"CAN I SUE THIS PLACE—JUST FOR THE FOOD?": PRIVATE ENFORCEMENT OF QUALITY OF LIFE REGULATION IN NURSING FACILITIES

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The Federal Nursing Home Reform Act sets quality of life standards for residents in nursing facilities, such as requiring facilities to provide high quality food, meaningful activities, and respectful interaction with the staff to their residents. While the law is settled that residents in nursing facilities have a legal right to sue if subjected to abuse, it has not yet been examined if residents can enforce their rights to quality of life. This Note answers that question and argues that the Federal Nursing Home Reform Act provides nursing facility residents a right to a standard of quality of life, and that residents of government owned facilities can enforce that right through 42 U.S.C. § 1983.

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I. Introduction

Rusty King is an expert in how quality of life standards affect a resident in a skilled nursing facility.[1] He is not a scientist or a doctor, but a resident of Deer Path Assisted Living in Huntley, Illinois, an assisted-living facility for people aged twenty-two to sixty-four with physical disabilities.[2]

Rusty feels that, while the facility provides him with three meals a day, entertaining activities, and opportunities for socializing, something is missing. He feels that the routines are restricting, and his options are narrow. Take for instance mealtimes. Dinner is only served twice a day regardless of whether he is hungry or not. The menu is limited to what is being offered and if he does not like it, the only alternative is something like a cheese sandwich. The food offered is, in his opinion, not of the best quality. In a way, his body is being fed, but not his soul.

Rusty cannot afford to get food other than what is served, and he is unable to drive a car to go elsewhere. The only way he can try to make a difference is to get the facility to change. He had gone to resident council meetings and asked for a better dining menu but saw no change. He spoke with the administrative staff about getting better quality food but saw no change. Frustrated and feeling as if he had no other option, he asked: "Can I sue this place—just for the food?"

While Rusty may not have been seriously considering filing a lawsuit to get a better dinner menu, his question raises a legitimate legal issue: whether nursing facility residents have a legal remedy to being subjected to a low quality of life. Rusty's problem was not that the facility did not serve food at all, but that he felt the quality of food he was being served was very low. In fact, most residents have complaints regarding their quality of life, such as the food they are served, the activities they are offered, and their ability to socialize with others.[3] Whether residents have a legal remedy for those complaints is a question that has not yet been answered—until now.

1. The name Rusty is a pseudonym to protect his identity. I met Rusty while working as a member of the activities team at Deer Path. While my time working there was brief, Rusty and I quickly became friends. He shared with me his perspective of being a resident at an assisted-living facility. The following account is based on my interactions with Rusty and other residents throughout my time at Deer Path.

2. *See Deer Path of Huntley*, GARDANT MGMT. SOLS., https://www.gardant.com/deerpathhuntley/ [https://perma.cc/D8F3-FDEH] (last visited Feb. 18, 2025).

3. *See* Amy Restorick Roberts & Kathryn Betts Adams, *Quality of Life Trajectories of Older Adults Living in Senior Housing*, 40 RSCH. ON AGING 511, 522–23 (2018).

A legal remedy to enforce quality of life is important to residents because their lives are effectively run by the facilities they live in.[4] Residents at assisted-living facilities and nursing homes have almost no say in the food they are served—they eat when, what, and where the facility decides.[5] The activities residents have access to are also almost exclusively at the discretion of the facility,[6] and because a resident's social life is often limited to the walls of the facility, they frequently depend on staff for meaningful interactions.[7] In fact, most of what makes up a resident's quality of life is at the discretion of the facilities and the facilities alone.[8] This lack of choice regarding their food, activity, or socialization causes many residents to raise complaints.[9]

Understanding a resident's practical ability to address those complaints is paramount to understanding their need for a legal remedy. Most residents, especially at Medicaid facilities, are without the resources or practical ability to do anything besides be complacent with the food and activities their facility provides.[10] For example, after subtracting the amount charged by the facility, Rusty and other residents at Deer Path receive less than fifty dollars a month in disability, and they are largely isolated from their friends, family, and support network.[11] Many residents have physical disabilities that make it hard to get around without help, many do not own cars, and many residents

4. BARBARA BOWERS, KIM NOLET, TONYA ROBERTS & SARAH ESMOND, IMPLEMENTING CHANGE IN LONG-TERM CARE 9–18 (2007), https://www.hhs.k-state.edu/aging/research/peak20/pcc-resources/other/implementing_change.pdf [https://perma.cc/3N98-LZB9].

5. *Id.*

6. Sandra F. Simmons, Daniel W. Durkin, Annie N. Rahman, John F. Schnelle & Linda Beuscher, *The Value of Resident Choice During Daily Care: Do Staff and Families Differ?*, 33 J. APPLIED GERONTOLOGY 655, 656–58 (2014).

7. Juh Hyun Shin, Taesung Park & Ik-soo Huh, *Nursing Staffing and Quality of Life in Western New York Nursing Homes*, 36 W. J. NURSING RSCH. 788, 789 (2013).

8. *See* Jennifer King, Lindsey Yourman, Cyrus Ahalt, Catherine Eng, Sara J. Knight, Eliseo J. Pérez-Stable & Alexander K. Smith, *Quality of Life in Late-Life Disability: "I Don't Feel Bitter Because I Am in a Wheelchair,"* 60 J. AM. GERIATRIC SOC. 569, 572–74 (2012); Mary M. Ball, Frank J. Whittington, Molly M. Perkins, Vickie L. Patterson, Carole Hollingsworth, Sharon V. King & Bess L. Combs, *Quality of Life in Assisted Living Facilities: Viewpoints of Residents*, 19 J. APPLIED GERONTOLOGY 304, 319 (2000).

9. Shin et al., *supra* note 7, at 793; *see* King et al., *supra* note 8, at 527–74.

10. *See* Sandra S. Butler, James Gomon & Winston Turner, *Satisfaction and Well-Being Among Residents of a Low-Income, Rural Assisted Living Facility and the Implications for Social Work Practice*, 3 J. SOC. WORK IN LONG-TERM CARE 61, 78 (2004).

11. Interview with Rusty King (Sept. 12, 2024); Telephone Interview with Rusty King (June 15, 2024) [hereinafter Interviews with Rusty].

cannot afford other transportation.[12] For Rusty, he cannot simply go to another facility, because there are only three other assisted-living facilities for non-elderly people in Illinois.[13]

Without the ability to change their circumstances once living in a facility, it is understandable why a resident may be so upset over what food is on their plate. What can a resident, otherwise helpless at the hands of their facility, realistically do to try and improve their quality of life?

That answer came in June 2023. In *Health & Hospital Corporation of Marion County v. Talevski*, the United States Supreme Court held that residents of long-term living facilities owned by the government can sue under 42 U.S.C. 1983 (§ 1983) to enforce rights conferred upon them in the Federal Nursing Home Reform Act (FNHRA).[14] The FNHRA requires facilities to care for residents in a way that promotes their quality of life, including serving quality food, offering meaningful activities, and treating residents with dignity and respect.[15] However, while the FNHRA at large can *potentially* create § 1983 enforceable rights, an individual provision of the statute must itself create a right in order to be enforced.[16] Accordingly, if the quality of life provisions *do* create a right, then residents of those living facilities may have legal grounds to enforce their complaints regarding quality of life.[17]

This Note will argue that the quality of life provisions do create federal rights and are therefore enforceable under § 1983. Part II will provide an overview of quality of life research, introduce the history of the FNHRA, and discuss the tests for determining when a statute creates a federal right. Part III will argue the FNHRA does create quality of life rights, examine the need for § 1983 quality of life litigation, and analyze what such litigation will need to claim and prove to be successful. Part IV will suggest that Congress codify private enforcement of

12. *Id.*

13. Rick Banas, *Your Guide to Affordable Assisted Living in Illinois*, GARDANT MGMT. SOLS. (Jan. 6, 2011), https://www.gardant.com/articles/your-guide-to-affordable-assisted-living-in-illinois/ [https://perma.cc/VLG4-6UUY]; *see Operational Supportive Living Program Provider Sites and Approved Applications by County*, ILL. DEPT. OF HEALTHCARE & FAM. SERVS., https://hfs.illinois.gov/medicalprograms/slf/table.html [https://perma.cc/UH44-3CXB] (last visited Feb. 18, 2025).

14. *See generally* Health & Hosp. Corp. of Marion Cnty. v. Talevski, 599 U.S. 166 (2023) (holding that 42 U.S.C. § 1983 is an appropriate remedy for residents of living facilities to enforce rights given under the Federal Nursing Home Reform Act).

15. 42 U.S.C. § 1396r(b)(l)(A), (b)(2)(A)–(C), (b)(4)(A)(iv)–(v).

16. Blessing v. Freestone, 520 U.S. 329, 340–42 (1997).

17. *See id.*

quality of life rights and provide a framework for what successful § 1983 quality of life litigation may look like.

This Note is written with residents and facilities in mind, both being designed to guide facility management on how to best enhance a resident's quality of life and serving a guide for residents who may be unhappy, dissatisfied, and curious as to if they have any legal remedy against their living facility. To supplement the understanding of the reality of living in a nursing facility, this Note will reference the stories and experiences lived by the residents at Deer Path during.[18] Most importantly, this Note is to answer Rusty's question: can residents sue a nursing facility—just for the food?

II. Background

Nursing facilities, as they are known today, came into prevalence in the 1940s.[19] While formerly a budding industry, nursing facilities blossomed in that decade because of the government's involvement in paying for resident care,[20] specifically, the enactments of Medicare and Medicaid.[21] In the modern day, ninety-five percent of nursing homes are Medicaid certified.[22] Traditional nursing homes, more appropriately named "skilled nursing facilities," provide residents with medical care, three meals a day, and assistance with daily activities.[23] Assisted-living facilities provide similar services for those who do not require as much daily care as a nursing home provides.[24] This Note will refer to both kinds of facilities collectively as "nursing facilities."

18. These stories are taken from my time working at Deer Path and supplemented by my interviews with Rusty King. Interviews with Rusty, *supra* note 11.

19. David Ray Papke, *A Stage Set for Disaster: For-Profit Nursing Homes, Federal Law, and COVID-19*, 1 J. ELDER POL'Y 199, 202–03 (2021).

20. *Id.*

21. *Id.* at 203.

22. NAT'L CTR. FOR HEALTH STAT., POST-ACUTE AND LONG-TERM CARE PROVIDERS AND SERVICES USERS IN THE UNITED STATES, 2017–2018 10 (2022).

23. *Long-Term Care Facilities: Assisted Living, Nursing Homes, and Other Residential Care*, NIH NAT'L INST. ON AGING (Oct. 12, 2023), https://www.nia.nih.gov/health/assisted-living-and-nursing-homes/long-term-care-facilities-assisted-living-nursing-homes [https://perma.cc/XN6W-EGZ2].

24. *Id.*

A. Quality of Life in Nursing Facilities

Quality of life is focused on adding "not more years to life, but more life to years."[25] It encompasses many aspects of human life including physical, social, and emotional needs,[26] each of which are subjective and a function of the individual's history and personality.[27] In the context of a nursing facility, quality of life refers to a resident's overall well-being and experience of receiving care.[28] Further, it can be distinguished from quality of care, which is clinical, medical, and based largely on health needs.[29]

Experts have identified multiple "domains" of quality of life that are shared between most if not all nursing facility residents.[30] These domains include: (1) food satisfaction, (2) meaningful activities, and (3) quality interaction with staff.[31] These three domains are most prominently identified across all research on resident quality of life.[32] Fittingly, those are the three domains which are most impacted by how a

25. Lawrence K. Frank, *Gerontology*, 1 J. GERONTOLOGY 1, 10 (1946) (quoting Dr. George Morris Piersol). The exact origin of this phrase is unclear, though some journals state (without citation) that it was the motto of the Gerontological Society of America circa 1940. *See* Herman T. Blumenthal, *Commentary*, 59 J. GERONTOLOGY 1156 (2004).

26. *See* Howard B. Degenholtz, Abby L. Resnick, Natalie Bulger & Lichun Chia, *Improving Quality of Life in Nursing Homes: The Structured Resident Interview Approach*, 2014 J. AGING RSCH. 1, 1–2 (2014); *see also* ERICA COE, MARTIN DEWHURST, LARS HARTENSTEIN, ANNA HEXTALL & TOM LATKOVIC, MCKINSEY HEALTH INSTITUTE, ADDING YEARS TO LIFE AND LIFE TO YEARS 9–10 (2022).

27. Degenholtz et al., *supra* note 26, at 1–2.

28. Weiwen Ng, John R. Bowblis, Yinfei Duan, Odichinma Akosionu & Tetyana P. Shippee, *Quality of Life Scores for Nursing Home Residents are Stable Over Time: Evidence from Minnesota*, 34 J. AGING. SOC. POL'Y 755, 756 (2022).

29. *See* Degenholtz et al., *supra* note 26, at 1.

