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MORE THAN JUST DOPE: ADVOCATING FOR ETHICAL MARIJUANA POLICIES IN LONG-TERM CARE FACILITIES

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Abstract. Many long-term care facilities currently have blanket policies prohibiting residents from possessing medicinal marijuana on premises. These facilities often use the Controlled Substances Act (CSA) to justify their prohibitions on possession, claiming that it is illegal under federal law to institute new policies allowing for medicinal marijuana possession by residents and that they could lose funding under Medicaid as a result. However, possession of marijuana by residents does not equate to possession by the facility themselves, and would likely not constitute a violation of the CSA triggering Medicaid termination. This Article argues that current policies in long-term care facilities which prohibit resident access to marijuana on facility premises are not only ethically unjustifiable (infringing on patient autonomy, privacy, dignity, and the duty to provide beneficent care), but could result in civil liability under section 1983. It also suggests that residents may be able to fight a potential discharge for marijuana use through their state's involuntary discharge appeal process. The Article concludes by proposing a policy which allows for marijuana on a long-term care facility's premises, abides by federal law, and adequately recognizes the autonomy, dignity, and privacy of the resident.

* University of Virginia School of Law, J.D. Candidate 2021. This piece is dedicated to my wonderful parents, Edie and Neil Steinberg, who have provided helpful critiques not only on this piece but throughout the entirety of my life. Impetuous youth are bitter towards the wise until they become wise themselves.

TABLE OF CONTENTS

INTRODUCTION

Ms. Crouse, an 88-year-old woman, had fallen, broken her neck, and for years afterward experienced chronic pain.[1] The doctor at Ms. Crouse's Florida nursing home initially prescribed opiates, but when these resulted in unpleasant symptoms such as depression, anxiety, constipation, and disagreeableness, her son decided to take his mother to a pain management physician.[2] This physician recommended marijuana tinctures,[3] which was a legal medicinal treatment under Florida state law.[4] But despite this physician's recommendation, the desires of Ms. Crouse and her son, and the legal status of medicinal marijuana under Florida law, the nursing home where Ms. Crouse resided had a policy against marijuana being used on its premises, preventing her use of the drug as prescribed.[5] Because of this policy, her son had to sneak into the facility and administer the tincture of marijuana to his mother himself three times a day – eventually, he moved her to another private facility.[6]

Many long-term care facilities believe that allowing cannabis use by residents is high risk,[7] because if they fail to comply with federal law, the facility may lose federal funding and potentially have penalties levied against them.[8] Under the Controlled Substances Act (CSA), possession or distribution of marijuana is illegal,[9] and the Centers for Medicaid and Medicare Services (CMS) could theoretically punish a certified facility for failing to comply.[10] Some facilities have policies forbidding

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1 Samantha J. Gross, *If You Need Medicinal Marijuana, You Better Not Be in a Florida Nursing Home or ALF*, MIAMI HERALD (Mar. 11, 2019), https://www.miamiherald.com/news/health-care/article227395904.html [https://perma.cc/WY9T-47CR].

2 *Id.*

3 *Id.*

4 FLA. STAT. ANN. § 381.986 (Westlaw through 2019 legislation) (describing one of the "qualifying medical conditions" to receive medicinal marijuana as "[c]hronic nonmalignant pain").

5 Gross, *supra* note 1 ("Fears over losing Medicaid . . . keep most nursing homes and assisted living facilities pot-free.").

6 *Id.*

7 *See* Shereef M. Elnahal & Jeff Brown, *To Fulfill Their Mission, Health Care Facilities Should Better Accommodate Cannabis Patients*, HEALTH AFF. BLOG (July 23, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190719.709108/full/ [https://perma.cc/NM5D-G8SE] ("Hospitals tell us they fear losing their deemed status from the Centers for Medicare and Medicaid Services (CMS) if they let patients use the [medicinal marijuana] on premises."). Veteran nursing homes, similarly, bound to follow federal law, have used federal law as a justification for banning residents from using marijuana. Kurt Erickson, *Missouri Says 'No' to Medical Marijuana in Veterans Nursing Homes*, ST. LOUIS POST-DISPATCH (Jan. 29. 2019), https://www.stltoday.com/news/local/govt-and-politics/missouri-says-no-to-medical-marijuana-in-veterans-nursing-homes/article_d4d0c438-d9cc-51cb-b182-68a125cae591.html [https://perma.cc/E8LP-G38L].

