IN THE SUPREME COURT
STATE OF GEORGIA

UNITED HEALTH SERVICES OF GEORGIA, INC., et al.,	)	
Defendants/Appellants,	)	
v.	)	CASE NO. S16G1143
BERNARD NORTON, as the Spouse of LOLA NORTON, by and through KIM NORTON, Power of Attorney, and on Behalf of the Wrongful Death Beneficiaries of LOLA NORTON,	)	
Plaintiffs/Appellees.	)	

BRIEF OF AMICI CURIAE AARP AND AARP FOUNDATION IN SUPPORT OF APPELLEES AND AFFIRMANCE

Iris Y. González
D.C. Bar No. 987156
Texas Bar No. 24042545
Pro Hac Vice Bar No. H10139
AARP Foundation Litigation
601 E Street, NW
Washington, DC 20049
Phone: (202) 434-6289
Facsimile: (855) 296-1218

Counsel for Amici Curiae AARP and AARP Foundation

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STATEMENT OF INTEREST

AARP is a nonprofit, nonpartisan organization dedicated to fulfilling the needs and representing the interests of people age fifty and older. AARP fights to protect older people's financial security, health, and well-being. AARP's charitable affiliate, **AARP Foundation**, creates and advances effective solutions that help low-income individuals fifty and older secure the essentials. Among other things, AARP and AARP Foundation advocate for access to affordable healthcare that compromises neither quality nor respect for individual rights. AARP supports the establishment and enforcement of laws and policies designed to protect the rights of nursing facility residents to obtain redress when they have been victims of neglect or abuse, including through civil actions brought by their survivors. The fair, efficient, and transparent resolution of claims of neglect and abuse are immensely important rights, especially to older nursing facility residents, who are at greater risk of abuse and neglect. Overbroad interpretations and inappropriate applications of the Federal Arbitration Act (FAA) infringe on these rights and on other substantive and due process rights granted by state laws.

AARP has filed amicus briefs in numerous federal and state cases around the country regarding the use of arbitration clauses in long-term care, consumer, and employment contracts. These briefs have addressed the importance of maintaining access to the civil justice system and ensuring that consumers can avail themselves

of the full range of enforcement mechanisms that Congress and state legislatures enacted for their benefit.

SUMMARY OF ARGUMENT

Decisions regarding admission to a long-term care facility are typically made in the midst of a crisis brought on by a precipitous deterioration in health or disability level, or the deterioration or death of a spouse or caregiver. It is in the midst of such a stressful and emotionally charged situation that nursing facilities with grossly superior bargaining power present nursing home residents or their family members with many admissions documents to review and sign, including agreements that require the resident to forego the use of the court system to resolve future disputes. Most of these unknown future disputes are beyond the resident's contemplation on the day of the admission and include disputes arising from issues like abuse, assault, malnutrition, neglect, and—as in this case—death. Several state courts, including the Georgia Court of Appeals, have held that agreements in nursing facility admission contracts to arbitrate such disputes cannot bind wrongful death claimants who did not sign the agreement on their own behalf. Such rulings are consistent with the Supreme Court's holding that "a court may order arbitration of a particular dispute only when satisfied that the parties agreed to arbitrate that dispute." Granite Rock Co. v. Int'l Bhd. of Teamsters, 561 U.S. 287, 288 (2010) (emphasis in original). Accordingly, the wrongful death beneficiaries in this case

cannot be bound by an arbitration agreement entered into by their deceased relative because they did not agree to submit their distinct and independent claims to arbitration.

ARGUMENT

I. The Decedent Did Not Have the Authority to Bind Her Survivors to Arbitration Because Wrongful Death Claims Belong to Survivors.

Amici concur with and hereby adopt Appellees' arguments that: (1) the FAA does not apply where no agreement to arbitrate exists, Appellees Br. 8-9, United Health Servs. of Ga., Inc. v. Norton, No. S16G1143, 2016 Ga. LEXIS 535 (Sep. 6, 2016); and (2) the arbitration agreement in this case cannot bind the wrongful death beneficiaries because wrongful death claims do not belong to the decedent, Appellees Br. 10-28. Though Amici believe that agreements to arbitrate in the context of admissions to nursing facilities are akin to contracts of adhesion, see infra Part II, Amici assume, for the sake of argument, that Mrs. Norton's representative had the requisite authority to agree to arbitrate her future claims. See Appellees Br. 12 (citing EHCA Cartersville, LLC v. Turner, 280 Ga. 333, 337, 626 S.E.2d 482, 487 (2006) (explaining distinction between substantive law and procedural law)).