30. *See* Tetyana P. Shippee, Hwanhee Hong, Carrie Henning-Smith & Robert L. Kane, *Longitudinal Changes in Nursing Home Resident-Reported Quality of Life: The Role of Facility Characteristics*, 37 RSCH. ON AGING 555, 561 (2015); *see also* Rosalie A. Kane, Kristen C. Kling, Boris Bershadsky, Robert L. Kane, Katherine Giles, Howard B. Degenholtz, Jiexin Liu & Lois J. Cutler, *Quality of Life Measures for Nursing Home Residents*, 58A J. GERONTOLOGY 240, 241 (2003).

31. *See* sources cited *supra* note 30.

32. *See, e.g.*, Erin E. Watkins, Christopher Walmsley & Alan Poling, *Self-Reported Happiness of Older Adults in an Assisted Living Facility: Effects of Being in Activities*, 41 ACTIVITIES, ADAPTATION & AGING 87, 94 (2017); *see also* Lauren R. Bangerter, Allison R. Heid, Katherine Abbott & Kimberly Van Haitsma, *Honoring the Everyday Preferences of Nursing Home Residents: Perceived Choice and Satisfaction with Care*, 57 GERONTOLOGIST 479, 482–83 (2017); *see also* N. Carrier, G.E. West & D. Ouellet, *Dining Experience, Foodservices and Staffing Are Associated with Quality of Life in Elderly Nursing Home Residents*, 13 J. NUTRITION, HEALTH & AGING 565, 569 (2009).

facility operates and is managed.[33] When asked what good care means, residents identified similar categories: access to quality food, options for meaningful activities, and staff who listen to them and treat them with respect.[34]

Quality of life is a concern for residents in nursing facilities,[35] and has been an issue for many years.[36] In fact, residents have concerns before they even move in: most residents have little to no say in their admission into the facility itself,[37] and for many residents, their initial admission reflects a permanent loss of autonomy and decision-making.[38] The move-in reflects a loss of the ability to take care of their own needs, choose who they associate with, select where they live, and decide their own schedules and activities.[39]

The move into these facilities is often traumatic for residents due to the above issues and the difficulties of adapting to a new way of life.[40] Despite the fact that before moving in, most residents look forward to at least some aspect of facility-living,[41] the reality is that quality of life for nursing facility residents decreases over time after moving in.[42] After six months of living in the facility, a resident's satisfaction begins to diminish;[43] within the first year, their emotional well-being begins to suffer;[44] and after five years, a third of residents are entirely dissatisfied with their quality of life.[45] Even those residents who have greater satisfaction with the facility overall still have complaints about the services provided.[46] Inevitably, some residents feel resigned and in despair about their lives,[47] with certain residents so dissatisfied with life in the facility that they express a desire to leave.[48]

33. Shippee et al., *supra* note 30, at 573.
34. Ball et al., *supra* note 8, at 318–19.
35. Degenholtz et al., *supra* note 26, at 5.
36. INST. OF MED., IMPROVING THE QUALITY OF LONG-TERM CARE 1 (Gooloo S. Wunderlich & Peter O. Kohler eds., 2001).
37. Ball et al., *supra* note 8, at 315.
38. *See id.*
39. *Id.* at 314.
40. *See* Butler et al., *supra* note 10, at 79.
41. *Id.* at 70.
42. Roberts & Adams, *supra* note 3, at 522–23.
43. Butler et al., *supra* note 10, at 75.
44. *Id.* at 81.
45. Roberts & Adams, *supra* note 3, at 525.
46. Butler et al., *supra* note 10, at 72.
47. Ball et al., *supra* note 8, at 312.
48. Butler et al., *supra* note 10, at 72.

One of the largest influences over a resident's satisfaction is their ability to make decisions.[49] Residents want to be able to make their own decisions about aspects of their life, including mealtimes, meaningful activities, and socializing with others.[50] Within these areas, they not only want to have options to choose from, but also to have options that interest them and engage them.[51] Once moved in, however, the resident's meals, activities, and ability to socialize are largely under the facility's exclusive control.[52] The exact ways in which residents lose control over those core areas of quality of life will be examined in further detail below.

1. FOOD SATISFACTION

First, food satisfaction and mealtime experiences are an important part of a resident's life.[53] Meals in a nursing facility are often served in a dining room with residents seated at tables with their peers.[54] It is a hybrid between dining at a restaurant and a school lunch, with servers coming to take your order from a menu that often provides only one or two options.[55] If a resident is not interested in what is on the menu during mealtime, they are usually provided a substitute, such as a cheese sandwich.[56]

Satisfaction with mealtimes is a valuable metric because it is highly correlated with overall satisfaction with the facility and enhances a resident's overall quality of life.[57] The actual dining experience itself also deeply affects quality of life—when residents eat meals with more people, their quality of life tends to be higher.[58] Menus that change periodically and provide options for therapeutic diets (such as low-fat, diabetic, or reduced salt diets) also positively impact resident quality of life.[59] Even minor changes, such as eating meals on porcelain

49. Bangerter et al., *supra* note 32, at 483–84.
50. *Id.* at 482–83; King et al., *supra* note 8, at 572–74.
51. Bangerter et al., *supra* note 32, at 482–84; King et al., *supra* note 8, at 572–74.
52. Simmons et al., *supra* note 6, at 656; BOWERS ET AL., *supra* note 4, at 9–18.
53. Carrier et al., *supra* note 32, at 569.
54. BOWERS ET AL., *supra* note 4, at 11–12.
55. *Id.*
56. *See id.*
57. Amber D. Howells, The Impact of Perceived Quality on Assisted Living Residents' Satisfaction with Their Dining Experience 90 (Apr. 25, 2007) (M.S. Thesis, Kansas State University); Carrier et al., *supra* note 32, at 569.
58. Carrier et al., *supra* note 32, at 569.
59. *Id.*

plates rather than plastic, can positively impact a resident's dining experience.[60]

Residents prioritize being able to make decisions about their food.[61] They want to have a say in what food they eat, when they eat it,[62] where they eat it, and who they eat it with.[63] However, many residents have no choice about *what* food is served, almost no residents have any say about *when* those meals are served,[64] and if they have a choice, most residents are dissatisfied with the options they have for either.[65] A resident who is dissatisfied with their mealtime choices tends to be more displeased with the dining experience overall.[66] In fact, lack of choice is often the most displeasing aspect of the dining experience to residents.[67]

Although it may seem insignificant, having limited mealtime options has profound impacts on a resident's quality of life.[68] Many residents are on medications that must be taken at certain times or under special circumstances (e.g., with food), so having meals on a rigid schedule can interfere with their ability to take care of themselves.[69] For example, one resident at Deer Path takes medicine at night that causes him to sleep well past when breakfast is served.[70] Sometimes, it makes him sleep through the lunch hour as well.[71] If not provided other options, he would have to wait until dinner is served to have any food whatsoever.[72]

2. MEANINGFUL ACTIVITIES

The second major area of resident quality of life is having more access to meaningful activities.[73] Activities staff at facilities often provide activities like social hours, arts and crafts, cooking classes, trivia

60. *Id.*
61. *Id.*
62. Bangerter et al., *supra* note 32, at 482.
63. Carrier et al., *supra* note 32, at 569.
64. Bangerter et al., *supra* note 32, at 482; Ball et al., *supra* note 8, at 315.
65. Howells, *supra* note 57, at 95.
66. *Id.*
67. *Id.* at 87.
68. *See* Bangerter et al., *supra* note 32, at 480.
69. Ball et al., *supra* note 8, at 315.
70. Interviews with Rusty, *supra* note 11.
71. *Id.*
72. *Id.*
73. Shippee et al., *supra* note 30, at 574.

events, and light sports such as cornhole or even playing video games.[74] Residents who participate in those activities report higher levels of happiness than those who do not.[75] Those same residents also have experienced a significantly slower decline in their quality of life than their peers who do not participate.[76] Those non-participatory residents consistently report lower levels of happiness.[77]

However, those residents may not simply be refusing to participate. When residents move into a nursing facility, they often lose the ability to choose what activities they want to do, when they want to do them, and how they want to do them.[78] The problem, then, is whether the facility offers activities the resident would be interested in or able to participate in.[79] The majority of residents require some amount of assistance with activities of daily living, such as bathing, dressing, walking, using the bathroom, getting in and out of bed, and eating.[80] It follows that many residents cannot participate in a number of the activities offered by the facility.[81] A resident's physical limitations can also result in their inability to get to the activity in the first place.[82] When it is already difficult to get out of bed, it can feel impossible to go to an activity on the far side of the facility, let alone one across town.[83]

Activities have the most impact on a resident's quality of life when their facility considers the interests of its residents.[84] For instance, one resident at Deer Path was unengaged with most of the programming at the facility.[85] He rarely left his apartment and seldom participated in any of the activities offered.[86] However, once the life enrichment team started a Dungeons & Dragons club, things began to

74. Interviews with Rusty, *supra* note 11; Anthony Cirillo, *Activities for Nursing Homes and Assisted Living*, VERYWELLHEALTH (Oct. 23, 2022), https://www.verywellhealth.com/activities-for-nursing-homes-and-assisted-living-197773 [https://perma.cc/F6RC-J2AV].
75. Watkins et al., *supra* note 32, at 94.
76. Roberts & Adams, *supra* note 3, at 523, 526.
77. Watkins et al., *supra* note 32, at 94.
78. Bangerter et al., *supra* note 32, at 482–83; Ball et al., *supra* note 8, at 320.
79. Watkins et al., *supra* note 32, at 94; *see* Bangerter et al., *supra* note 32, at 482–83.
80. NAT'L CTR. FOR HEALTH STAT., *supra* note 22, at 26 (2022).
81. *See* Bangerter et al., *supra* note 32, at 482–83.
82. *Id*.
83. *Id*.
84. *Id*.
85. Interviews with Rusty, *supra* note 11.
86. *Id*.

change:[87] Once Deer Path offered a single activity that the resident was interested in, not only did he come to that program, but he also began exploring other activities provided by the facility.[88] Soon, he became one of the most frequent attendees of the activity program.[89] This example shows why activities are so important: when given meaningful options that pique their interests, residents are empowered to become more engaged with their community and more satisfied with life.[90]

3. QUALITY INTERACTION WITH STAFF

The last major area of resident satisfaction is their relationships and interactions with facility staff.[91] The relationship between live-in residents and staff is important due to its inherent long-lasting nature.[92] Those relationships can help combat the widespread loneliness in nursing facilities, as well as the isolation that naturally results from moving into such a facility.[93] Having a greater number of interactions with staff increases the resident's quality of life, and that affect is even more pronounced when those interactions are positive.[94] That positive correlation is particularly true of interactions with registered nurses and activities staff.[95] Indeed, a facility-wide focus on caregiving beyond "bread-and-butter considerations" leads to a higher quality of life for the residents.[96]

Residents themselves value quality relationships with their care providers, especially when predicated on respect and communication,[97] and they enjoy forming emotionally gratifying friendships with the staff.[98] They want their caregivers to be responsive to their needs and

87. *Id*.
88. *Id*.
89. *Id*.
90. *See* Bangerter et al., *supra* note 32, at 483–84.
91. *See id.* at 483.
92. Shin et al., *supra* note 7, at 789.
93. *See generally* Lucia A. Silecchia, *Covid-19, Visitation and Spiritual Care: Responding to the Silent Suffering of the Isolated in Times of Crisis*, 74 BAYLOR L. REV. 634 (2022) (discussing the implications of isolation compounded on residents during the pandemic).
94. Shippee et al., *supra* note 30, at 573–76.
95. *Id.*
96. V. Tellis-Nayak, *A Person-Centered Workplace: The Foundation for Person-Centered Caregiving in Long-Term Care*, 8 J. AM. MED. DIRS. ASS'N. 46, 53 (2007).
97. Bangerter et al., *supra* note 32, at 483.
98. Nan Sook Park, Sheryl Zimmerman, Kathleen Kinslow, Hae Juyng Shin & Lucinda Lee Roff, *Social Engagement in Assisted Living and Implications for Practice*, 31 J. APPLIED GERONTOLOGY 215, 221–22, 232 (2012).

preferences, with the relationship being one where the resident has some choice in how they are being taken care of.[99] Improved relationships with staff can increase resident satisfaction in the other key areas of quality of life, such as mealtimes and activities.[100] Despite these benefits, however, most residents do not receive much interaction with staff.[101] The average nursing home resident only receives about 2.65 hours of individualized interaction with staff a day.[102]

More interaction truly does lead to more meaning—at Deer Path, Rusty himself befriended a staff member through their shared love of board games.[103] Their friendship blossomed from playing board games at facility events to the staff member staying after hours to play more complex board games.[104] That relationship enabled Rusty to have meaningful conversations about shared passions and interests, while also providing him with a more fulfilling experience in a personally meaningful activity (playing board games).[105] Such relationships also benefit the staff: after that staff member left his position, he still returned to Deer Path to play board games with Rusty.[106]

At the end of the day, quality of life comes down to genuine care for the individual resident.[107] By providing more individualized care directed at the interests and needs of a particular resident, nursing facility employees can directly benefit the quality of life of the facility's residents as a whole.[108] Small-scale changes that allow staff to respond to the individual resident's preferences are even more impactful on quality of life than large-scale changes in facilities.[109]