8 Laura M. Borgelt & Kari L. Franson, *Considerations for Hospital Policies Regarding Medical Cannabis Use*, 52 HOSP. PHARMACY 89, 89 (2017) (citing Gillian Graham, *Sanford Hospital Patient Denied Medical Marijuana*, PORTLAND PRESS HERALD (Aug. 24, 2015), http://www.pressherald.com/2015/08/23/hospital-patient-denied-medical-marijuana-lotion/ [https://perma.cc/A8H4-G6MH]).

9 21 U.S.C. § 841(a)(1) (2018). ("[I]t shall be unlawful for any person knowingly or intentionally to manufacture, distribute, or dispense, or possess with intent to manufacture, distribute, or dispense, a controlled substance."); Marijuana is currently classified as a schedule one controlled substance. *See* 21 U.S.C. § 812 (c)(1)(c)(10) (2018).

the use of marijuana within their premises by residents, regardless of whether the facility itself administers it.[11] However, while federal law prohibits administration or possession of marijuana by the staff, the mere possession by the resident would likely not be a violation of federal law by the facility.[12]

Given the large number of residents in long-term care facilities that receive Medicare or Medicaid funding,[13] and the pervasiveness of policies forbidding marijuana use, many individuals throughout the United States likely experience situations similar to that of Ms. Crouse: suffering a medical condition that marijuana could help relieve, receiving a doctor recommendation for marijuana treatment because of that condition, actively choosing to pursue that treatment course, but then being denied access to said treatment by their residential facility. As Ms. Crouse's situation demonstrates, this can pose significant burdens on the resident's caregiver - in her case, her son, who had to expend time and effort, and potentially risk discipline and legal repercussions for breaking the facility's policies by sneaking in and administering the marijuana himself. And in situations where the resident does not have a caregiver, the effect on the resident could be quite severe. Practically speaking, an elderly resident without a caregiver willing to sneak in marijuana could be denied access to their recommended medicinal marijuana entirely.[14]

If policies prohibiting marijuana use on premises stay in place, it is likely that the number of individuals in long-term care facilities that deny residents access to medicinal marijuana will increase in the future. If the current proportion of those 65-years-old and up residing in nursing homes holds constant, by 2040 the number of residents in nursing homes will rise from the current 1.3 million to approximately 1.9 million.[15]

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[10] Veterans Affairs Facilities, such as community nursing homes, largely model their oversight program off of the model used by CMS, and their facilities too must comply with federal requirements. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-19-428, VA NURSING HOME CARE*:* VA HAS OPPORTUNITIES TO ENHANCE OVERSIGHT AND PROVIDE MORE COMPREHENSIVE INFORMATION ON ITS WEBSITE 6 (2019).

[11] One veterans' affairs agency with eight residential facilities in California has a policy of immediately discharging the resident from the home if they use marijuana. *See* Libby Denkmann, *Can Veterans be Penalized for Using Pot? Answer is Hazy,* KPCC LOCAL NEWS (Jan. 8, 2018), https://www.scpr.org/news/2018/01/08/79589/california-veterans-who-use-marijuana-are-caught-i/ [https://perma.cc/H57E-N8WD]; *see also* Jessica Portner, *Federal Law Complicates Medical Marijuana Use in Nursing Homes*, CAL. HEALTH REP. (June 2, 2017), https://www.calhealthreport.org/2017/06/02/federal-law-complicates-medical-marijuana-use-nursing-homes/ [https://perma.cc/U29V-VDTX] (describing how "[s]ome communities might not allow marijuana at all").

[12] A hospital, similarly, bound by federal law if it wants to participate in Medicare or Medicaid, is not required to prevent inpatients from bringing cannabis into medical facilities. Ryan Marcus, *Medicare, Medicaid, and Medical Marijuana: Why Hospitals Should Not Be High on Patient Certification*, 24 ANNALS HEALTH L. ADVANCE DIRECTIVE 1, 9–10 (2014).

[13] As of 2016, there were over 8.3 million people in long-term care facilities, and of those approximately 1,347,600 resided in nursing homes throughout the United States that were certified by Medicare or Medicaid. NATIONAL CENTER FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH & HUMAN SERVICES, VITAL AND HEALTH STATISTICS, LONG-TERM CARE PROVIDERS AND SERVICES USERS IN THE UNITED STATES 2015–2016 43 (2019), https://www.cdc.gov/nchs/fastats/nursing-home-care.htm [https://perma.cc/K9XF-J943]. Of all long-term care facilities, nursing homes have the highest percentage of their facilities certified by Medicaid and Medicare. *Id.*

[14] *See infra* Part I.D.