Mrs. Norton had the authority to waive her right to bring a claim against the nursing facility for breach of duties and obligations owed her. Had Mrs. Norton released the nursing facility from any liability for acts or omissions related to her

care in the facility, for example, her survivors would not have had the right to make a claim stemming from the alleged negligent care. This is so because, under Georgia law, a claim for wrongful death stems from the right of the decedent (or her estate) to bring a claim, and is, therefore, subject to the same substantive defenses. See Dion v. Y.S.G. Enters., 296 Ga. 185, 187, 766 S.E.2d 48, 50 (2014) (affirming dismissal of wrongful death claim against a sports bar for allegedly causing the death of an intoxicated driver because, under the "common-law rule" that "the man who drank the liquor [is] liable," the driver himself could not have brought an action against the bar); see also Appellees Br. 16-20 (distinguishing cases cited by Appellants in which decedents were precluded from bringing any claim, in any forum, because they assumed all liability, released the party from liability, or were precluded from obtaining a finding of liability by some other substantive affirmative defense). So, if the decedent could not have brought a claim at all, then neither could the survivors.

However, Mrs. Norton retained her right to bring claims against the nursing facility and only agreed to waive her right to bring those claims in a judicial forum. Mrs. Norton did not have the authority to bind her survivors to her choice of forum, because wrongful death claims—if not barred by a substantive defense—belong to the survivors. Though a wrongful death claim relies on the facts and substantive legal theories that would have supported decedent's claim, it is brought

by different parties, has a different statute of limitations, and allows for different damages. See McAuley v. Wills, 251 Ga. 3, 4, 303 S.E.2d 258, 259 (1983) (holding that wrongful death action had different statute of limitations than decedent's personal injury suit); Norton v. United Health Servs. of Ga., Inc., 336 Ga. App. 51, 54, 783 S.E.D. 3d 437, 440 (2016) cert granted, No. S16C1143, 2016 Ga. LEXIS 535 (Ga. Sep., 6 2016); O.C.G.A. § 51-4-2 (persons entitled to bring wrongful death actions); O.C.G.A. § 51-4-5 (damages for death caused by negligence include the "full value of the life of the decedent" and "the funeral, medical, and other necessary expenses resulting from the injury and death of the deceased person.").

The nature of a wrongful death claim in Georgia—and to whom it belongs—is, therefore, critical to determining whether the arbitration agreement can bind the wrongful death claimants. On this issue, other state court decisions cited by Appellees are instructive and in accord with the Georgia Court of Appeals decision under review. See Norton, 336 Ga. App. 51; Appellees Br. 21-28. Amici provide additional authority not cited by Appellees that further supports the argument that because a wrongful death claim is separate and distinct from the decedent's claim, with distinct procedural rights, a decedent's agreement to arbitrate does not bind the wrongful death claimant.

In Roth v. Evangelical Lutheran Good Samaritan Soc'y, 886 N.W.2d 601 (Iowa 2016), the Iowa Supreme Court addressed the question, certified by the federal district court in an action against a nursing facility, of whether the Iowa statute that created a loss-of-parental-consortium claim requires that such claims "be arbitrated when the deceased parent's estate's claims are otherwise subject to arbitration." The court concluded that the statute did not permit the deceased parents to bind their children to arbitration because the loss-of-consortium claim belongs to the children and they never agreed to arbitrate. Id. at 613. In support of this conclusion, the court cited to the statutorily prescribed attributes of a loss-of-consortium claim: that it has its own statute of limitations and can be prosecuted independently. Id. The distinct characteristics of a loss-of-consortium claim are important because, as the court noted:

> '[T]he substantive rights of a plaintiff can be at stake through the application of a statute of limitations.' Rucker v. Taylor, 828 N.W.2d 595, 603 (Iowa 2013). Accordingly, we do not allow the identity of the nominal plaintiff to define substantive rights when it comes to the statute of limitations for consortium claims.

Id. Similarly, because Appellees' wrongful death claim is separate and distinct from the decedent's claim, having its own statute of limitations and its own distinct damages,[1] the procedural right of the decedent to choose her forum must not be

[1] See Clark v. Singer, 250 Ga. 470, 471, 298 S.E.2d 484, 485-86 (1983) (holding that application of medical malpractice statute of limitations, which accrued from the date of the negligent act as opposed to the date of death, to wrongful death

allowed to limit the substantive rights of the wrongful death claimant when he did not also agree to the same forum.