B. The Federal Nursing Home Reform Act

Having now examined residents' quality of life, it is important to understand the law surrounding it. The statute setting quality of life standards for most nursing facility residents is the aforementioned

99. Bangerter et al., *supra* note 32, at 482–84.
100. Degenholtz et al., *supra* note 26, at 6.
101. *See* NAT'L CTR. FOR HEALTH STAT., *supra* note 22, at 14.
102. *Id.*
103. Interviews with Rusty, *supra* note 11.
104. *Id.*
105. *Id.*
106. *Id.*
107. Degenholtz et al., *supra* note 26, at 6; *see also* Shippee et al., *supra* note 30, at 653.
108. Degenholtz et al., *supra* note 26, at 6.
109. *Id.*

FNHRA.[110] The FNHRA applies to any "nursing facility," meaning institutions that provide residents skilled nursing care, rehabilitation services, or health-care services in long term residency.[111] The FNHRA is the industry standard because, while it only affects facilities that receive federal funding through Medicare or Medicaid, most facilities do receive that funding.[112]

Congress developed the FNHRA as part of an effort to better regulate the quality of care in Medicaid-certified and Medicare-certified nursing homes.[113] The Act was developed in conjunction with the Institute of Medicine (Institute) in response to concerns over the poor quality of care in nursing facilities.[114] At the time, there were more low-quality homes than high-quality ones.[115] Many residents were receiving "shockingly deficient" care, and the Institute considered the absence of choice residents had regarding their food, activities, and ability to socialize to be unacceptable.[116]

The Institute recognized that the regulation of nursing homes was suboptimal: even nursing facilities that were able to pass a government inspection were still providing unacceptably poor care.[117] It conducted a study on the quality of care being provided in nursing facilities at the time and published its recommendations for creating legislation designed to increase the standards of care.[118] This report would come to be the foundation of the FNHRA.[119]

The Institute found that regulations like the FNHRA could create better, more consistent high-quality options for nursing facility residents.[120] Having nursing facilities consistently maintain a high quality

110. *See* 42 U.S.C. § 1396r; Shekinah A. Fashaw, Kali S. Thomas, Ellen McCreedy & Vincent Mor, *30-Year Trends in Nursing Home Composition and Quality Since the Passage of OBRA*, 21 J. AM. MED. DIR. ASSOC. 233, 234 (2020).

111. 42 U.S.C § 1396r(a)(1)(A)–(C).

112. Richard Mollot, *Distribution of Certified Nursing Facility Residents by Primary Payer Source*, KFF (July 2023), https://www.kff.org/other/state-indicator/distribution-of-certified-nursing-facilities-by-primary-payer-source/ [https://perma.cc/CB9A-ABJS].

113. Fashaw et al., *supra* note 110, at 234.

114. JOSHUA M. WIENER, MARC P. FREIMAN, DAVID BROWN & RTI INT'L, NURSING HOME CARE QUALITY TWENTY YEARS AFTER THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 5 (2007).

115. COMM. ON NURSING HOME REGUL., IMPROVING THE QUALITY OF CARE IN NURSING HOMES 11 (Nat'l Acad. Press 1986).

116. *Id.* at 2–3.

117. *Id.* at 7.

118. WIENER ET AL., *supra* note 114, at 5.

119. *Id.*

120. *See* COMM. ON NURSING HOME REGUL., *supra* note 115, at 5.

was important due to the reality of the move-in process.[121] The Institute recognized that the choice to move into a facility in the first place is not a choice most residents want to make; rather, it is a necessary choice made as a last resort due to change in their health, family, or financial situation.[122] Residents often settle for subpar options because they have little time to peruse the options of nursing facilities given the sudden changes in their lives.[123]

The Institute found that a "major weakness" of then-existing regulations was their lack of standards regarding quality of life[124] and that better quality of life standards were needed to protect the interests of these practically involuntary facility residents.[125] Quality of life was so important that the Institute recommended it be explicitly distinct from quality of care and included in the new regulations.[126] The report even recommended the very language later incorporated into the FNHRA: "that residents shall be cared for in such a manner and in such an environment as will promote maintenance or enhancement of their quality of life."[127]

Armed with these recommendations, Congress set out to establish high standards to govern resident quality of life through the FNHRA.[128] That Act came with several new requirements for nursing facilities, as well as certain rights guaranteed to residents.[129] The Act covers a wide range of nursing facility life, from mandating standards of admission into facilities to requiring ways for residents to voice grievances and requiring individual care plans for each resident.[130]

Compared to its legislative predecessors, the FNHRA shifted the focus from the facility's ability to provide care to the actual outcomes of care.[131] Prior to the Act's passing, surveyors of facilities did not even need to observe the residents, let alone engage with them and ask for

121. *See id.* at 5–6.
122. *Id.*
123. *Id.*
124. *Id.* at 45–46, 81.
125. *Id.* at 6.
126. *Id.* at 81.
127. *Id.*; 42 U.S.C. § 1396r(b)(l)(A).
128. WIENER ET AL., *supra* note 114.
129. *Id.*
130. *Id*. at 6–7; 42 U.S.C. § 1396r(b)(2), (c)(5), (c)(1)(vi).
131. *See* WIENER ET AL., *supra* note 114, at 3; Malcolm J. Harkins III, *The Broken Promise of Obra '87: The Failure to Validate the Survey Protocol*, 8 ST. LOUIS U. J. HEALTH L. & POL'Y 89, 99 (2014).

their opinions on the care they received.[132] The Act required the creation of a new survey method inclusive of observing the residents and asking for their opinions on quality of care.[133]

Now, because of the FNHRA, states are required to perform unannounced surveys and resident interviews every fifteen months, and are directed to investigate specific complaints in specific facilities.[134] If a facility is out of compliance, diverse sanctions can be imposed, including mandatory staff training, monetary penalties, shutting down the facility's operations entirely, and revoking Medicare and Medicaid eligibility.[135] The last option, revoking Medicare and Medicaid eligibility, is effectively the same as shutting down the facility,[136] given the majority of funding for nursing facilities comes from those federal funds.[137]

The implementation of the FNHRA has resulted in some improvements in the quality of care provided to residents of nursing facilities, but in other areas, progress has plateaued.[138] The issues identified in the Institute's report continued to exist, decades after the legislation's passage.[139] In 2023, most facilities averaged nine separate cited deficiencies,[140] and there is reason to believe more issues go undetected and uncited.[141]

C. The FNHRA, 42 U.S.C. § 1983, and Quality of Life

The FNHRA allows the government to impose the sanctions mentioned above on noncompliant facilities, but it does not contain any remedy for the individual residents who suffer at the hands of those

132. WIENER ET AL., *supra* note 114, at 3–4.
133. *See* Harkins III, *supra* note 131, at 100; WIENER ET AL., *supra* note 114, at 3–4.
134. WIENER ET AL., *supra* note 114, at 8.
135. *Id.*
136. Papke, *supra* note 19, at 216.
137. NAT'L CTR. FOR HEALTH STAT., *supra* note 22, at 3 ("Medicaid finances the largest portion of paid long-term care services, followed by Medicare, out-of-pocket payments by persons and families, other private sources, private insurance, and other public programs.").
138. WIENER ET AL., *supra* note 114, at 34.
139. *Id.* at 36.
140. *Average Number of Deficiencies per Certified Nursing Facility*, KFF (July 2023), https://www.kff.org/other/state-indicator/avg-of-nursing-facility-deficiencies/ [https://perma.cc/WE2K-EPF4].
141. *See generally* Harkins III, *supra* note 131, at 89 (analyzing the history of reporting measures used to enforce the FNHRA and the consistent lack of validity and accuracy in their results).

facilities.[142] Fortunately, 42 U.S.C. § 1983 is there to help. The section provides:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.[143]

Without creating any rights itself, § 1983 serves as an avenue for enforcing rights that have otherwise been conferred.[144] It allows individual plaintiffs to sue a defendant who, acting under color of state law, violated the plaintiff's federal rights arising either from the Constitution or federal statutes.[145]

The Supreme Court has opened the door to the potential enforcement of any federal statute under § 1983.[146] In determining if a right has been created, the provisions of a statute must be individually reviewed rather than analyzing the entirety of a statute.[147] For the sake of this Note, that means individual provisions of the FNHRA will need to be independently reviewed to determine if they create a § 1983 enforceable right, rather than the Act at large.

Another area to look for rights-creating language is the Code of Federal Regulations (CFR). The CFR is a compilation of the rules created by various executive agencies and can be viewed somewhat like a companion to the U.S. Code, with the former expanding upon and clarifying how to enforce the latter.[148] Typically, the CFR itself cannot create a federal right, but it can invoke a right otherwise created by Congress.[149] In this way, the CFR can be used to determine the scope of a

142. 42 U.S.C. § 1396r.
143. *Id.* § 1983.
144. Graham v. Connor, 490 U.S. 386, 393–94.
145. MARTIN A. SCHWARTZ, SECTION 1983 LITIGATION 75 (Kris Markarian ed., 3d ed. 2014).
146. Maine v. Thiboutot, 448 U.S. 1, 4 (1980); SCHWARTZ, *supra* note 145, at 75.
147. Blessing v. Freestone, 520 U.S. 329, 340–42 (1997) ("Only when the complaint is broken down into manageable analytic bites can a court ascertain whether each separate claim satisfies the various criteria we have set forth for determining whether a federal statute creates rights.").
148. Alexander v. Sandoval, 532 U.S. 275, 284 (2001) ("A Congress that intends the statute to be enforced through a private cause of action intends the authoritative interpretation of the statute to be so enforced as well.").
149. *See Alexander*, 532 U.S. at 291 ("Language in a regulation may invoke a private right of action that Congress through statutory text created, but it may not

Congressionally conferred right.[150] Said another way, "[a]gencies may play the sorcerer's apprentice but not the sorcerer himself."[151] The main inquiry to determine if a CFR provision can be § 1983 enforceable is whether Congress intended to create the right invoked in the CFR.[152]

There are two alternative tests a court may use to determine if a statutory provision grants a federal right.[153] The first is a three-factor test articulated by the Supreme Court in *Blessing v. Freestone*.[154] Those factors are: (1) "Congress must have intended that the provision in question benefit the plaintiff," (2) "the right assertedly protected by the statute is not so vague and amorphous that its enforcement would strain judicial competence," and (3) "the statute must unambiguously impose a binding obligation on the States."[155] This test is most widely used by district courts and courts of appeal.[156]

The second test to determine if a federal right has been conferred comes from *Gonzaga University v. Doe*.[157] This test asks if the provision in question is "phrased in terms of the persons benefited and contains rights-creating, individual-centric language with an unmistakable focus on the benefited class."[158] The main idea behind *Gonzaga* is to determine "that Congress intended to create a federal right *for* the identified class, not merely that the plaintiffs fall within the general zone of interest that the statute is intended to protect."[159]

The Supreme Court applies *Gonzaga* over *Blessing*.[160] Yet, because *Gonzaga* did not explicitly overrule *Blessing*, the courts of appeals still

create a right that Congress has not."); Thurman v. Med. Transp. Mgmt., Inc., 982 F.3d 953, 957 (5th Cir. 2020) (collecting cases).

150. Save Our Valley v. Sound Transit, 335 F.3d 932, 943 (9th Cir. 2003).

151. *Alexander*, 532 U.S. at 291.

152. *Thurman*, 982 F.3d at 957.

153. Blessing v. Freestone, 520 U.S. 329, 340–41 (1997); Gonzaga Univ. v. Doe, 536 U.S. 273, 284, 287 (2002).

154. *Blessing*, 520 U.S. 329.

155. SCHWARTZ, *supra* note 145, at 75; *Blessing*, 520 U.S. at 340–41.

156. *See, e.g.*, N.Y. State Citizens' Coal. for Child. v. Poole, 922 F.3d 69, 79 (2d Cir. 2019); Grammer v. John J. Kane Reg'l Centers-Glen Hazel, 570 F.3d 520, 525 (3d Cir. 2009); Rolland v. Romney, 318 F.3d 42, 52 (1st Cir. 2003).

157. *Gonzaga Univ.*, 536 U.S. 273 (2002).

158. Health & Hosp. Corp. of Marion Cnty. v. Talevski, 599 U.S. 166, 183 (2023) (citing *Gonzaga Univ.*, 536 U.S. at 284, 287).