[15] The current population age 65 and older numbered 50.9 million in 2017. U.S. DEP'T OF HEALTH AND HUMAN SERVICES, 2018 PROFILE OF OLDER AMERICANS 3 (2018), https://acl.gov/sites/default/files/

Additionally, if long-term care facilities retain current policies, the percentage of individuals denied access to marijuana in long-term care facilities is likely to increase because demand for marijuana among the elderly is rising.[16] As this demand grows, coupled with the expected increase in residents in the future, it is highly likely that going forward, more individuals' choice of preferred medical treatment will be stymied, or *de facto* prohibited due to practical limitations.

Part I of this Article will explain how current policies in long-term care facilities that prohibit access to medicinal marijuana limit residents' autonomy, infringe on their privacy, and harm their dignity. Part II will argue that these policies could potentially result in civil liability under section 1983 and will illustrate how residents could fight a potential discharge for marijuana use through their state's involuntary discharge appeal process. Part III will conclude with a policy proposal that allows for marijuana on a long-term care facility's premises while abiding by federal law and adequately recognizing the autonomy, dignity, and privacy of the resident.

I. ETHICAL CONSIDERATIONS SURROUNDING BLANKET BANS ON MARIJUANA

Ms. Crouse and her son were in a difficult situation: a physician recommended to use medicinal marijuana, she wanted to pursue that treatment option, but access to that treatment was limited by the nursing home's policy banning marijuana use by residents.[17] In her case, she had a son willing to break the facility's rules to administer the marijuana himself three times a day.[18] But it is easy to imagine how another resident might not be as lucky. The resident may be alone and unable to find a caregiver to help administer the marijuana, or their family might not be willing to break the facility's policy by administering marijuana and risk discharge. In these circumstances, residents could lose the ability to secure the treatment option they prefer. The following Sections will explore the ethical implications of a blanket ban on marijuana on a resident's dignity, autonomy, and privacy. Before considering these potential harms, however, an important limiting principle must be discussed: patient safety.

A. Beneficence, Non-maleficence, and Maintaining Patient Safety as a Limiting Consideration

In the case of nursing home residents, carrying the principles of privacy and autonomy to their extremes would result in situations that may intuitively strike one as unwise. For example, allowing a resident to *choose* to keep an irascible pet rattlesnake in the *privacy* of their room would seem unwise because the snake could injure that resident, as well as other residents and the staff if it escaped.

Aging%20and%20Disability%20in%20America/2018OlderAmericansProfile.pdf [https://perma.cc/6RX6-ZQLS]; As of 2017, 1.2 million people over the age of 65 live in nursing homes. *Id.* at 4. Therefore, the percentage of those age 65 and up currently in nursing homes is 2.35%. By 2040, the population of those age 65 and older will balloon to 80.8 million, and by 2060 it will be 94.7 million. *Id.* at 3.

[16] The segment of the population with the most significant growth in marijuana use was in the 65 years and older category. Marijuana usage among this group increased 15.3% annually from 2001 to 2014. Shawnta L. Lloyd & Catherine W. Striley, *Marijuana Use Among Adults 50 Years or Older in the 21st Century*, 4 GERONTOLOGY & GERIATRIC MEDICINE 1, 3 (2018).

[17] Gross, *supra* note 1.

[18] *Id.*

Thus, an important limitation on a resident's autonomy and privacy stems from the belief that medical-practitioners should not be allowed to cause harm to their patients when making decisions about their care – a principle is known as *non-maleficence*.[19] Practitioners also have an obligation to benefit the patient and act with compassion by considering the needs and feelings of the patient – an obligation known as *beneficence*.[20] In determining what policy to implement, a long-term care facility should consider whether the benefits gained from enacting the policy outweigh the potential suffering caused.[21]

Sometimes a medical practitioner will have a straightforward decision when balancing these principles. A patient who requests his healthy leg be amputated would present a situation where the potential harm of doing the procedure clearly outweighs any potential benefit.[22] A policy prohibiting the use of drugs like heroin, meth, or cocaine by residents would likewise align with notions of non-maleficence and beneficence as these drugs are known to pose numerous harms without offsetting benefits.[23] But the harms and benefits of medicinal marijuana are far less clear than these situations.

