents, or to punish or discipline a resident. *Id.* Yet the FDA has not approved these drugs to treat people who do not have a mental health diagnosis. *Id.*

In the HRW Study, residents and their family members reported that the facilities gave residents drugs without their knowledge, without explaining the risks, or over their objections. *Id.* Residents described the trauma of losing their ability to stay awake, think, and communicate. *Id.* Their families described the pain of witnessing these losses. Staff admitted that they did not always inform residents that they were giving them antipsychotic drugs. *Id.* While most staff were adamant that they used the drugs appropriately, other staff admitted giving residents these drugs for their own convenience. *Id.* Outside observers noted this as well. Some doctors would prescribe drugs at the staff's request, without first evaluating or even seeing the patients. *Id.*

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

It found that around 20 percent of all residents in the U.S. – about 298,650 people every week – received some form of antipsychotic medication in the fourth quarter of 2019, even though only about two percent had qualifying conditions for such drugs. *Id*. at 6. Most residents did not even have diagnosis for the administered drugs. *Id.*

The NHRA prohibits abuse like chemical restraints by guaranteeing residents the right to avoid restraints of all kinds imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. 42 U.S.C. §§ 1395i-3(c)(1)(A)(ii), 1396r(c)(1)(A)(ii).

In sum, the prevalence of abuse and neglect in nursing facilities and the failure of regulatory authorities to hold them accountable create an urgent need for residents to use every tool of redress and deterrence available to protect

themselves from harm. The NHRA guarantees residents legal rights that nursing facilities must protect and promote. When state-run facilities violate these rights, residents must be able file an action under Section 1983 to get the full benefit of their protection and hold the facilities accountable.

CONCLUSION

For reasons above, the lower court's decision should be reversed.

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Respectfully Submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because this brief contains 4,590 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in 14 point font.

Dated: August 7, 2020

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CERTIFICATE OF SERVICE

I hereby certify that on August 7, 2020, I electronically filed the foregoing Brief for Amici Curiae AARP, AARP Foundation, Center for Medicare Advocacy Long Term Care Community Coalition, The National Consumer Voice for Quality Long-Term Care, and California Advocates for Nursing Home Reform Supporting Appellants with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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