Roth is also instructive for the way in which the court analyzed the question of the arbitrability of the wrongful death claim in that case. The court acknowledged that "in jurisdictions where wrongful death is regarded as an independent claim for the direct benefit of the estate's beneficiaries . . . courts generally do not find the decedent's arbitration agreement to be binding." Id. at 609-10 (citing to cases in nine jurisdictions).[2] The Iowa Supreme Court contrasted

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claim was unconstitutional), superseded by statute on other grounds, O.C.G.A. §§ 9-3-71 (setting new statute of limitations for medical malpractice claims accruing either from the date of the negligent act or the date of death).

[2] See Estate of Decamacho v. La Solana Care & Rehab, Inc., 316 P.3d 607, 614 (Ariz. Ct. App. 2014) (wrongful-death claim against a nursing home was not arbitrable because wrongful death under state's law is separate and distinct claim); Norton, 336 Ga. App. at 54, 783 S.E.2d at 440-41 (same); Carter v. SSC Odin Operating Co., LLC, 976 N.E.2d 344, 355-58 (Ill. 2012) (wrongful death claim cannot be limited by decedent's agreement to arbitrate because it does not belong to the decedent); Ping v. Beverly Enters., 376 S.W.3d 581, 600 (Ky. 2012) (wrongful death claims are "statutorily distinct" and do "not derive from any claim on behalf of the decedent, and they therefore do not succeed to the decedent's dispute resolution agreements"); FutureCare NorthPoint, LLC v. Peeler, 143 A.3d 191, 209-10, 213 (Md. Ct. Spec. App. 2016) (decedent's arbitration agreement was not binding in a wrongful death claimant because under state's law wrongful death is a separate and distinct claim that does not belong to decedent); Lawrence v. Beverly Manor, 273 S.W.3d 525, 529 (Mo. 2009) (en banc) (decedent's arbitration agreement not enforceable in wrongful-death claim against a nursing home because wrongful death claim under state's law is "separate" and "not derivative"); Wolcott v. Summerville at Outlook Manor, LLC, 61 N.E.3d 853, 855-56 (Ohio Ct. App. 2016) (under Ohio law, a decedent cannot bind his or her beneficiaries to arbitrate their wrongful death claims); Boler v. Sec. Health Care,

these jurisdictions with ones like Iowa, in which the wrongful death claim is "brought by a personal representative who stands in the shoes of the decedent" and courts hold that the representative is bound by the decedent's agreement to arbitrate. Id. (citations omitted). As noted by the Iowa Supreme Court in Roth, Georgia is not among these jurisdictions.

II. Arbitration Clauses in Nursing Facility Admissions Contracts are Akin to Contracts of Adhesion; Therefore, Courts Should Construe Them Narrowly.

Admission to a nursing facility is almost always a stress-laden, emotionally charged, time-pressured event in which the potential resident is in the midst of a crisis brought on by an abrupt increase in disability level, precipitous deterioration in health, or the deterioration in health or death of a spouse or caregiver. Under these circumstances, prospective residents and their family members do not have the ability to fully review and understand all of the many provisions in the admissions agreement. They often do not have the time or the options to select another caregiver. Their bargaining power is woefully unequal to that of the corporations that draft and present arbitration agreements that eliminate the right to

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LLC, 336 P.3d 468, 477 (Okla. 2014) (decedent cannot bind wrongful death claimant to arbitration because state's wrongful death statute created separate and distinct cause of action to benefit the wrongful death claimant); Woodall v. Avalon Care Ctr.- Fed. Way, LLC, 231 P.3d 1252, 1258-61 (Wash. Ct. App. 2010) (a wrongful death action was not subject to the decedent's arbitration agreement because the personal representative of the estate is merely a statutory agent or trustee acting in favor of the beneficiaries, with no benefits flowing to the estate of the injured deceased) (internal citations in quote omitted).

access the courts to seek justice for neglect and abuse, which can result in the resident's death. Prospective residents and their family members are at the mercy of the nursing facility (and parent company) that will control every aspect of the resident's living conditions, medical care, and quality of life from the very minute the resident is admitted. In light of all of these factors, an arbitration clause buried in nursing facility admissions paperwork very much resembles a contract of adhesion—"'a standardized contract offered on a 'take it or leave it' basis and under such conditions that a consumer cannot obtain the desired product or service except by acquiescing in the form contract. Such contracts, while permissible, are construed strictly against the drafter.'" Hosp. Auth. v. Bohannon, 272 Ga. App. 96, 98-99, 611 S.E.2d 663, 666 (2005) (citations omitted).