159. *Id.*

160. *See id.* at 189 (citing *Blessing* a singular time in the majority opinion, only for sake of "collecting cases").

apply and prefer the *Blessing* analysis.[161] This Note applies both *Blessing* and *Gonzaga*. Because the District or Circuit Court will likely apply *Blessing* when analyzing the quality of life provisions for § 1983 compatibility, that analysis will be given slight priority.[162]

When a statute has been found to create a right under either test, that creates a "rebuttable presumption" of § 1983 compatibility.[163] That presumption is only overcome by a showing that Congress "foreclosed a remedy under § 1983" either explicitly forbidding private remedies within the statute or by creating a "comprehensive enforcement scheme" that renders § 1983 incompatible.[164] When examining if Congress did foreclose such a remedy, the entire statute is reviewed, rather than the individual provision.[165]

In June 2023, the Supreme Court decided that the FNHRA *can* create federal rights enforceable through § 1983.[166] In *Health & Hospital Corporation of Marion County. v. Talevski*, Gorgi Talevski asserted that the county-owned nursing home he lived in violated two of his FNHRA rights.[167] His first claim was that the nursing home chemically restrained him with six powerful medications, which made him lose the ability to communicate in English and eat on his own.[168] He claimed these acts violated his FNHRA right to be free from "any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms."[169] His next claim was that the nursing home further violated his FNHRA rights by forcing him to transfer to a dementia facility without notifying him or his family.[170] That claim sought to enforce the section providing residents the "transfer and discharge right" that nursing facilities "must

161. *See, e.g.*, *Poole*, 922 F.3d at 79 ("*Gonzaga*, however, did not overrule *Blessing*; rather, it clarified the rule in *Blessing* by correcting a misinterpretation of that rule that had been adopted by some lower courts."); D.O. v. Glisson, 847 F.3d 374, 377 (6th Cir. 2017); Saint Anthony Hosp. v. Eagleson, 40 F.4th 492, 503 (7th Cir. 2022).

162. *See, e.g.*, *Poole*, 922 F.3d at 79.

163. *Blessing*, 520 U.S. at 340–41.

164. *Id.*

165. *See* Health & Hosp. Corp. of Marion Cnty. v. Talevski, 599 U.S. 166, 186 ("For evidence of such intent, we have looked to the statute creating the right.").

166. *Id*. at 180.

167. *Id.* at 173–74.

168. *Id.* at 172–73.

169. *Id.* at 181–82; 42 U.S.C. § 1396r(c)(1)(A)(ii).

170. *Talevski*, 599 U.S. at 172–74.

not transfer or discharge a resident unless certain enumerated preconditions . . . are met."[171]

The district court dismissed Talevski's complaint, concluding that the FNHRA could not be enforced through § 1983.[172] The Seventh Circuit reversed this decision, stating that the above FNHRA provisions indeed provided individual rights to nursing home residents that could be enforced through § 1983.[173] The Supreme Court affirmed, holding that those FNHRA provisions clearly established rights that could be enforced through § 1983.[174]

The Court held that the FNHRA was a "law" within the meaning of § 1983, meaning it had the capability of creating an enforceable right.[175] Further, it found that the chemical restraint and discharge provisions did create enforceable rights under the *Gonzaga* test.[176] Lastly, it determined there was no evidence that Congress intended to preclude private enforcement of FNHRA rights under § 1983, either directly or by creating an incompatible enforcement scheme.[177] Thus, Talevski could use § 1983 to enforce his rights under the FNHRA.[178]

III. Analysis

Having now defined precisely what quality of life means and provided an overview of the FNHRA and § 1983 litigation at large, the inquiry turns to whether the FNHRA gives residents rights to a certain quality of life.

A. The FNHRA Creates Enforceable Rights to Quality of Life

By holding that "[t]he FNHRA *can* create § 1983-enforceable rights," *Talevski* opens the door for private enforcement of the FNHRA's other provisions.[179] The decision means any provision of the FNHRA could, theoretically, be found to create a right.[180] The decision overturns dozens of opinions that found the FNHRA did not create

171. *Id.* at 184–85 (citing 42 U.S.C. § 1396r(c)(2)(A)–(B)).
172. *Id.* at 174.
173. *Id*.
174. *Id.* at 180.
175. *Id.* at 174–80.
176. *Id.* at 180–86.
177. *Id.* at 186–92.
178. *Id.* at 192.
179. *Id.* at 180.
180. *See id.* at 192.

enforceable rights,[181] whose courts will necessarily need to review future litigation in light of *Talevski*. Most importantly, *Talevski* tells us that the Act's internal remedial scheme is *not* incompatible with § 1983.[182] Thus, so long as a provision of the FNHRA can pass either *Blessing* or *Gonzaga*, it is enforceable without fear of rebuttal.[183] That overturns dozens more opinions that have held the Act's internal remedial structure and § 1983 were incompatible,[184] but because of *Talevski*, those courts will need to readdress that issue.[185]

Because of the precedent set in *Talevski*, the only analysis needing to be applied to the remaining provisions of the FNHRA to determine their § 1983 compatibility are the *Blessing* and *Gonzaga* tests. Briefly, the *Blessing* test asks whether (1) the provision in question was specifically intended to benefit a class of persons inclusive of the plaintiff, (2) the proposed right is not "vague and amorphous," and (3) the statute imposes mandatory obligations on the States.[186] The *Gonzaga* test looks for whether "Congress has unambiguously conferred individual rights upon a class of beneficiaries to which the plaintiff belongs."[187] Because the *Gonzaga* test is effectively the same as the first step of *Blessing*, it will be addressed at the same time as that step.[188] As a reminder, courts analyze the individual provision at issue for rights-creating language rather than the statute at large.[189] Should a provision of the FNHRA pass either of these tests, it will be enforceable via § 1983.[190] Several provisions of the FNHRA relating to quality of life pass either test, which will collectively be referred to as the "quality of life provisions":

181. *See* McCarthy v. 207 Marshall Drive Operations, LLC, No. 615-CV-2121-ORL-18, 2015 WL 9701089, at *2 (M.D. Fla. Dec. 24, 2015) (collecting cases).
182. *Talevski*, 599 U.S. at 191 (citing 42 U.S.C. § 1396r(h)(8)).
183. *See id.* at 188–89, 191 (citing 42 U.S.C. § 1396r(h)(8)).
184. *See, e.g.*, Kalan v. Health Ctr. Comm'n, 198 F. Supp. 3d 636, 643 (W.D. Va. 2016); Fiers v. La Crosse Cnty., 132 F. Supp. 3d 1111, 1116 (W.D. Wis. 2015); Hawkins v. Cnty. of Bent, 800 F. Supp. 2d 1162, 1166–67 (D. Colo. 2011); Duncan v. Johnson-Mathers Health Care, Inc., No. 5:09-CV-00417-KKC, 2010 WL 3000718, at *8 (E.D. Ky. July 28, 2010).
185. *See Talevski*, 599 U.S. at 191 (citing 42 U.S.C. § 1396r(h)(8)).
186. SCHWARTZ, *supra* note 145, at 75; Blessing v. Freestone, 520 U.S. 329, 340–41 (1997).
187. *Talevski*, 599 U.S. at 183 (citing Gonzaga Univ. v. Doe, 536 U.S. 273, 283, 285–86 (2002)).
188. *Compare Blessing*, 520 U.S. at 340–41, *with Gonzaga Univ.*, 536 U.S. at 283, 287.
189. *Blessing*, 520 U.S. at 340–42.
190. *See Talevski*, 599 U.S. at 192.

- "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."[191]
- "A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident . . . ."[192]
- "[A] nursing facility must provide . . . dietary services that assure the meals meet the daily nutritional and special dietary needs of each resident."[193]
- "[A] nursing facility must provide . . . an on-going program, directed by qualified professional, of activities designed to meet the interests and the physical, mental and psychosocial well-being of each resident."[194]

The Third Circuit has applied the *Blessing* test to each of these provisions, and found that each one created § 1983 enforceable rights.[195] In addition, the First Circuit found the FNHRA at large contained rights-creating language, with a "laundry list of [resident] rights," inclusive of the quality of life provisions.[196] Finally, the Supreme Court has acknowledged the FNHRA does contain rights-creating language.[197] Still, to determine if the quality of life provisions themselves can be enforced, it is necessary to analyze these provisions individually through each factor of the *Blessing* test.[198]

Also relevant are the sections of the CFR that relate to the FNHRA's quality of life provisions. As discussed above, typically a CFR provision alone is insufficient to create a § 1983 enforceable right, but can evoke and help define a right created by Congress.[199] The relevant provisions of the CFR for this analysis are contained within Part 483: Requirements for States and Long Term Care Facilities.[200] This provision was written by the Department of Health and Human Services

191. 42 U.S.C. § 1396r(b)(l)(A).

192. *Id.* § 1396r(b)(2). While § 1396r(c)(1)(a)(viii) states that residents have a right to participate in activities, it refers to "other" activities, reserving the right of a resident to participate in independent or external activities rather than facility-sponsored programming, which is the subject of this Note's analysis.

193. *Id.* § 1396r(b)(4)(A)(iv).

194. *Id.* § 1396r(b)(4)(A)(v).

195. Grammer v. John J. Kane Reg'l Centers-Glen Hazel, 570 F.3d 520, 522, 527–28 (3d Cir. 2009).

196. Rolland v. Romney, 318 F.3d 42, 53 & n.10 (1st Cir. 2003).

197. Health & Hosp. Corp. of Marion Cnty. v. Talevski, 599 U.S. 166, 184–85 (2023).

198. *See* Blessing v. Freestone, 520 U.S. 329, 340–42 (1997).

199. Alexander v. Sandoval, 532 U.S. 275, 291 (2001); Thurman v. Med. Transp. Mgmt., Inc., 982 F.3d 953, 957 (5th Cir. 2020) (collecting cases).

200. 42 C.F.R. § 483 (2024).

through the Centers for Medicaid & Medicare Services, and explicitly derives its authority from the FNHRA (42 U.S.C. 1396r). The most relevant subsections of Part 483 are: 42 C.F.R. § 483.10—Resident Rights;[201] 42 C.F.R. § 483.24—Quality of Life;[202] and 42 C.F.R. § 483.60—Food and Nutrition Services.[203]

1. THE QUALITY OF LIFE PROVISIONS CONTAIN RIGHTS-CREATING LANGUAGE

The first step of *Blessing*, and the entirety of the *Gonzaga* test, is to determine if the statute was specifically intended to benefit a class of persons, rather than simply regulate the State actor.[204] In the case of the FNHRA, the residents are the benefitted class, and the facilities are the state body. The essential dilemma is whether the FNHRA's focus is on the rights of residents or the regulation of facilities.[205] District courts have previously interpreted the quality of life provisions solely as matters of institutional policy, finding their focus was on the facilities rather than the residents.[206] These courts recognize that while there are certainly rights given to the residents within the FNHRA, that those rights are not the "unmistakable focus" of the statute.[207]

However, that is far from the truth. The Supreme Court has now acknowledged that the FNHRA "inexorably" confers certain rights.[208] The Court found the restraint and discharge provisions of the FNHRA had the necessary focus on the benefited class: the facility residents.[209] Those provisions, like the above quality of life provisions, were predicated on an instruction to the facility: "A nursing facility must protect and promote the rights of each resident."[210] Nevertheless, the Court still held that the FNHRA regulated the facilities exclusively to further the residents' interests—such as requiring the facilities to protect and

201. *Id.* § 483.10.
202. *Id.* § 483.24.
203. *Id.* § 483.60.
204. Blessing v. Freestone, 520 U.S 329, 340–41 (1997); Gonzaga Univ. v. Doe, 536 U.S. 283, 287 (2002).
205. *See* Kalan v. Health Ctr. Comm'n, 198 F. Supp. 3d 636, 643 (W.D. Va. 2016).
206. *See, e.g.*, *id.*; Fiers v. La Crosse Cnty., 132 F. Supp. 3d 1111, 1116 (W.D. Wis. 2015); Hawkins v. Cnty. of Bent, 800 F. Supp. 2d 1162, 1166–67 (D. Colo. 2011); Duncan v. Johnson-Mathers Health Care, Inc., No. 09-CV-00417, 2010 WL 3000718, at *8 (E.D. Ky. July 28, 2010).
207. *Kalan*, 198 F. Supp. 3d at 643; *Fiers*, 132 F. Supp. 3d at 1116; *Hawkins*, 800 F. Supp. 2d at 1166–67 ; *Duncan*, 2010 WL 3000718, at *8.
208. Health & Hosp. Corp. of Marion Cnty. v. Talevski, 599 U.S. 166, 192 (2023).
209. *Talevski*, 599 U.S. at 184–85 (2023).
210. 42 U.S.C. § 1396r(c)(1)(A).

promote the residents' rights to be free from restraint.[211] The Court duly noted that "it would be strange to hold that a statutory provision fails to secure rights simply because it considers, alongside the rights bearers, the actors that might threaten those rights."[212]

To be sure, the provisions at issue in *Talevski* are in a different section of the statute than the quality of life provisions.[213] The restraint and discharge provisions examined in *Talevski* are included in the enumerated list of resident rights, a fact which the Court found persuasive.[214] Nevertheless, the placement of the provision within the statute is only one factor which the Court considered.[215] It also considered the FNHRA's language, which showed the focus was on individual residents, listing specifically the Act's emphasis on "the *resident's* health [and] the *resident's* urgent medical needs."[216]

That language is directly mirrored in the language of the quality of life provisions.[217] Those provisions state that a nursing facility must provide care, services, activities, and dietary services that meet the needs of each *resident* and help secure the physical, mental and psychosocial well-being of each *resident*.[218] The very notion that a nursing facility *must* care for its residents in such a way as to promote their quality of life is indicative of the focus on individual residents.[219] The quality of life provisions mandate that the facilities provide certain services to and for its residents.[220] Those provisions are exclusively focused on the "needs of the resident," not simply regulating the facilities.[221]

211. *Talevski*, 599 U.S. at 184–85.
212. *Id.* at 185.
213. *Talevski* dealt with provisions located in 42 U.S.C. § 1396r(c): Requirements relating to residents' rights, while the quality of life provisions examined here are found in 42 U.S.C. § 1396r(b): Requirements relating to provision of services.
214. *See Talevski*, 599 U.S. at 184 ("[B]oth [provisions] reside in 42 U.S.C. § 1396r(c), which expressly concerns requirements relating to residents' rights . . . . [t]his framing is indicative of an individual rights creating focus."); see also Estate of Tester ex rel. Tester v. Vill. at Hamilton Pointe, LLC, 24-CV-00005, 2024 WL 4433040, at *5–6 (S.D. Ind. Sept. 20, 2024) (finding 42 U.S.C. § 1396r(b)(1) and (b)(4)(A) do not create rights partly because they are not within the enumerated list of resident rights).
215. *See Talevski*, 599 U.S. at 184–85.
216. *Id.*
217. 42 U.S.C. § 1396r(b)(l)(A), (2), (4)(A)(iv)–(v).
218. *Id.*
219. Health & Hosp. Corp. of Marion Cnty. v. Talevski, 599 U.S. 166, 184–85 (2023); 42 U.S.C. § 1396r(b)(l)(A).
220. 42 U.S.C. § 1396r(b).
221. *Id.* § 1396r(b)(2).