Marijuana is currently a Schedule 1 drug, and because this classification has largely curtailed research into its medical efficacy, there is some ambiguity as to its harms, benefits, and best-practice administration procedures.[24] However, a majority of doctors believe that marijuana has medicinal benefits and that it should be legalized.[25]

Commonly accepted medical benefits of marijuana include providing significant pain reduction while posing far less addictive risk than opiates, managing nausea and weight loss, and treating glaucoma.[26] While there is disagreement in the medical field as to marijuana's efficacy, the

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[19] Facilities should balance other interests with patient safety. *See* Eran Metzger*, Ethics and Intimate Sexual Activity in Long-Term Care*, 19 AM. MED. ASS'N J. ETHICS 640, 640 (2017); *see also* George J. Annas, *Commentary: Patients Should Have Privacy as Long as They Do Not Harm Themselves or Others,* 316 BRIT. MED. J. 924, 924 (1998) ("If allowing his mother to supply cannabis in cake helps medically, does not harm any other patient or staff member, and is what Mr. K wants, it should be permitted."). The belief in modern medical ethics that medical practitioners should ensure that the patient is safe from injury or harm is known as non-maleficence. Maliheh Kadivar et al., *Ethical and Legal Aspects of Patient's Safety: A Clinical Case Report*, 10 J. MED. ETHICS HIST. MED. 1, 2 (2017).

[20] Eileen E. Morrison, ETHICS IN HEALTH ADMINISTRATION: A PRACTICAL APPROACH FOR DECISION MAKERS 46–50 (2006).

[21] *Id.* at 46.

[22] David H. Sohn & Robert Steiner, *Nonmaleficence in Sports Medicine*, 16 AM. MED. ASS'N J. ETHICS 539, 540 (2014).

[23] Heroin severely damages individuals' health. Henk Ten Have & Paul Sporken, *Heroin Addiction, Ethics and Philosophy of Medicine*, 11 J. MED. ETHICS 173, 174 (1985). Yet, even drugs like cocaine and methamphetamine may have limited medical potential in vaccines to help treat dependence on the illicit substance. *See* W. Hall & L. Carter, *Ethical Issues in Using a Cocaine Vaccine to Treat and Prevent Cocaine Abuse and Dependence*, 30 J. MED. ETHICS 337, 337–338 (2004).

[24] Joseph Gregorio, *Physicians, Medical Marijuana, and the Law*, 16 AM. MED. ASS'N J. ETHICS 732, 734 (2014) ("Marijuana's schedule 1 status makes it difficult to conduct research because any cultivation, clinical testing, or research on it must attain the extremely rare approval of the federal government. . . .").

[25] *Id.* at 735 ("A study reported in April 2014 [found that] 1,544 doctors in 12 specialties and 48 states and found that 56 percent of those surveyed believed that medicinal marijuana should be legalized nationally and 69 percent believed that it can deliver real benefits. . . ."); Lindsey M. Philpot et al., *A Survey of the Attitudes, Beliefs and Knowledge About Medical Cannabis Among Primary Care Givers,* 20 BMC FAM. PRAC. 1,3 (2019) ("A majority of providers believed . . . that medical cannabis was a legitimate medical therapy.").

[26] Peter Grinspoon, *Medical Marijuana,* HARV. HEALTH BLOG (last updated June 25, 2019, 9:36 AM),

medical profession has trended towards accepting that it has certain medical benefits for particular conditions.[27] Given that long-term care facilities are supposed to do what is best for the health of their residents, treat them with compassion, and consider their needs and feelings, facilities should allow for the storage and use of medicinal marijuana on their premises.

Extending the moral principle of non-maleficence to interactions between residents would entail that a resident should not be able to cause harm to others.[28] That suggests prohibitions on certain forms of marijuana may be appropriate. For instance, some long-term care facilities have policies against smoking on facility premises because of concerns for other residents' health.[29] Similar policies against smoking marijuana could be implemented in order to protect the health and quality of life of the other residents. But marijuana comes in different forms, such as pills or tinctures, which do not have the same potential to harm other residents.[30]

The subsequent discussions presume that the ultimate goal of a long-term care facility is to maximize residents' dignity, autonomy, and privacy, while seeking to protect resident's safety by minimizing the risk for harm.[31]

B. Dignity and Equality

When considering what policy to implement, long-term care facilities should consider how to provide care that maximizes or, at the very least, maintains the dignity and individuality of the resident.[32] A large body of academic scholarship has focused on the difficulties of transitioning from one's home to long-term care facilities.[33] The resulting transfer into a facility may be difficult for a resident for multiple reasons. One is the challenge of leaving a familiar environment and entering into an unfamiliar one.[34] Others include changing social contacts, uncertain social status, and previous

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https://www.health.harvard.edu/blog/medical-marijuana-2018011513085 [https://perma.cc/JWV7-CLTC].