A. Prospective Nursing Facility Residents Are Presented with Arbitration Agreements During Stress-Laden, Time-Pressured, Crises, When They Are Without the Necessary Resources to Make Free and Informed Decisions.

Decisions regarding admission into a nursing facility are emotionally charged, stress-laden events typically made in the midst of a crisis brought on by a precipitous deterioration in health, disability level, or the deterioration or even death of a spouse or other caregiver. See Donna Myers Ambrogi, *Legal Issues in Nursing Home Admissions*, 18 L. Med. & Health Care 254, 255, 258 (1990) (also noting that nursing facilities almost always insist on dealing with a family member or responsible party as the principal or only signer of an admission agreement);

Marshall B. Kapp, *The "Voluntary" Status of Nursing Facility Admissions: Legal, Practical, and Public Policy Implications*, 24 New Eng. J. on Crim. & Civ. Confinement 1, 3 (1998) (explaining that an older person's move to a nursing facility often follows a period of acute hospitalization when she and/or her family cannot manage the care demands at home). The need to find a long-term care placement arises quickly and often is unplanned, leaving little time to investigate options or to wait for an opening at a facility of one's choice. Denese Ashbaugh Vlosky, et al., *"Say-so" As A Predictor of Nursing Home Readiness*, 93 J. of Fam. & Consumer Scis. 59 (2001) ["*Predictor of Nursing Home Readiness*"].

Family members who find themselves having to make these decisions for their loved ones fare no better, as they are also under extreme pressure brought about by a loved one's medical crisis and their inability to provide the necessary care at home. See Maureen Armour, *A Nursing Home's Good Faith Duty "To" Care: Redefining a Fragile Relationship Using the Law of Contract*, 39 St. Louis L.J. 217, 221-22, 225 (1994) (describing medical crises that precipitate the need for long-term institutional care, the stressful decision to admit a loved one to a nursing facility, and the perception by family caregivers that they can no longer provide the necessary care). At the time of admission to a nursing facility, prospective residents and their family members/representatives are presented with stacks of complex documents during a time of crisis with no meaningful

opportunity to read, ask questions, or get advice about the terms. See id. at 225-226 (describing the "voluminous" admission documents that families are asked to sign, including waivers of liability, consents to restraints, physician directives, and copies of state and federal regulations). Arbitration agreements are often buried in these stacks and are not noticed by residents and family members nor pointed out by facility staff. See Ann E. Krasuski, *Comment, Mandatory Arbitration Agreements Do Not Belong in Nursing Home Contracts With Residents*, 8 DePaul J. Health Care L. 263, 263-64 (2004) (describing reasons why arbitration agreements go unnoticed when admission documents are signed). Nursing facility staff offer minimal guidance or provide inaccurate information about the meaning and effect of the arbitration provision. See S. Rep. No. 110-518, at pt. I.B (2008) ["S. Rep. 110-518"].

Even if family members were displeased with contractual terms, they would have little time to investigate options or to wait for an opening at a facility of one's choice because the need to find a long-term care placement for loved ones arises quickly and often is unplanned. See *Predictor of Nursing Home Readiness*, 93 J. Fam. & Consumer Scis. at 59. Under these circumstances, it is extremely difficult for potential residents and their families, faced with the crises accompanying admission to a nursing facility, to make informed decisions about the numerous provisions contained in an admissions contract—especially provisions requiring

nursing facility residents to waive the right to access the courts and to a trial by jury for future disputes that they do not know may involve allegations of abuse or neglect causing the resident's death. All of these factors have led some to conclude that pre-dispute binding arbitration agreements in long-term care are contracts of adhesion. See, e.g., Wascovich v. Personacare of Ohio, Inc., 943 N.E.2d 1030, 1034, 1040 (Ohio Ct. App. 2010) (finding arbitration agreement in nursing facility admission contract unconscionable and noting the "troubling" circumstances under which arbitration agreements are presented to residents); McGregor v. Christian Care Ctr. of Springfield, LLC, 2010 Tenn. App. LEXIS 309, *11, 2010 WL 1730131 (Tenn. Ct. App. Apr. 29, 2010) (finding that arbitration clause in nursing facility admission agreement was a contract of adhesion because the sick resident had no opportunity to bargain, was in pain, and had little choice but to sign the agreement in order to receive needed medical care); Robert Hornstein, *The Fiction of Freedom of Contract – Nursing Home Admission Contract Arbitration Agreements: A Primer on Preserving the Right of Access to Court Under Florida Law*, 16 St. Thomas L. Rev. 319, 320-21 (2003).