Yet within that enumerated list of resident rights Congress explicitly included "any other right created by the Secretary [of Health and Human Services]."[222] This section explicitly authorizes the Secretary to create resident rights, not only expand upon those listed in the FNHRA. [223] While it is unclear whether this provision specifically would allow any right created exclusively within the CFR to be enforced via § 1983, it at the very least goes to show that Congress intended not to limit resident rights to those enumerated in that list.

Fittingly, the CFR treats quality of life as a right.[224] Under its section entitled "resident rights," the CFR plainly states that a facility must "care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life."[225] In the section detailing quality of life, the CFR goes on to say that "[q]uality of life is a *fundamental* principle that applies to all care and services provided to facility residents."[226] By writing such language, the executive branch explicitly states that quality of life is a practical and necessary right of the residents.[227] If Congress' authorization for the Secretary of Health and Human Services to create nursing facility resident rights is to be taken literally,[228] this provision in and of itself creates a privately enforceable right to quality of life. If not, and at the very least, it is an interpretation of the FNHRA which suggests the FNHRA itself grants residents the right to quality of life.

2. THE QUALITY OF LIFE PROVISIONS ARE NOT "VAGUE OR AMORPHOUS"

The next *Blessing* factor is whether the provisions are "vague or amorphous," meaning if the proposed right is so unclear as to strain judicial competence.[229] This step asks if the language is clear enough to be practically enforced as a right by the courts.[230] Regarding quality of life, courts have found those FNHRA provisions undefined and unspecific when compared to enumerated rights within the same statute,

222. *Id.* § 1396r(c)(1)(a)(xi); *see id.* § 1301(a)(6) (defining the use of "Secretary" within the chapter to refer to the Secretary of Health and Human Services).
223. *See* 42 U.S.C. § 1396r(c)(1)(a)(xi).
224. 42 C.F.R. § 483.10(a)(1) (2024).
225. *Id.*
226. *Id*. § 483.24 (2024).
227. *See id.*
228. *See* 42 U.S.C. § 1396r(c)(1)(a)(xi).
229. Blessing v. Freestone, 520 U.S. 329, 340–41 (1997).
230. *See, e.g.*, Shanklin v. Coulee Med. Ctr., No. 2:17-CV-377-RMP, 2019 WL 1601360, at *5 (E.D. Wash. Apr. 15, 2019).

such as the right to choose case or to be free from restraint.[231] It is true that the FNHRA itself does not contain a definition of "quality of life,"[232] and those courts find that alone makes the provision judicially unenforceable.[233]

Yet stopping the analysis there overlooks the maxim of *certum est quod certum reddi potest*—something is certain if it can be made certain.[234] Both the FNHRA and the CFR use the phrase "quality of life" in conjunction with the language "the highest practicable physical, mental, and psychosocial well-being" of each resident.[235] The FNHRA requires a nursing facility to provide nursing and medically related social services to achieve "the highest practicable physical, mental, and psychosocial well-being of each resident."[236] The CFR explicitly includes that phrase in its definition of quality of life.[237]

Indeed, a person's physical, mental, and psychosocial well-being *is* the definition of quality of life.[238] Consider the definition of quality of life provided to Congress when drafting the FNHRA: the subjective combination of a person's satisfaction with life, self-worth, and sense of well-being.[239] Taking it all together, when Congress writes "quality of life," it is referring to the factors that impact "physical, mental, and psychosocial well-being" of residents.[240] Accordingly, the FNHRA explicitly recognizes several factors related to the physical, mental, and psychosocial well-being of residents, such as quality food services,[241] access to meaningful activities,[242] and being treated with dignity and respect.[243] The CFR explicitly lists dining, activities, and communication with others as factors that contribute to quality of life.[244]

231. *E.g.*, Kalan v. Health Ctr. Comm'n of Orange Cnty., Virginia, 198 F. Supp. 3d 636, 643 (W.D. Va. 2016); Fiers v. La Crosse Cnty., 132 F. Supp. 3d 1111, 1117 (W.D. Wis. 2015) (discussing the FNHRA provisions).

232. 42 U.S.C. § 1396r(b)(2).

233. *E.g.*, *Kalan*, 198 F. Supp. 3d at 647; *Fiers*, 132 F. Supp. 3d at 1117 (discussing the Court's decisions regarding the FNHRA provisions).

234. *Certum est quod certum reddi potest*, BLACK'S LAW DICTIONARY (9th ed. 2009).

235. *Compare* 42 U.S.C. § 1396r(b)(4)(A), *with* 42 C.F.R. § 483.24 (2024).

236. 42 U.S.C. § 1396r(b)(4)(A)(i), (ii).

237. 42 C.F.R. § 483.24 (2024) ("Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being . . . .").

238. *See* Degenholtz, *supra* note 26, at 1–2.

239. COMM. ON NURSING HOME REGUL., *supra* note 115, at 51.

240. 42 C.F.R. § 483.24 (2016).

241. 42 U.S.C. § 1396r(b)(4)(A)(iv).

242. *Id.* § 1396r(b)(4)(A)(v).

243. *See id.* § 1396r(b)(2).

244. 42 C.F.R. § 483.24(b)(4)–(5), (c) (2024).

Yet still, the Southern District of Indiana grappled with that definition and asked the question: "How would a court determine if a nursing facility complied with that directive?"[245] The answer, again, lies beyond the simple phrase quality of life and is detailed in the CFR.[246] Food served to residents must be palatable and prepared in a way preserving nutrition, flavor, and appearance.[247] Residents must be offered three meals times a day at regular times, and if a resident wishes to eat at a different time, they must be provided a nourishing alternative meal.[248] Not only must the activities provided be tailored to the residents' interests and preferences, encourage interaction in the community, and promote resident independence, but residents must also be given a choice of such activities.[249]

While there are numerous factors that affect the quality of life of residents, such factors do not make the rights to quality of life *per se* unenforceable or nonjusticiable. Both the First and Third Circuits have found that quality of life is a justiciable right because the phrase is not so vague as to strain efforts to do so.[250] Any lack of clarity within the FNHRA itself is remedied by the CFR's robust explanation of those rights.[251] Quality of life is nuanced, intricate, and encompassing of multiple factors,[252] but it is by no means vague.[253]

245. Estate of Tester ex rel. Tester v. Vill. at Hamilton Pointe, LLC, 24-CV-00005, 2024 WL 4433040, at *17 (S.D. Ind. Sept. 20, 2024).
246. *See* 42 C.F.R. §§ 483.60, 483.24, 483.1 (2024).
247. *Id.* § 483.60(d)(1).
248. *Id.* § 483.60(f).
249. *Id.* § 483.24(c)(1).
250. Grammer v. John J. Kane Reg'l Centers-Glen Hazel, 570 F.3d 520, 529 (3d Cir. 2009); Rolland v. Romney, 318 F.3d 42, 53 n.10, 55 (1st Cir. 2003).
251. *See generally* 42 C.F.R. § 483 (2024).
252. *See supra* Section II.A.
253. *See Grammer*, 570 F.3d at 529.

3. THE FNHRA IMPOSES MANDATORY OBLIGATIONS ON THE STATES

Thus, only the last factor remains; whether the provisions impose mandatory obligations on the states.[254] This step is more easily answered than the last. The FNHRA repeatedly states that the facilities *must* provide the services contained in the statute.[255] That usage imposes a mandatory, non-permissive obligation, as found by both the First and Third Circuits.[256]

Still, one could argue that because the minority of nursing facilities are government run, Congress could not have intended to bind the isolated instances of States providing nursing facility care.[257] It is true: only 6.8% of nursing home residents live in government-owned facilities.[258] Yet, the Supreme Court has not been convinced by such arguments that "invite speculation about ostensible marketplace realities."[259] In fact, the Court, by finding that the FNHRA can be enforced by § 1983, has implicitly determined that the FNHRA does impose binding regulations on the States.[260] Following this analysis, with *Gonzaga* and all the *Blessing* factors now satisfied, this Note has shown that the quality of life provisions *can* be enforced via § 1983.[261]

B. The Need for Private Quality of Life Enforcement

Beyond the ability to be enforced, the quality of life provisions of the FNHRA should be enforced because the current remedial systems surrounding nursing facilities fail to meaningfully impact resident quality of life and the FNHRA is the most prominent statute allowing for such protections. Furthermore, vulnerable residents should be emboldened with a means to protect their rights to quality of life.

254. Blessing v. Freestone, 520 U.S. 329, 340–41 (1997).
255. *See, e.g.*, 42 U.S.C. § 1396r(b)(1)(A)–(B).
256. *Grammer*, 570 F.3d at 528; Rolland v. Romney, 318 F.3d 42 at 55 (1st Cir. 2003).
257. *See* Health & Hosp. Corp. of Marion Cnty. v. Talevski, 599 U.S. 166, 190 (2023).
258. NAT'L CTR. FOR HEALTH STAT., *supra* note 22, at 8–9 (2022).
259. *Talveski*, 599 U.S. 166 at 190.
260. *See id.* at 186.
261. *See supra* Section III.A.

1. THE FAILURE OF THE FNHRA'S REMEDIAL SYSTEM

The FNHRA's current remedial system fails to consistently and thoroughly support quality of life for nursing facility residents. The FNHRA's internal enforcement scheme requires states to perform inspections on their facilities to ensure compliance with the FNHRA, issue citations to those with deficiencies, and impose other sanctions or punishments as a result of that failure.[262] Despite many of the positives the FNHRA has brought with it, the reality is that ninety-five percent of nursing facilities are still cited for deficiencies,[263] sixty-seven percent are subject to civil monetary penalties,[264] and within a given year, up to twenty-nine percent of facilities are cited for a deficiency relating to quality of life.[265] Specifically, compared to not-for-profit and government nursing facilities, for-profit facilities have the most total deficiencies, the most deficiencies causing harm or jeopardy to their residents, and the lowest staffing levels.[266]

Those already staggering numbers may not even tell the whole story: there have been—and continue to be—widespread fluctuations among the states in the number of citations, the accuracy of citations, and the enforcement of citations.[267] Right now, serious deficiencies in nursing facilities go unreported because of sporadic and incomplete surveys.[268] Current surveys and citations often fail to accurately report

262. Harkins III, *supra* note 131, at 100.

263. *Percent of Certified Nursing Facilities with Deficiencies*, KFF (July 2024), https://www.kff.org/other/state-indicator/nursing-facilites-with-zero-deficiencies/ [https://perma.cc/XPL9-HV9].

264. *Percent of Certified Nursing Facilities with Civil Monetary Penalties*, KFF (July 2024), https://www.kff.org/other/state-indicator/percent-of-certified-nursing-facilities-with-civil-monetary-penalties/ [https://perma.cc/9WV8-SNVS].

265. *Percent of Certified Nursing Facilities with Top Ten Deficiencies*, KFF (July 2023) https://www.kff.org/other/state-indicator/percent-of-certified-nursing-facilities-with-top-ten-deficiencies-2014/ [https://perma.cc/XPL9-HV9].

266. *See generally* GOV'T ACCOUNTABILITY OFF. NURSING HOMES: PRIVATE INVESTMENT HOMES SOMETIMES DIFFERED FROM OTHERS IN DEFICIENCIES, STAFFING, AND FINANCIAL PERFORMANCE, GAO-11-571 (2011) (finding that for profit nursing facilities have more cited deficiencies than nonprofit facilities).