[27] Gregorio, *supra* note 24, at 735–36.

[28] *See* Annas, *supra* note 19, at 924.

[29] *See* Zachary J. Palace & Daniel A. Reingold, *Medical Cannabis in the Skilled Nursing Facility: A Novel Approach to Improving Symptom Management and Quality of Life*, 20 J. AM. MED. DIR. ASS'N. 94, 97 (2019) (explaining how their nursing facility bans smoking while allowing for other forms of marijuana to be kept on premises); *see also* Gary Kochersberger et al., *Resident Smoking in Long-Term Care Facilities – Policies and Ethics*, 111 PUB. HEALTH REP. 66, 69–70 (1996) (describing the balancing between autonomy and other patients' health that long-term care facilities should undertake when deciding what smoking policy to implement).

[30] *See* Palace & Reingold, *supra* note 29.

[31] *See* Metzger, *supra* note 19.

[32] CENTERS FOR MEDICARE AND MEDICAID SERVICES, PUB. 100-07, STATE OPERATIONS PROVIDER CERTIFICATION MANUAL § 483.15(A) (2009) ("[Nursing homes] must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.").

[33] Stephen Richards & Christina Hagger, *The Experiences of Older Adults Moving into Residential Long-Term Care. A Systematic Review of Qualitative Studies*, 9 JBI DATABASE SYS. REV. IMPLEMENTATION REP. 1, 4–6 (detailing the scholarship surrounding relocation and factors associated with increased adverse effects during relocation).

[34] It can take time for nursing home residents to adapt and feel comfortable living in the long-term care-facility. George Bollig et al., *Nothing to Complain About? Residents' and Relatives' Views on a "Good Life" and Ethical Challenges in Nursing Homes*, *23* NURSING ETHICS 142, 146 (2016).

habitual activities which provided comfort becoming unavailable.[35] In preserving the dignity of the resident,[36] it is important that facilities consider how to minimize the distress experienced during this often-difficult transition.[37]

When a facility prohibits the use of marijuana on their premises, residents who may have previously used marijuana as a treatment for an underlying condition before entering the facility may be faced with another frightening transition: from using medicinal marijuana, a recommended medical treatment which they may have found efficacious, to a potentially new treatment they may not be familiar with and which may not be as effective for them.[38]

There are three aspects of this transition that could be particularly harmful to the dignity of the transitioning resident: (1) there may be distressing physical symptoms that result from stopping marijuana treatment, including irritability, nervousness, depressed mood, and anger;[39] (2) there may be a feeling of increased degradation due to the facility compelling them to not use their previous treatment method,[40] especially considering how personal the choice of medication can be;[41] and (3) residents may experience stress in the process of determining a new course of treatment to replace the marijuana they had previously been using.[42] Given that residents already have difficulty transitioning from their homes into long-term care facilities, these consequences suggest that taking away the ability to use medicinal marijuana on facility premises would make the situation even more distressing and undignified.

While the potential for increased indignities due to blanket prohibitions on marijuana is particularly troublesome in the context of resident relocation into a facility, blanket prohibitions on marijuana affect the dignity of new users and previous users alike. In states where medicinal marijuana is legalized, residents may experience indignity due to the perception that they lack equal status to those individuals outside the facility who *do* have access to marijuana – both medicinally and

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35 Maria Riedl et al., *Being a Nursing Home Resident: A Challenge to One's Identity*, 2013 NURSING RES. PRAC. 1, 1–2 (2013).

36 There are various definitions of dignity in medical ethics, but they typically embody the notion of respect for the individual, either by their position in society, their specific qualities, or simply by virtue of their position as human beings. David Albert Jones, *Human Dignity in Healthcare: A Virtue Ethics Approach*, 21 NEW BIOETHICS 87, 87–88 (2015).

37 Kate Lothian & Ian Philp, *Maintaining the Dignity and Autonomy of Older People in the Healthcare Setting*, 322 BMJ 668, 668 (2001) ("Health services should aim to preserve dignity and autonomy and minimize distress among patients.").