B. Nursing Facility Residents and Their Family Members Are In Inherently and Grossly Unequal Bargaining Positions Compared to the Nursing Facility Corporation.

Prospective residents and their family members are placed at further disadvantage by virtue of nursing facilities' grossly superior bargaining power,

knowledge, and control over the contract's formation. Nursing facilities enter into contracts to admit residents to their facilities on a regular basis. In 2015, Georgia's 358 nursing facilities certified to participate in the Medicare and/or Medicaid programs had 39,857 available beds, which were occupied at a rate of 84% throughout the year. See Skilled Nursing Facilities.org, *Georgia Nursing Home Statistics*, available at http://www.skillednursingfacilities.org/directory/GA/ (last visited on Dec. 12, 2016). In addition to the frequency with which they enter into admission agreements, nursing facilities have the advantage of drafting these agreements with the expert advice of professionals who have a sophisticated understanding of each term in the agreement and its implications for their clients, the nursing facilities. See *Fairness in Nursing Home Arbitration Act: Hearing on S. 2838 Before the S. Subcomm. on Antitrust, Competition Policy and Consumer Rights of S. Comm. on the Judiciary and the S. Special Comm. on Aging*, 110th Cong. 9 (2008) (statement of Kelley C. Rice-Schild, Executive Director, Floridean Nursing and Rehabilitation Center) (noting that the American Health Care Association and the National Center for Assisted Living, organizations representing long-term care providers, created a model arbitration agreement for their members to use in the admission process). The nursing facility industry's focus on pre-dispute arbitration is a reflection of that fact that arbitration agreements are more favorable to nursing facilities than they are to residents who

are victims of their negligent care. See, e.g., Myriam Gilles, *Operation Arbitration: Privatizing Medical Malpractice Claims*, 15 Theoretical Inquiries L. 671, 673-74 (2014) (examining studies to conclude that long-term-care facilities generally fare better in arbitration than in litigation).

In contrast, people seeking admission to nursing facilities, their families, and their representatives have probably never before seen a nursing facility contract, let alone read the arbitration provisions contained therein. See S. Rep. No. 110-518. Moreover, they do not have an attorney present during the admission process to explain the terms of the agreement, advise on whether to accept the terms, and help negotiate different terms. Id. Importantly, this means that prospective residents and their family members have no one present during the admission process who can tell them that they can decline to agree to pre-dispute arbitration and that the facility may not deny admission based on refusal to accept this term. See 42 U.S.C. §1396r(c)(5)(A)(iii) (2012); 42 C.F.R. § 483.12(d)(3) (2015) (prohibiting a nursing facility receiving payments from Medicare or Medicaid from charging, accepting, or receiving, in addition to any amount paid under the plan, any other consideration as a precondition for admission, an expedition of admission, or a requisite for continued stay in the facility).

For these reasons, it is important that courts carefully scrutinize pre-dispute arbitration clauses in nursing facility admissions contracts to determine whether

they are valid and enforceable—in particular, when one person purports to bind another to arbitrate future unknown disputes. See Bohannon, 272 Ga. App. at 98-99.

III. Civil Actions Are an Important Complement to a Regulatory Enforcement Process That is Often Inadequate to Protect Nursing Facility Residents from Abuse and Neglect.

The prevalence of abuse and neglect in nursing facilities and the inability of regulatory authorities to effectively detect and remedy this problem make it imperative that victims and their families have fair access to complementary remedial measures available through the civil justice system—particularly when the bad conduct results in the suffering and death of a vulnerable person.

A. Vulnerable Nursing Facility Residents Are Frequent Victims of Abuse and Neglect.

Nursing facility residents are more vulnerable to abuse and neglect due to their isolation from social networks; their congregate living setting; their dependence on others to perform activities of daily living such as eating, bathing, dressing, and toileting; and their cognitive impairments. See Panel to Review Risk and Prevalence of Elder Abuse and Neglect, Nat'l Research Council, *Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America*, 91-100 (Richard J. Bonnie & Robert B. Wallace eds., 2003) (reviewing studies on risk factors for abuse in different settings) ["*Elder Mistreatment*"]. In 2014, more than 1.4 million Americans lived in 15,634 nursing homes certified to participate in the

Medicaid and/or Medicare health insurance programs. Ctrs. for Medicare and Medicaid Servs., U.S. Dep't of Health and Human Servs., *Nursing Home Data Compendium 2015 Edition*, 36, 181 (2015) ["*2015 Compendium*"], available at https://goo.gl/6yx9tT. The vast majority of these nursing facility residents shared at least one characteristic that put them at risk of abuse and neglect: 84.5% were 65 years of age or older, 69.3% had functional impairments in three or more activities of daily living, and 61.4% had moderate or severe cognitive impairments. Id. at 181, 185.