267. Harkins III, *supra* note 131, at 103–04; WIENER ET AL., *supra* note 114, at 34; Papke, *supra* note 19, at 215.

268. WIENER ET AL., *supra* note 114, at 34; Papke, *supra* note 19, at 210.

concerns relating to quality of life.[269] Overall, the FNHRA's remedial system does not meaningfully address quality of life concerns.[270]

Even when citations are actually issued, the penalties attached are rarely sufficient to elicit change.[271] Sanctions are routinely delayed or go unimposed, and poor-quality facilities cycle in and out of compliance.[272] Nursing facilities cited for violations related to discharge and eviction receive penalties so minimal that some prefer to risk the chance of being penalized rather than comply with the law.[273] Again, under the current structure, facilities would literally rather pay money and violate residents' rights than comply with the law.[274]

Enforcement of the FNHRA is even more troublesome in assisted-living facilities.[275] In at least half of the fifty states, the state agencies responsible for enforcing nursing facility regulations were more focused on nursing homes than on assisted-living facilities.[276] In several states, assisted-living facilities are inspected less frequently than nursing homes, and, when deficiencies are found, the agencies do not enforce penalties.[277] Assisted-living facilities consistently lack regular reporting of information concerning quality of life: for example, only a

269. Even the Centers for Medicare & Medicaid Services' 5-Star rating system for nursing homes (where a higher rating supposedly means higher quality) does not accurately reflect the quality of life of the residents in those facilities—higher rating on their scale does not translate to higher quality of life for the residents. *See Five-Star Quality Rating System*, CTRS. FOR MEDICARE & MEDICAID SRVS., DEPT. OF HEALTH & HUM. SERVS. (Jan. 7, 2022), https://www.cms.gov/medicare/health-safety-standards/certification-compliance/five-star-quality-rating-system [https://perma.cc/J5XB-6P4L]; Sun Jung Kim, Eun-cheol Park, Sulgi Kim, Shuncichi Nakagawa, John Lung, Jong Bum Choi, Woo Sang Ryu, Too Jae Min, Hyun Phil Shin, Kyudam Kim & Ji Won Yoo, *The Association Between Quality of Care and Quality of Life in Long-Stay Nursing Home Residents with Preserved Cognition*, 15 J. AM. MED. DIRS. ASS'N. 220, 224 (2014).

270. Tetyana Pylypiv Shippee, Romil R. Parikh, Yinfei Duan, John R. Bowlis, Mark Woodhouse & Teresa Lewis, *Measuring Nursing Home Quality of Life: Validated Measures Are Poorly Correlated with Proxies from MDS and Quality of Life Deficiency Citations*, 24 J. AM. MED. DIRS. ASS'N. 718, 721 (2023).

271. Papke, *supra* note 19, at 210.

272. WIENER ET AL., *supra* note 114, at 34.

273. Papke, *supra* note 19, at 210.

274. *See id.*

275. *See generally* Brian Kaskie, Lili Xu, Seamus Taylor, Lindsey Smith, Portia Cornell, Wenhan Zhang, Paula Carder & Kali Thomas, *Promoting Quality of Life and Safety in Assisted Living: A Survey of State Monitoring and Enforcement Agents*, 79 MED. CARE RSCH. & REV. 736 (2022) (analyzing regulatory enforcement of assisted living facilities).

276. *Id.* at 734.

277. *See id.* at 736.

quarter of states require those communities to report falls.[278] Most states offer no assistance understanding legislative requirements to assisted-living providers, compounding the issue by failing to educate.[279] Almost half of those state agencies have no allocated budget for the enforcement of these statutes to begin with, and most states have no distinct allocation for the specific enforcement of assisted-living facility laws.[280]

This lackluster enforcement of the FNHRA fails to incentivize facilities to promote quality of life.[281] To no surprise, then, it has a limited impact on residents' quality of life.[282] The same problems that spawned the creation of the FNHRA are still around despite its creation,[283] and any attempts to improve the survey process die in Congress.[284]

2. COMPARABLE STATUTES FAIL TO ENHANCE RESIDENT QUALITY OF LIFE

Beyond the FNHRA, enforcement of protections generally for the vulnerable populations in nursing facilities is uniformly poor.[285] In most cases, elder abuse statutes fail to minimize such abuse.[286] Criminal elder abuse fails to be routinely reported,[287] to be effectively prosecuted,[288] and arguably to be properly punished.[289]

Indeed, civil litigation may be more impactful than criminal, because such litigation shows that residents, when empowered, will fight for their safety and can make meaningful change.[290] Historically, the FNHRA has enabled more ready access to the courts to rectify abuse in nursing facilities.[291] It was only at the turn of the last century, after the

278. *Id.*
279. *Id.*
280. *Id.* at 735–36.
281. *See* Harkins III, *supra* note 131, at 143–44.
282. *See* Papke, *supra* note 19, at 212.
283. *See* COMM. ON NURSING HOME REGUL., *supra* note 115, at 21–25.
284. *See* Nursing Home Improvement and Accountability Act of 2021, S. 2694, 117th Cong. § 104 (2021).
285. *See generally* David Ray Papke, *Good Intentions Are Not Enough: A Critique of Elder Abuse Law*, 31 ELDER L.J. 279 (2024) (arguing that current statues and prosecutions of elder abuse are ineffective in its prevention, indicated by growing occurrences of elder abuse in the United States).
286. *Id.* at 305–07.
287. *Id.* at 286–91.
288. *Id.* at 291–98.
289. *Id.* at 299–305.
290. *See* Steven M. Levin, David B. Wilson & Jane A. Volberding, *Protecting the Rights of Nursing Home Residents Through Litigation*, 84 ILL. BAR J. 36, 36 (1996).
291. *See id.*

FNHRA went into effect, when courts began to see more nursing facility tort litigation.[292] That litigation has brought results: residents have litigated issues that successfully changed the FNHRA survey process while Congress routinely fails to accomplish the same goal.[293]

The FNHRA is the only current statute that can adequately protect residents' quality of life: only five states—Alabama,[294] Kansas,[295] New York,[296] West Virginia,[297] and Vermont[298]—have a dedicated statute outlining a resident's right to quality of life.[299] Adjacent laws, like elder abuse statutes, are more focused on malicious actions against one specific person.[300] While such statutes address physical abuse, psychological abuse, financial exploitation, neglect, or sexual abuse, they do not encompass issues of daily life for residents.[301]

Residents know what issues they have and how they are being harmed.[302] No one understands the impact a living facility has on its residents more than the residents themselves.[303] By enabling those residents to push back against a facility that denies them the ability to live a truly full life, we open up the most effective means to enforce quality of life.

3. RESIDENTS NEED AN AVENUE TO ENFORCE THEIR AUTONOMY

The overarching problem residents have with nursing facilities comes down to autonomy and choice.[304] Consider the immense number of choices an individual makes every day: what to have for breakfast, lunch, and dinner; who to socialize with; what hobbies to have; what events to go to; how to spend downtime; what entertainment to consume. Those are the choices that make life worth living, and being able to make such choices directly benefits an individual's health.[305] Yet, for

292. *See id*.
293. *See* Harkins III, *supra* note 114, at 138–41; Nursing Home Improvement and Accountability Act of 2021, S. 2694, 117th Cong. § 206 (2021).
294. ALA. ADMIN. CODE § 420-5-10-.08 (1999).
295. KAN. ADMIN. REGS. § 28-39-153 (1997).
296. N.Y. COMP. CODES R. & REGS. tit. 10, § 415.5 (1996).
297. W. VA. CODE R. § 64-13-5 (2021).
298. VT. ADMIN. CODE R. § 12-4-200:4 (2018).
299. *See also* D.C. MUN. REGS. tit. 22-B, § 10109 (2020).
300. *See, e.g.*, 720 ILL. COMP. STAT. 5/12-4.4a (2024).
301. *See id.*
302. *See* Shippee et al., *supra* note 270, at 722.
303. *See* Degenholtz et al., *supra* note 26, at 5.
304. *See supra* Section II.A.
305. *See* COE ET AL., *supra* note 26, at 20.

a nursing facility resident, those everyday choices are almost entirely beyond their control.[306] Without any genuine choice in their quality of life, the only way they can improve their quality of life is by addressing their concerns with the facilities. When the facilities routinely ignore their voices or fail to adequately remedy their concerns, FNHRA litigation is necessary to allow residents to make a genuine impact on their own quality of life.

C. Who, What, and How of Quality of Life Litigation

Having established that the FNHRA's quality of life provisions are § 1983 enforceable, the analysis turns next to exactly who potential defendants would be, what actions may create liability, and how plaintiffs can assert their claims effectively.

1. WHO THE FNHRA CAN BE PRIVATELY ENFORCED AGAINST

To prevail on any § 1983 claim, the defendant must have been acting under color of state law when it deprived a plaintiff of their rights.[307] Thus, any nursing facility acting under color of state law would be potentially liable.[308] However, the kinds of parties that can be subject to a § 1983 suit are limited.[309] States, territories, and their agencies cannot be liable through § 1983 due to sovereign immunity concerns, but municipalities and local government units can be.[310] Still, local governments are not liable for the actions of its employees alone and must itself cause the harm.[311] State officials may be sued in their personal capacity under § 1983, and municipal government officials can be sued in both their personal and official capacity.[312] Thus, a local or municipal government that runs a nursing facility could be liable through an appropriate theory of liability.[313]

306. Ball et al., *supra* note 8, at 320.
307. SCHWARTZ, *supra* note 145, at 75.
308. 42 U.S.C. § 1983.
309. SCHWARTZ, *supra* note 145, at 87–90.
310. *Id.*
311. Monell v. Dep't of Soc. Servs. of New York, 436 U.S. 658, 691, 694 (1978) ("[A] municipality cannot be held liable under § 1983 on a respondeat superior theory . . . . [I]t is when execution of a government's policy or custom . . . inflicts the injury that the [local] government as an entity is responsible under § 1983.").
312. SCHWARTZ, *supra* note 145, at 87.
313. *See* Schlaybach v. Berks Heim Nursing & Rehab., 434 F. Supp. 3d 342, 350 (E.D. Pa. 2020), *aff'd*, 839 F. App'x 759, 760 (3d Cir. 2021).

The door is theoretically open for an argument that a private party acting in accordance with Medicare and Medicaid requirements acts under color of law.[314] Courts, however, have not entertained such a notion under multiple theories of "state action."[315] Although the Fourth Circuit once found a sufficient nexus between the "congressional purpose of providing health care" and the actions of private medical providers funded by the government to be considered state action, it has since reneged.[316] Thus, even private nursing facilities with substantial government support through Medicaid are unlikely to be considered acting under color of state law.[317]

2. WHAT ACTIONS ARE GROUNDS FOR LIABILITY

There are two primary types of state action that could create liability for government owned nursing facilities.[318] First, the policy or custom of a government unit can create grounds for liability, should that policy or custom deprive a citizen of a federal right.[319] Some choices made by high-ranking municipal officials can be grounds for municipal liability, as such a choice is treated effectively the same as a policy.[320] To trigger liability, a policy or custom must have objective "deliberate indifference" to the individual's right.[321] Deliberate indifference refers

314. *See* David S. Douglas, David Feinberg, Robin Jacobson & Alice B. Stock, *Rx for the Elderly: Legal Rights (and Wrongs) Within the Health Care System*, 20 HARV. C.R.-C.L. L. REV. 425, 477 (1985); *see* Johnson v. Rodrigues, 293 F.3d 1196, 1203 (10th Cir. 2002) (indicating that running a nursing facility is "traditionally the exclusive prerogative of the state").

315. *E.g.*, Alexander v. Pathfinder, Inc., 189 F.3d 735, 740 (8th Cir. 1999) ("[The defendant] is a private corporation and the fact that it receives Medicaid funds does not convert it into a state actor."); Cape Cod Nursing Home Council v. Rambling Rose Rest Home, 667 F.2d 238, 240 (1st Cir. 1981) (holding no state action arose under the "company town" rationale as presented in Marsh v. Alabama, 326 U.S. 501 (1946)); Hodge v. Paoli Mem'l Hosp., 576 F.2d 563, 564 (3d Cir. 1978) (collecting cases).

316. *See generally* Modaber v. Culpeper Mem'l Hosp., Inc., 674 F.2d 1023, 1027 (4th Cir. 1982) (finding no nexus between the state and medical providers utilizing Medicaid or Medicare funds based on Jackson v. Metro. Edison Co., 419 U.S. 345, 351 (1974)).

317. *See* Blum v. Yaretsky, 457 U.S. 991, 1007–09 (1982); *see* SCHWARTZ, *supra* note 145, at 84–85.

318. *See* SCHWARTZ, *supra* note 145, at 100–11.

319. *Id.* at 100–11; Ponzini v. PrimeCare Med., Inc., 269 F. Supp. 3d 444, 526 (M.D. Pa. 2017), *aff'd by, in part, vacated by, in part, sub nom.* Ponzini v. Monroe Cnty., 789 F. App'x 313 (3d Cir. 2019).

320. SCHWARTZ, *supra* note 145, at 109–12 (discussing Connick v. Thompson, 563 U.S. 51 (2011)).

321. *Id.*

to a choice made "without regard to known or obvious consequences."[322] The alleged harm must be attributable to a policy of the facility,[323] and the plaintiff must show *how* the policy was inadequate in a way that led to harm.[324] In the context of a nursing home facility, policies regarding dining, activities, and how staff interact with residents could potentially open the door to liability if those policies are not aligned with the FNHRA and CFR.