38 Studies have indicated that compared to other pain medications such as opioids, respondents 'overwhelmingly' reported that cannabis provided the same relief, without the negative side effects. Amanda Reiman et al., *Cannabis as a Substitute for Opioid-Based Pain Medication: Patient Self-Report*, 2.1 CANNABIS CANNABINOID RES. 160, 160 (2017).

39 A clinical research study found that 57% of those with marijuana dependence experienced at least six symptoms of moderate severity. Alan J. Budney et al., *Marijuana Withdrawal Among Adults Seeking Treatment for Marijuana Dependence,* 94 ADDICTION 1311, 1315 (1999).

40 Riedl, *supra* note 35, at 2.

41 The Supreme Court has recognized the deeply personal nature of choices regarding medical care in cases such as in *Jacobson v. Massachusetts* and *Griswold v. Connecticut*. Jessie Hill, *The Constitutional Right to Make Medical Treatment Decisions: A Tale of Two Doctrines,* 86 TEX. L. REV. 277, 295 (2007).

42 *See* Marianne S. Matthias et al., *The Patient-Provider Relationship in Chronic Pain Care: Providers' Perspectives*, 11 PAIN MEDICINE 1688, 1689 (2010) (describing how coming to a decision on what pain medication to choose can be difficult for both the patient and the physician).

recreationally.[43]

Inequality and dignity, while distinct concepts, are interrelated. The experiences of inequality in societal position and the feeling of inferiority to another social group can have pernicious effects on a person's self-esteem.[44] In turn, low self-esteem can hinder an individual's ability to feel in control because one starts to attribute to others responsibility for their own actions.[45] Lastly, a loss of control and self-determination over one's self (especially one's own body) when transitioning to a long-term care facility bespeaks the resident's loss of dignity.[46] Therefore, when one experiences inequality, one can expect to feel a loss of dignity as a result.

In states that have legalized medical marijuana, the rest of the populace who have a physician's recommendation for marijuana (and the funds necessary to purchase the marijuana) have the opportunity to purchase it and use it in their homes without a justified fear of punishment by federal or local authorities.[47] The perception of inequality relative to individuals outside the facility may be all the worse for those residents who reside in states where recreational marijuana is legalized. In that situation, a resident with a physician's recommendation to help treat a medical ailment may be effectively prohibited from getting that treatment, while those outside the facility, with absolutely no medical need, have the option to procure it.

There may also be a particularly acute sense of inequality based on perceived inferior socio-economic status.[48] Like Ms. Crouse, some residents can afford to transfer to private nursing homes and get their recommended medicinal marijuana.[49] Prohibiting some long-term care residents from accessing medicinal marijuana on premises while allowing other residents with the financial means to transfer to other private facilities violates the ethical prerogative to prevent socioeconomic disparities from determining inequalities of health treatment.[50]

Some of the justifications to ease resident transition also apply to the proposition that long-term care facilities should permit former recreational marijuana users to continue using on facility premises. Recreational users would similarly experience increased distress from physical symptoms of marijuana withdrawal[51] as well as feelings of inequality in states that have legalized recreational marijuana. However, safety interests may justify prohibitions of recreational use even where it might

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[43] Eleven states have legalized marijuana for recreational use. *Marijuana Overview,* NATIONAL CONFERENCE OF STATE LEGISLATURES (Oct. 17, 2019), http://www.ncsl.org/research/civil-and-criminal-justice/marijuana-overview.aspx [https://perma.cc/XM7S-X5DD].

[44] *See* Lynne Belaief, *Self-Esteem and Human Equality*, 36 PHIL. & PHENOMENOLOGICAL RES. 25, 31–32 (1975).

[45] *See* Anna Bortolan, *Self-Esteem and Ethics: A Phenological View*, 33 HYPATIA 56, 56 (2018).

[46] *See* Andrea Rodríguez-Prat et al., *Patient Perspectives of Dignity, Autonomy and Control at the End of Life: Systematic Review and Meta-Ethnography*, 11 PLOS ONE 1, 1–2 (2016).

[47] The federal government cannot coerce the states to enforce federal law, nor does the DEA have the resources to enforce the laws, meaning that marijuana enforcement by federal agents is unlikely. *See* Zachary Ford, *Reefer Madness: The Constitutional Consequence of the Federal Government's Inconsistent Marijuana Policy*, 6 TEX. A&M L. REV. 671, 703 (2019).