The available empirical data suggest that nursing facility residents are frequent victims of abuse and neglect. Residents report abuse. In one study conducted in 2000, 44% of the nursing facility residents interviewed said they had been abused, and 95% said they had been neglected or had witnessed the neglect of another resident. See *Elder Mistreatment* at 453, 463 (citing Karen Broyles, *The Silenced Voice Speaks Out: A Study of Abuse and Neglect of Nursing Home Residents* (2000) (A Report from the Atlanta Long-Term Care Ombudsman Program and Atlanta Legal Aid Soc'y to the Nat'l Citizens Coalition for Nursing Home Reform)). The Long-Term Care Ombudsman Office receives complaints of abuse that implicate as many as one-third of all nursing facilities. See Nicholas Castle, Jamie C. Ferguson-Rome & Jeanne A. Teresi, *Elder Abuse in Residential Long-Term Care: An Update to the 2003 National Research Council Report*, 34 J.

Applied Gerontology 407, 429 (2015) ["*Elder Abuse in Residential Long-Term Care*"]. Nursing facility staff also report abuse. In one study, over 50% of nursing facility staff admitted to subjecting older patients to physical violence, mental abuse, or neglect within the prior year. See Merav Ben Natan & Ariela Lowenstein, *Study of Factors That Affect Abuse of Older People in Nursing Homes*, 17 J. Nursing Mgmt. 20, 22 (2010).

National databases also provide evidence of the significant levels of abuse and neglect in nursing facilities. An estimated 7.5% of all complaints to the long-term care ombudsmen regarding nursing facilities were complaints of abuse, gross neglect, or exploitation. See Admin. for Community Living, Aging Integrated Database (AGID), National Ombudsman Reporting System (NORS) Complaints Results, available at http://www.agid.acl.gov/CustomTables/NORS_Complaints/Results/ (last visited Dec. 20, 2016). In 2014, state surveys (inspections mandated by federal regulations and used to determine whether facilities are in compliance with federal and state law) revealed that 10.6% of the facilities surveyed had been cited for causing actual harm to residents or putting them in immediate jeopardy, 3.2% for substandard care, and 4.3% for use of restraints. *2015 Compendium*, at 90, 114, 126. The complex challenge of collecting accurate data on the prevalence of abuse in nursing facilities means that these numbers, though unacceptably high,

are a mere sampling of a problem that is largely under-detected and under-reported. See *Elder Abuse in Residential Long-Term Care* at 429.

B. Federal and State Enforcement Efforts Have Failed to Effectively Address Abuse and Neglect in Nursing Facilities.

Nursing facilities are regulated on the state and federal level in order to ensure quality care. In particular, nursing facilities that receive federal funding[3] must comply with the 1987 Omnibus Budget Reconciliation Act (OBRA) and its implementing regulations, which set forth minimum standards of care for long-term care facilities. See 42 U.S.C. §§ 1395i-3, 1396r (2012); 42 C.F.R. §§ 483.1-75 (2015).[4] States are responsible for inspecting nursing homes to ensure compliance with these minimum standards of care. See 42 C.F.R. §§ 488.10(a),

[3] The national expenditure on nursing facilities and continuing care retirement communities is projected to be $178.3 billion in 2017—$96.5 billion of which will be covered by Medicaid and Medicare. Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., *National Health Expenditure Projections 2015-2025*, Table 13, available at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html (last visited Jan. 4, 2017).

[4] Though CMS recently prohibited the use of pre-dispute arbitration agreements as a condition of participation in the Medicare and Medicaid programs, the new rule has no effect on existing arbitration agreements, nursing facilities that do not participate in the programs, or other long-term care settings. See 42 C.F.R. § 483.70(r)(n)(1) (effective Nov. 28, 2016); Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 81 Fed. Reg. 68,688, 68,800 (Oct. 4, 2016) (codified at 42 C.F.R. pt. 483). Additionally, the rule has been challenged in federal court and its implementation is stayed pending final resolution of that challenge.