Second, a government unit's failure to train and/or supervise its employees (but not the actions of its employees alone) can make that unit liable.[325] Under this theory, there must also be a deliberate indifference to the rights of people who will interact with the government employees, or a conscious decision to disregard those rights.[326] A plaintiff will need to establish a pattern of rights violations by the inadequately trained employees.[327] They will also likely need to show some notice that the training is insufficient, i.e., the facility is aware it is causing the residents harm.[328] Again, plaintiffs will need to show "specific deficiencies" in the facility's training in order to impose liability.[329] This means that nursing facilities could be liable for failing to train their employees to protect, preserve, and promote a resident's quality of life as required by the FNHRA.

Under either of these theories, the plaintiff must be able to show that the inadequate training, policy, or custom directly resulted in the harm, and that the injury could have been avoided if the employee were not deficiently trained, or that policy/custom had not been in place.[330] The evidence must show not only that a different policy or better training would have reduced the risk of a rights deprivation, but also that the injury would have been avoided altogether if the policy had not been in place or if the employee had not undergone deficient training.[331] Evidence that the inadequate training, policy, or custom only increases the possibility of harm is insufficient, so plaintiffs must show that a

322. *PrimeCare Med., Inc.*,, 269 F. Supp. 3d at 529.
323. Robinson v. Fair Acres Geriatric Ctr., 722 F. App'x 194, 198 (3d Cir. 2018).
324. *See id*.
325. SCHWARTZ, *supra* note 145, at 100–11; *PrimeCare Med., Inc*., 269 F. Supp. 3d at 526.
326. City of Canton v. Harris, 489 U.S. 378, 389 (1989).
327. *PrimeCare Med., Inc*., 269 F. Supp. 3d at 526.
328. *See id*.
329. *Id.* at 527.
330. *Id.* at 530.
331. *Id.*

deprivation of rights was the "plain[,] obvious consequence" of that failure.[332] Litigation through the FNHRA would then need to show that the violation of a resident's right to quality of life was the obvious consequence of the nursing facility's policy, custom, or training.

3. HOW: CURRENT STATE OF QUALITY OF LIFE LITIGATION

Currently, these provisions can be enforced by residents living within the Third Circuit (Pennsylvania, New Jersey, and Delaware).[333] The First Circuit (Maine, New Hampshire, Massachusetts, Rhode Island, and Puerto Rico) has suggested the quality of life provisions do create a right, so its residents can likely enforce these provisions.[334] The Second,[335] Seventh,[336] and Ninth Circuits have shown previous support for the FNHRA's enforceability generally,[337] which creates a strong argument for the residents of those circuits (Arizona, California, Connecticut, Idaho, Illinois, Indiana, Montana, Nevada, New York, Oregon, Vermont, Washington, and Wisconsin) seeking to enforce the quality of life provisions.[338] Residents in other states can, of course, still assert claims under the FNHRA based on the findings in *Talevski*.[339]

The docket of the Third Circuit, which held the FNHRA's quality of life provisions are enforceable,[340] provides insight into how the quality of life provisions are being enforced.[341] Currently, while plaintiffs' complaints cite the quality of life provisions, their allegations do not specifically arise out of the rights given by those provisions.[342]

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332. *Id.* at 528.

333. Grammer v. John J. Kane Reg'l Centers-Glen Hazel, 570 F.3d 520, 525 (3d Cir. 2009).

334. Rolland v. Romney, 318 F.3d 42, 53 n.10 (1st Cir. 2003).

335. Concourse Rehab. & Nursing Ctr. Inc. v. Whalen, 249 F.3d 136, 143–47 (2d Cir. 2001).

336. Talevski *ex rel.* Talevski v. Health & Hosp. Corp. of Marion Cnty., 6 F.4th 713, 718–21 (7th Cir. 2021), *aff'd sub nom.* Health & Hosp. Corp. of Marion Cnty. v. Talevski, 599 U.S. 166, (2023).

337. Anderson v. Ghaly, 930 F.3d 1066, 1073–80 (9th Cir. 2019).

338. 48 U.S.C. § 41 (explaining the geographic bounds of the Circuits).

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

340. Grammer v. John J. Kane Reg'l Centers-Glen Hazel, 570 F.3d 520, 525 (3d Cir. 2009).

341. *See id.*

342. Complaint at 15, Raph v. Cnty. of Northampton, Gracedale Nursing Home, No. 5:22-cv-03064 (E.D. Pa. Aug 3, 2022); Complaint at 17, Beaty v. Fair Acres Geriatric Ctr., No. 2:21-cv-01617 (E.D. Pa. Apr. 6, 2021); Complaint at 18–19, Alexander v. Fair Acres Geriatric Ctr., No. 2:20-cv-02550 (E.D. Pa. May 29, 2020).

Instead, in most of these lawsuits, the violation of the quality of life provisions is tucked in amongst dozens of other allegations.[343] Current litigation focuses on standard negligence by the nursing facility, alleging medical harms like ulcers, bedsores, significant weight loss, infection, or at worst, wrongful death.[344] As such claims are more akin to state torts law, federal courts prefer such claims go through the appropriate state courts.[345]

The docket also provides valuable insight into what claims will be heard before a court.[346] In order to state a claim under § 1983, the plaintiff must allege the specific harm suffered and that it was directly caused by the state action.[347] Residents will have to show how their quality of life was actually diminished because of the facility.[348] General allegations regarding a facility's suboptimal standards or procedures, or simply stating a nursing facility failed to provide care in the way dictated by the FNHRA, are insufficient to state a claim.[349] Examples of specific allegations that do adequately state a claim are: alleging that the facility failed to provide "sufficient staff" to meet resident needs, failed to prevent or document alleged harm, failed to create policies that would avoid alleged harm, or allowed other staff to perform tasks that regulations require nurses or physicians to perform.[350] Potential plaintiffs will need to allege specifically how the facility violated their FNHRA rights rather than simply stating there was a violation thereof.[351]

343. *E.g.*, Complaint at 9–13, *Raph*, No. 5:22-cv-03064 (E.D. Pa. Aug 3, 2022); Complaint at 13–19, *Beaty*, No. 2:21-cv-01617 (E.D. Pa. Apr. 6, 2021); Complaint at 10–15, *Alexander*, No. 2:20-cv-02550 (E.D. Pa. May 29, 2020).

344. *E.g.*, Complaint at 9–13, *Raph*, No. 5:22-cv-03064 (E.D. Pa. Aug 3, 2022); Complaint at 13–19, *Beaty*, No. 2:21-cv-01617 (E.D. Pa. Apr. 6, 2021); Complaint at 10–15, *Alexander*, No. 2:20-cv-02550 (E.D. Pa. May 29, 2020).

345. *See* Massey v. Fair Acres Geriatric Ctr., No. CV 09-3170, 2011 WL 13380506, at *4–6 (E.D. Pa. May 3, 2011) ("Plaintiff appears to be using Section 1983 to assert a state law negligence claim, but the proffered evidence falls short of a federal constitutional claim.").

346. *See, e.g.*, Robinson v. Fair Acres Geriatric Ctr., 722 F. App'x 194, 197–98 (3d Cir. 2018).

347. *Id.*; Thomas v. Westmoreland Cnty., No. CV 20-1903, 2021 WL 1627725, at *3–4 (W.D. Pa. Apr. 27, 2021).

348. Schlaybach v. Berks Heim Nursing & Rehab., 434 F. Supp. 3d 342, 351, 358 (E.D. Pa. 2020), *aff'd*, 839 F. App'x 759 (3d Cir. 2021). *See Thomas*, 2021 WL 1627725, at *3–4.

349. *Robinson*, 722 F. App'x at 198; *Schlaybach*, 434 F. Supp. 3d at 354; *Thomas*, 2021 WL 1627725, at *3–4.

350. *Robinson*, 722 F. App'x at 197.

351. *Schlaybach*, 434 F. Supp. 3d at 358.

The Third Circuit's docket also provides insight as to the kinds of evidence that will support § 1983 claims.[352] Expert testimony regarding how the policies and procedures cause harm to the residents would support a claim.[353] Previous citations from an investigating body showing deficiencies of the facility are insufficient alone to make a claim,[354] but they may be used to show that the facility was aware its policies or training failed to prevent harm.[355] Evidence that staff were either unavailable or not available often enough can show causation, if the alleged harm arose from their absence.[356]

IV. Recommendation

This Note urges Congress to explicitly create a private remedy internal to the FNHRA so residents of all nursing facilities, regardless of what entity owns or operates it, can independently protect their rights. Furthermore, this Note proposes a model of what potential quality of life litigation could look like.

A. Remedy the Discrepancy Created in *Talevski*

While *Talevski* made clear that the FNHRA can be enforced through § 1983, a problem remains: only 6.8% of nursing home residents live in government-owned facilities.[357] Because § 1983 is limited to those acting under color of state law,[358] the FNHRA can only be enforced by those 6.8% of nursing facility residents.[359] The law is thus uneven: residents in the government-owned facilities, the small minority, can enforce their rights, but those in private facilities, the large majority, cannot.[360] This issue is not limited exclusively to the quality of life provisions discussed in this Note; it is relevant to any FNHRA suits arising

352. *See, e.g.*, Ponzini v. PrimeCare Med., Inc., 269 F. Supp. 3d 444, 527 (M.D. Pa. 2017).

353. *PrimeCare Med., Inc.*, 269 F. Supp. 3d at 553, *aff'd by, in part, vacated by, in part, sub nom.* Ponzini v. Monroe Cnty., 789 F. App'x 313 (3d Cir. 2019); Est. of Will v. Neshaminy Manor, Inc., No. 11-CV-5482, 2013 WL 1187085, at *9 (E.D. Pa. Mar. 21, 2013).

354. *Schlaybach*, 434 F. Supp. 3d at 354; *Thomas*, 2021 WL 1627725, at *3–4.

355. *Robinson*, 722 F. App'x at 200.

356. *See id.*

357. NAT'L CTR. FOR HEALTH STAT., *supra* note 22, at 8–9.

358. 42 U.S.C. § 1983.

359. NAT'L CTR. FOR HEALTH STAT., *supra* note 22, at 9 fig.4.

360. *See id.*

under § 1983.[361] The remedy to this discrepancy is to create a way for residents of private nursing facilities to enforce the same FNHRA rights as their peers in government-owned facilities.

Two reasons compel this recommendation. First, as previously discussed, for-profit homes are of overall lower quality than non-for profit or government facilities.[362] The need for such enforcement, therefore, is *higher* in those for-profit facilities benefiting from federal funds.[363] Additionally, the government's involvement in the nursing facility industry is immense.[364] Because the government is largely responsible for the widespread prevalence of nursing facilities by creating Medicare and Medicaid, it naturally follows that a government solution can remedy a government-spurred problem.[365]

Certainly, one remedy to the unevenness would be for courts to find that reliance on federal funds renders the operation of nursing facilities a state function.[366] In light of *Talevski*, there may be grounds to do just that.[367] Still, that would require overturning precedent across most circuits,[368] a lengthy and arduous process.[369] Alternatively, and more simply, Congress should explicitly amend the FNHRA to provide a remedial scheme for nursing facility residents to individually enforce their rights—including to quality of life. That would not only remedy the incongruency of the law but immediately enable the remaining ninety-three percent of nursing facility residents to protect their rights to quality of life.[370]

B. Model of Potential Quality of Life Litigation

The following lays out potential claims residents may make when enforcing their quality of life rights. Unique when compared to similar claims, quality of life litigation inherently lends itself to class or mass

361. Health & Hosp. Corp. of Marion Cnty. v. Talevski, 599 U.S. 166, 175–80 (2023).
362. GOV'T ACCOUNTABILITY OFF., *supra* note 266, at 16.
363. *See id.*
364. Mollot, *supra* note 112.
365. *See* Johnson v. Rodrigues, 293 F.3d 1196, 1203 (10th Cir. 2002).
366. *See id.*
367. *See* Health & Hosp. Corp. of Marion Cnty. v. Talevski, 599 U.S. 166, 175–80 (2023).
368. *See supra* Section III.B.1.
369. *E.g.*, United States v. Reyes-Hernandez, 624 F.3d 405, 412–13 (7th Cir. 2010).
370. *See* NAT'L CTR. FOR HEALTH STAT., *supra* note 22, at 9.

actions.[371] A quality of life claim against an entire facility may be targeting an issue that affects the entire body of residents.[372] Therefore, residents could likely satisfy class action certification requirements.[373] While an individual resident alone may not be able to afford an attorney, the class could bear that weight, especially when an attorney works on a contingency basis.[374] With an entire class of persons whose federal rights have been violated, civil litigation becomes more practical: while the damages for one resident might be minimal, the damages for an entire group of nursing home residents are naturally much larger, making it easier for plaintiffs' attorneys working on contingency fees to assert the claims.[375] Recommendations are also provided for nursing facilities regarding changes to policy that may reduce the likelihood of such a lawsuit.