[48] Gry Wester, *When Are Health Inequalities Unfair*, 11 PUB. HEALTH ETHICS 346, 349 (2018) ("Health inequalities between socio-economic groups [are] of particular concern . . . [since they] reflect systematic disadvantage.").

[49] Gross, *supra* note 1.

[50] *See* Jennifer Prah Ruger, *Ethics of the Social Determinants of Health*, 364 LANCET 1092, 1092–1094 (2004).

[51] *See* Budney et al., *supra* 39, at 1315.

cause increased distress during transition. The key distinction is that for medicinal marijuana, a doctor has determined that there is a medical benefit to using the marijuana, whereas for recreational use, a doctor has not indicated it has any medical benefit. A policy prohibiting recreational marijuana would be justified based on weighing the danger of potential interactions between the marijuana and other drugs,[52] in addition to the lack of medical benefit, against potentially difficult transitions for residents.

But for medicinal marijuana users, a doctor has indicated there is a medicinal benefit to using the marijuana. In re-evaluating their current marijuana policies, facilities should consider these benefits as well as the indignities that medicinal marijuana users face due blanket bans. Moreover, by coercing residents off their marijuana, facilities exhibit force and diminish choice, both of which present harms distinct in nature from residents' loss of dignity.

C. Autonomy

Philosophers generally "agree that the concept of 'self-government' is central to autonomy."[53] In the healthcare context, autonomy typically refers to allowing the patient to make their own decision about the health treatment they receive.[54] As a general matter, autonomy should be respected because an autonomous individual is in the best position to determine what would be good and bad for them.[55] If a person makes a choice as a result of compulsion or manipulation, then that decision is not fully autonomous.[56] In the context of nursing home facilities, the question of autonomy may be complicated by high rates of dementia, which affects a significant minority of residents.[57] These residents may need assistance in certain areas of their lives, but a traditional autonomy rationale nonetheless agitates against the presumption that such residents completely lack the ability to contribute to their medical decision-making and threatens to worsen their medical treatment.

Policies that disrespect a resident's ability to make choices regarding their health care may not only diminish the quality of the health treatment also undermines their sense of self-worth insofar as they internalize the negative characterizations being absent mentally.[58] Furthermore, limiting patient participation in the choice of treatment harms trust in medical providers, since these providers may be forced to ignore residents' self-judgements.[59]

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[52] *See generally* Emily J. Cox et. al., *A Marijuana Drug Interaction Primer: Precipitants, pharmacology, and pharmacokinetics*, 201 PHARMACOLOGY & THERAPEUTICS 25, 31-35 (2019).

[53] Andrew J. Boyd, *Medical Marijuana and Personal Autonomy*, 37 J. MARSHALL L. REV. 1253, 1278 (2004) (quoting John Christman, *Constructing the Inner Citadel: Recent Work on the Concept of Autonomy*, 99 ETHICS 109, 109 (1988)).

[54] *See* Vikki A. Entwistle et al., *Supporting Patient Autonomy: The Importance of Clinician-Patient Relationships*, 25 J. GEN. INTERNAL MED. 741, 741 (2010).

[55] Jukka Varelius, *The Value of Autonomy in Medical Ethics, Medicine, Health Care and Philosophy*, 9 MED. HEALTH CARE & PHIL. 377, 377 (2006) (citing L.W. Sumner, WELFARE, HAPPINESS, AND ETHICS (1996)).

[56] *Id.* at 378.

[57] As of 2016, 47.8% of residents in long-term care facilities have some form of dementia. NATIONAL CENTER FOR HEALTH STATISTICS, *supra* note 13, at 23.

[58] Susan Sherwin & Meghan Winsby, *A Relational Perspective on Autonomy for Older Adults Residing in Nursing Homes*, 14 HEALTH EXPECTATIONS 182, 188 (2010).

[59] *See* Yusrita Zolkefi, *Evaluating the Concept of Choice in Healthcare*, 24 MALAYS. J. MED. SCI. 92, 94. ("When patient

Prohibitions against marijuana on facility premises may also affect the doctor-patient relationship. Before a doctor can recommend marijuana as a treatment, they typically establish a physician-patient relationship devoted to the health and well-being of the patient, conduct an examination based on patient history and their present illness, and ensure that the patient's ailment is one for which marijuana treatment is beneficial and follows best medical practices.[60] The doctor will then discuss the risks and benefits of the treatment before coming to a mutual decision with the patient to determine whether medicinal marijuana is a proper treatment course.[61]

When a patient has chosen a medical marijuana treatment course recommended by their physician, a facility's prohibition on the patient from possessing marijuana this interferes with the shared-decision-making process between doctor and patient.[62] In practice, shared-decision-making not only respects patient autonomy but is also necessary to comply with duties of beneficence and non-maleficence.[63] Marijuana prohibitions' interference with this relationship results in treatments less preferred by the patient and / or doctor that does not serve the best interest of the patient's health.