488.11(2015). Despite the mandatory nature of these minimum standards of care, the majority of facilities fail to comply. In 2010, for example, more than 93% of nursing facilities in the country were cited for violations of federal health and safety standards. See Charlene Harrington et al., *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2005 Through 2010*, 79 (Henry J. Kaiser Family Found., Kaiser Comm'n on Medicaid and the Uninsured, 2011). An average of 23.36% of all facilities surveyed in 2010 were cited for one or more deficiencies that caused harm or immediate jeopardy to residents and 7.18% were cited for substandard care. Id. at 80, 82.

Georgia nursing facilities have also failed to comply with regulatory minimum standards of care. From April 7, 2011, to July 14, 2016, inspection reports showed that 344 of Georgia's nursing facilities were cited for 3,653 deficiencies. See ProPublica, *Nursing Home Inspect: Georgia*, http://projects.propublica.org/nursing-homes/ (last visited Dec. 12, 2016) (raw data available at https://data.medicare.gov/data/nursing-home-compare). The vast majority of these deficiencies (3,481) involved the potential for more than minimal harm to the residents. Id.[5] A significant number of these deficiencies—281—were

[5] "Health inspections are based on federal regulations, which surveyors implement using national interpretive guidance and a federally-specified survey process. Federal staff train state surveyors and oversee state performance." Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., *Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide*

categorized in the higher-severity levels, those that cause actual harm to residents. Id. These reports reveal only a fraction of the care deficiencies because state surveys of compliance with federal quality standards repeatedly understate serious care problems. U.S. Gov't Accountability Off., GAO-08-517, *Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses*, 11 (2008), available at http://www.gao.gov/new.items/ d08517.pdf. "From fiscal year 2002 through 2007, about 15 percent of federal comparative surveys nationwide identified state surveys that failed to cite at least one deficiency at the most serious levels of noncompliance—the actual harm and immediate jeopardy levels." Id. at 4.

Federal and state regulatory enforcement efforts are inadequate to remedy the problem, as demonstrated by the fact that many nursing facilities, even after being cited by regulators, continue the practices that harm and sometimes kill residents. The GAO found that in 2005 about 17% of nursing facilities were cited for deficiencies that caused "actual harm or immediate jeopardy" to patients. See U.S. Gov't Accountability Off., GAO-07-241, *Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents*, 65 (2007) ["*GAO Nursing Home Federal Enforcement*

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5 (2015), available at http://goo.gl/3cf8P (describing the designations for severity and scope of deficiencies used by state surveyors).

Report"], available at http://www.gao.gov/products/GAO-07-241. Federal enforcement efforts have "not deterred some homes from repeatedly harming residents." See U.S. Gov't Accountability Off., GAO-07-794T, *Nursing Home Reform: Continued Attention Is Needed to Improve Quality of Care in Small but Significant Share of Homes* 3, 9-16 (2007), available at http://www.gao.gov/new.items/d07794t.pdf. Almost half of the nursing facilities with past citations for serious quality problems "continued to cycle in and out of compliance, continuing to harm residents." *GAO Nursing Home Federal Enforcement Report* at 26. In another study four years later, the GAO found that the number of nursing facilities cited for the most serious deficiencies, referred to as "immediate jeopardy," had increased over the previous several years, particularly in for-profit and multi-facility chains. U.S. Gov't Accountability Off., GAO-11-571, *Nursing Homes: Private Investment Homes Sometimes Differed from Others in Deficiencies, Staffing, and Financial Performance*, at Highlights (2011), available at http://www.gao.gov/assets/330/321067.pdf.

Federal law mandates the most severe consequences for facilities that fail to timely remedy serious, longstanding, or repeated violations of federal quality-of-care standards. These consequences include exclusion from participation in Medicare or Medicaid or temporary suspension of reimbursement. See 42 C.F.R. §§ 488.406, 488.412, 488.14, 488.417 (2015). However, a 2006 report by the U.S.

Department of Health and Human Services found that, for violations requiring a nursing facility's permanent exclusion from participation in Medicare, CMS failed to impose that mandatory sanction 55% of the time. See Office of the Inspector Gen., Dep't of Health & Human Servs., OEI-06-03-00410, *Nursing Home Enforcement: Application of Mandatory Remedies*, at i (2006), available at http://goo.gl/vsQJqn. For violations requiring temporary suspension of Medicare reimbursement, CMS failed to impose that mandatory sanction 28% of the time. Id. at ii. Even though cited facilities often remedied the violations after the time for Medicare exclusion or payment suspension had expired, all those reviewed in a subsequent survey were found to have new instances of noncompliance that again required referral to CMS for enforcement action. Id.