1. FOOD SATISFACTION

Regarding mealtimes, residents' rights are violated if (1) they are not served food that is palatable; (2) the food is not prepared in a way that preserves nutrition, flavor, and appearance; or (3) there are no options provided for residents wanting other food.[376] While hyperbolic, an example of such a violation would be if residents were served exclusively a gray, droll slop that contains all the vitamins and nutrients needed to survive–this clearly would not be "palatable" food nor is it prepared in a way preserving flavor or appearance, despite it checking every box needed nutritionally.[377] For a more practical example, if most residents dislike the food that is regularly served at these facilities, have expressed such distaste to the administration, and the administration refuses to change its offerings, those residents may sue the facility.[378] Similarly, residents have a claim if there is some fundamental error in where the facility gets its food, how it prepares its food, or how it serves its food that results in the food becoming unpalatable to a reasonable

371. *See* Dunakin v. Quigley, 99 F. Supp. 3d 1297, 1324–34 (W.D. Wash. 2015) (certifying a class of residents across nursing facilities alleging violations of the FNHRA).
372. *Id*. at 1328–31.
373. FED. R. CIV. P. 23.
374. *See* Papke, *supra* note 285, at 295.
375. *See id*.
376. 42 U.S.C. § 1396r(b)(4)(A)(iv); 42 C.F.R. § 483.60(d) (2024).
377. *See* 42 U.S.C. § 1396r(b)(4)(A)(iv); 42 C.F.R. § 483.60(d) (2024).
378. *See* 42 U.S.C. § 1396r(b)(4)(A)(iv); 42 C.F.R. § 483.60(d) (2024).

resident.[379] Still, there is some degree of tolerance a resident must have: it is unlikely that a single resident could claim a rights violation for simply not enjoying the food.[380] However, if a facility does not provide food that meets the dietary needs of a resident, such as providing low-salt or gluten-free food, the resident can enforce their right to such food under § 1983.[381]

Residents also have § 1983 enforceable rights regarding how they are provided food.[382] Residents' meals must be offered three times a day, must be offered at regular times, and must be offered according to resident needs and wants.[383] If those requirements are not met, the facility has violated the residents' rights, and those residents can file suit.[384] The same is true if a facility offers an extremely limited menu that seldomly changes, such as only serving one dish for every meal for an extended period of time.[385] Residents should also know that the facility is required to offer meals or snacks to residents who want to eat at different times.[386] If a facility continues to exclusively serve food at designated mealtimes over the complaints of residents, a rights violation has occurred, and residents harmed by that choice can sue the facility for such an offense.[387]

Turning to what facilities should do to ensure they preserve a resident's rights, it is paramount that facilities provide residents reasonable choices in what and when they eat. The resident's right is not only to be served food but to be served food in a way that will nourish and enrich their physical and mental well-being.[388] Facilities can ensure this end is met by considering what food they are serving and how they are serving it, making sure to conform their offerings with the preferences of their residents.[389] While the feedback may be variable depending on each resident's own preferences, it is important for the staff to make their best efforts to provide residents with food that most of them will

379. *See* 42 U.S.C. § 1396r(b)(4)(A)(iv); 42 C.F.R. § 483.60(d) (2024).
380. *See* 42 C.F.R. § 483.60 (2024).
381. 42 U.S.C. § 1396r(b)(4)(A)(iv).
382. *See* 42 C.F.R. § 483.60(d) (2024).
383. *Id.* § 483.60(f) (2024).
384. *See supra* Section III.A.
385. *See* 42 C.F.R. § 483.60(c)(5) (2024).
386. *Id.* § 483.60(f) (2024).
387. *See supra* Section III.A.
388. 42 U.S.C. § 1396r(b)(2).
389. 42 C.F.R. § 483.60 (2024) ("The facility must provide each resident with a . . . [diet] taking into consideration the preferences of each resident.").

enjoy. Dining managers should consider doing regular surveys of the residents to see what those residents enjoy about mealtimes and what they want to see changed. If pre-made or pre-prepared food is being served on a regular basis, staff should consider buying raw ingredients and preparing more traditional "home-cooked" style meals.

Facilities must take care with when and how they provide meals.[390] Dining staff should review whether meals are offered too infrequently or at odd times based on the preferences of the residents.[391] Staff should also consider how food will be made available for residents outside of regular mealtimes and provide at least some access to snacks in the intervening hours,[392] especially for people who might need to take medicine with their food, like certain residents at Deer Path.[393] A practical example that allows food to be offered even when dining staff are unavailable would be providing a vending machine full of snacks and allowing residents a monthly allowance to pull food from it at no additional cost.

2. MEANINGFUL ACTIVITIES

Residents can also sue if their facility fails to provide them activities that are of their interest and to their betterment.[394] If a resident is unable to participate in the large majority of activities offered by the facilities due to physical limitations, they have been effectively denied their right to participate in the activities program.[395] If activities are accessible but are offered at times grossly inconvenient or impossible for the residents, like over the lunch period or in the middle of the night, residents could also sue the facility for a rights violation.[396]

Residents should be aware of their right to choose activities within their interests.[397] A program that deliberately fails to meaningfully engage with its residents can be liable.[398] If the facility actively refuses to

390. *See id.* § 483.60.
391. *See id.* § 483.60(f)(1) (2024).
392. *See id.* § 483.60(f)(3)(2024); 42 U.S.C. § 1396r(b)(2), (4)(A)(iv).
393. *See supra* Section II.A.1.
394. *See* 42 U.S.C. § 1396r(b)(4)(A)(v) (2021); 42 C.F.R. § 483.24(c) (2016).
395. 42 C.F.R. § 483.10(f)(1) (2024).
396. *Id.* ("[R]esident[s have] a right to choose activities [and] schedules (including sleeping and waking times) . . . consistent with his or her interests.").
397. 42 U.S.C. § 1396r(c)(1)(A)(v) (stating that a resident has the right "to . . . receive services with reasonable accommodation of individual needs and preferences"); 42 C.F.R. §§ 483.24(c), 483.10(f)(1) (2024).
398. *See* City of Canton, Ohio v. Harris, 489 U.S. 378, 389 (1989) (regarding deliberate indifference).

account for a resident's preferences, such as intentionally not soliciting or listening to feedback, that begins to amount to a rights violation.[399] Does that mean a nursing facility is liable for not offering to host a showing of *Wayne's World* after the request of one resident? Likely not. While a program must account for interests of its residents when designing and offering activities, there is no requirement that a facility obey every specific wish for an activity. [400]

Activities staff should accommodate the limitations of their residents.[401] Most residents have at least some restrictions on the activities they can participate in,[402] and the activities offered should be reflective of the ability of the residents (e.g., chair yoga, not kickboxing). Events should be offered at different times of the day to make sure that all residents have an option to attend regardless of their schedules. If an event is usually only offered once a week on the same day and at the same time, staff should try to provide at least one alternative time for that activity.

To ensure facilities keep their activities in accordance with residents' interests,[403] activities staff should have regular check-ins with their residents to receive feedback on the activities being offered. Such feedback is especially important from those residents who do not participate in activities, because like the resident at Deer Path who came out of his shell after joining the Dungeons & Dragons group, the reason a resident does not participate in activities might be that they have wants that are not currently being met.[404] That feedback will enable activities staff to provide an activities schedule well-tailored to the wants and needs of residents.

Facilities at large should also be aware of structural issues that may arise from the activities program. For instance, a facility cannot in any way charge residents for access to the activities program, as such action would violate the residents' rights.[405] More practically, facilities should consider the number of activities staff they have available and whether that staff is sufficient to offer the kind of activities and number

399. *See* 42 U.S.C. § 1396r(b)(4)(A)(v); 42 C.F.R. § 483.10(f)(1) (2024).
400. *See* 42 U.S.C. § 1396r(b)(4)(A)(v); 42 C.F.R. § 483.10(f)(1) (2024).
401. *See* 42 U.S.C. § 1396r(b)(4)(A)(v); 42 C.F.R. § 483.10(f)(1) (2024); 42 C.F.R. § 483.24(c)(1) (2024).
402. *See* Bangerter, *supra* note 32, at 482–83.
403. 42 U.S.C. § 1396r(b)(4)(A)(v); 42 C.F.R. § 483.10(f)(1), (3) (2024).
404. *See supra* Section II.A.2.
405. 42 C.F.R. § 483.24(c) (2024).

of activities needed to meet the needs and wants of the residents.[406] Managers should also consider how the activities staff is trained and ensure staff are receptive to the accessibility concerns of the residents and considerate of residents' interests when offering activities.[407]

3. QUALITY INTERACTION WITH STAFF

Residents could also sue if they are not treated with respect and dignity or if the facility does not encourage their independence and interaction in the community.[408] Practically, that means that facilities must allow their staff to interact with the residents and engage in meaningful discussion with them.[409] For example, a nursing facility could not maintain a policy that forbade staff from making any small talk or talking with residents at all except for clinical matters without violating their right to respect.[410] Residents can sue the facility if a policy were in place that restricted the length of time staff could converse with residents or that explicitly discouraged staff to engage with them.[411] While not related to staff, residents could also sue if the facility fails to encourage interactions between residents by not providing common spaces to talk or opportunities for residents to interact with one another, such as during activities or mealtimes.[412]

Again, tolerance is a limitation to such suits. If one staff member is particularly disrespectful to a resident, that alone cannot establish liability under the FNHRA because the municipality cannot be liable for its employees actions alone.[413] However, if a resident could show that the staff member was only treating residents in such a way as the direct cause of a failure to supervise that employee, that resident can sue the facility.[414] For example, if a staff member was particularly cruel to a

406. *Id.* § 483.10(f)(3) (2024); Robinson v. Fair Acres Geriatric Ctr., 722 F. App'x 194, 199 (3d Cir. 2018).

407. *See* Ponzini v. PrimeCare Med., Inc., 269 F. Supp. 3d 444, 530 (M.D. Pa. 2017), *aff'd by, in part, vacated by, in part, sub nom.* Ponzini v. Monroe Cnty., 789 F. App'x 313 (3d Cir. 2019).

408. 42 U.S.C. § 1396r(b)(l)(A); 42 C.F.R. § 483.10(a)(1) (2024); *id.* § 483.24(c) (2024). *See also* 42 U.S.C. § 1396r(b)(1)(2).

409. *See* 42 U.S.C. § 1396r(b)(l)(A); 42 C.F.R. § 483.10(a)(1) (2024).

410. *See* 42 U.S.C. § 1396r(b)(l)(A); 42 C.F.R. § 483.10(a)(1) (2024).

411. *See PrimeCare Med., Inc.*, 269 F. Supp. 3d at 530, aff'd in part, vacated on other grounds in part sub nom. Monroe Cnty., 789 F. App'x 313.

412. 42 C.F.R. § 483.24(c) (2024). *See also* 42 U.S.C. § 1396r(b)(1), (2).

413. Monell v. Dep't of Soc. Servs. of NYC, 436 U.S. 658, 691, 694 (1978).

414. SCHWARTZ, *supra* note 145, at 100–11; *PrimeCare Med., Inc.*, 269 F. Supp. 3d at 526.

resident behind closed doors, humiliating them and degrading them, and the facility fails to monitor that staff member more closely after a resident's complaint, then the resident can likely sue the facility for a failure to supervise that employee.[415] Still, it is unlikely that a resident could sue because they simply do not get along with one of their caregivers. The right to respect is not violated because a staff member is lazy or apathetic; it is violated when a staff member has a deliberate indifference towards showing a resident respect.[416]

To ensure that facilities treat residents with dignity and respect, administrators should lay the framework for its staff to do so. Facilities should create a foundation upon which employees *can* engage meaningfully with residents.[417] That includes training staff in a way that enables them to treat residents with respect and providing enough staff so that the residents can have meaningful interactions with them.[418] Facilities should train staff to be patient and kind when talking to residents, and encourage staff to take time to listen to the residents if they have something they want to say.[419] Training should be offered not only during the onboarding process, but on a regular basis. Policies should be put into place requiring all staff to treat every resident with respect and dignity in a way that encourages communication between staff and residents in a natural, productive way.[420] Facilities should be operated in a way that allows residents and staff to have a meaningful relationship like Rusty and his board-gaming friend.[421]

415. *See PrimeCare Med., Inc.*, 269 F. Supp. 3d at 530.
416. *See id.*
417. *See id.*
418. *See* Robinson v. Fair Acres Geriatric Ctr., 722 F. App'x 194, 197 (3d Cir. 2018); *PrimeCare Med., Inc.*, 269 F. Supp. 3d at 527.
419. *See* 42 U.S.C. § 1396r(b)(l)(A); 42 C.F.R. § 483.10(a)(1) (2024).
420. *See* 42 U.S.C. § 1396r(b)(l)(A); 42 C.F.R. § 483.10(a)(1) (2024).
421. *See supra* Section II.A.3.

V. Conclusion

Residents of nursing facilities have a right to the highest quality of life possible. This Note has demonstrated their legal need to enforce that right, as well as the potential avenues that a resident may take to do so. It has provided a roadmap for any resident or group of residents who have been denied their rights to a quality of life and demonstrated multiple feasible claims that could be made against facilities. Further, this Note has provided facilities numerous ways to make simple changes in its policies, training of staff, and its offerings to residents that will exponentially increase resident satisfaction and quality of life. Most importantly, it has answered the poignant question Rusty asked: if a facility has violated a resident's rights under the FNHRA, then yes, a resident can and indeed should sue the place—just for the food.