C. Civil Actions Supplement Lax Federal and State Regulatory Enforcement.

Civil lawsuits against nursing facilities for negligence have complemented the regulatory enforcement system as a means to penalize and deter violations of minimum care standards that harm residents and even cause their deaths. Indeed, the effectiveness of these lawsuits led the nursing facility industry to successfully lobby state legislatures for caps on punitive damages in nursing facility neglect cases. See Michael L. Rustad, *Neglecting the Neglected: The Impact of Noneconomic Damage Caps on Meritorious Nursing Home Lawsuits*, 14 Elder L.J. 331, 334 (2007). Despite the negative effect that limits on punitive damages and

other "tort reforms" have on elderly and vulnerable victims of abuse and neglect, see id. at 368-82, personal injury lawsuits continue to be filed against nursing facilities. The sheer prevalence and severity of abuse and neglect in nursing facilities and the historic and continued failure of state and federal governments to hold nursing facilities accountable create a continued need for nursing facility residents to use every tool of deterrence available to them.

CONCLUSION

This case has far-reaching implications for Georgians requiring admission to long-term care facilities and their families. Abuse and neglect of vulnerable nursing facility residents resulting in their deaths is an all-too-common occurrence that is not effectively remedied or deterred through regulatory enforcement efforts; and for which civil lawsuits, especially by surviving family members, remain an important remedial and deterrent measure. The stress-laden and time-pressured nature of admission to a nursing facility and the nursing facility's grossly superior bargaining power make agreements to arbitrate future disputes in nursing facility admission contracts akin to contracts of adhesion. As such, they must be strictly construed. Well-established contract law principles and the Georgia wrongful death statute and related interpretive jurisprudence compel a finding that the wrongful death claimants in this case cannot be bound by the decedent's agreement

to arbitrate future disputes. For these reasons, and those set forth in Appellees' brief, this Court should affirm the decision of the Georgia Court of Appeals.

Date: January 5, 2017

Respectfully submitted,

/s/ Iris Y. González
Iris Y. González
Admitted *Pro Hac Vice*
Bar No. H10139

AARP Foundation Litigation
601 E Street, NW
Washington, DC 20049
igonzalez@aarp.org
Phone: (202) 434-6289
Fax: (202) 434-6424

Counsel for *Amici Curiae* AARP and AARP Foundation

CERTIFICATE OF SERVICE

I hereby certify that I have filed the foregoing Brief of Amici Curiae AARP and AARP Foundation in Support of Appellees and Affirmance using the Court's Electronic Filing system and served the persons identified below with a copy of the document by facsimile and/or by depositing a true and correct copy in the United States Mail, sufficient postage attached, on this the 5th day of January, 2017:

Jason E. Bring, Esq.
William Jerad Rissler
Arnall Golden Gregory, LLP
ARNALL GOLDEN GREGORY LLP
171 17th Street, NW, Suite 2100
Atlanta, GA 30363
Fax: (404) 873-8501
Counsel for Appellants

James Burke McHugh
Michael J. Fuller, Jr.
Anthony Lance Reins
MCHUGH FULLER LAW GROUP, PLLC
97 Elias Whiddon Road
Hattiesburg, Mississippi 39402
Fax: (601) 261-2481
Counsel for Appellees

Hunter S. Allen Jr.
Simuel F. Doster Jr.
ALLEN, MCCAIN & O'MAHONY, P.C.
Two Midtown Plaza, Suite 1700
1349 West Peachtree Street, N.W.
Atlanta, Georgia 30309
Amicus Appellant

Earl W. Gunn
Brannon Jones Arnold
WEINBERG, WHEELER, HUDGINS, GUNN & DIAL LLC
3344 Peachtree Road, NE Suite 2400
Atlanta, Georgia 30326
Amicus Appellant

Stephen Chance
WATKINS, LOURIE, ROLL & CHANCE, PC
Tower Place 200, Suite 1050
3348 Peachtree Road, N.E.
Atlanta, Georgia 30326
Amicus Appellee

Jonathan Marigliano
PRIETO MARIGLIANO HOLBERT & PREITO LLC
Two Ravinia Drive Suite 1330
Atlanta, Georgia 30346
Amicus Appellee

/s/ Iris Y. González
Iris Y. González

Counsel for *Amici Curiae* AARP and AARP Foundation