D. Privacy

When an individual resides in a long-term care facility, the medical facility becomes their home, and should so entail a degree of privacy of personal space.[64] Allowing for residents in facilities to have personal space gives them a sense of independence,[65] which is a major factor in allowing the resident to adjust to, and feel comfortable in, their new living situation.[66] Eventually, respect for personal space helps the residents embrace the facility as their home.[67]

Invasions of personal space, such as the nursing staff touching a resident's possessions

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choice is ignored or devalued, patients are likely to distrust and, perhaps, disregard health professionals' recommendations, which may later result in the jeopardising of the effectiveness of the treatment.").Not acknowledging an individual's choices diminishes the ability of the patient to have confidence in their own desires and emotions (self-trust), and in developing self-trust, one must first rely on the trust of others. *See* Thomas Nys, *Autonomy, Trust, and Respect*, 41 J. MED. & PHIL. 10, 12 (2016); *see also* Sherwin & Winsby, *supra* note 58.

60 *See* MEDICAL BOARD OF CALIFORNIA, GUIDELINES FOR THE RECOMMENDATION OF CANNABIS FOR MEDICINAL PURPOSES 2 (2018).

61 *Id.* at 3.

62 A prohibition on marijuana could alter the preferred treatment the doctor and patient agree upon. *See* Fiona A. Stevenson et al., *Doctor-Patient Communication About Drugs: The Evidence for Shared Decision Making*, 50 SOC. SCI. & MED. 829, 829 (2000) (explaining that one necessary element for shared-decision-making is the patient and doctor forming a consensus about their preferred treatment method).

63 A.M. Stigglebout et al., *Shared Decision Making: Really Putting Patients at the Centre of Healthcare*, 344 BMJ 1,1 (2012).

64 Annas, *supra* note 19.

65 Yiqi Tao et al., *Privacy and Well-Being in Aged Care Facilities with a Crowded Living Environment: Case Study of Hong Kong Care and Attention Homes*, 15 INT'L J. ENVTL. RES. PUB. HEALTH 1, 2 (2018).

66 M.D. Rijnaard et al., *The Factors Influencing the Sense of Home in Nursing Homes: A Systematic Review from the Perspective of Residents,* 2016 J. AGING RES. 1, 10–12 (2016).

67 *See Id.*

without permission, cause residents to feel as if their privacy has been violated.[68] This invasion of privacy can be especially salient for residents who feel lonely and isolated in their new environment.[69] Any invasion into the residents' limited personal space by a nurse who touches their personal possessions or threatens to touch their personal possessions may increase residents' discomfort in their new home.[70]

Some limits on privacy are permissible because of the need for safe medical care for the individual.[71] Practically speaking, the facility must be informed that the resident is consuming medicinal marijuana because other drugs that the resident is taking could present potentially dangerous interactions.[72] Additionally, facilities should consider competing privacy interests between residents. For example, a policy banning certain forms of marijuana that produce smoke, which could invade the personal space of others, would likely be appropriate.[73]

However, policies banning marijuana on facility premises entirely intrude too heavily on resident privacy. Under a blanket ban on marijuana, residents who attempted to keep their medicinal marijuana on premises could see their privacy invaded in multiple ways. For instance, they could potentially have their marijuana confiscated by the nursing staff,[74] resulting in a physical invasion of their personal space and interference with their personal belongings. Even without physical confiscation, many residents already express significant concerns over intrusions into their personal possessions and territorial space, which the threat of searches for marijuana is likely to exacerbate.[75]

In the alternative, a resident could try to enlist a family to bring the marijuana facility on premises. In the case of Ms. Crouse, for example, due to the facility's blanket prohibition of marijuana on the premises, she was barred from keeping her own marijuana in her room, so instead

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[68] Caroline Roveri Marin et al., *The Perception of Territory and Personal Space Invasion Among Hospitalized Patients*, 13 PLOS ONE, 2018 at 4–6.

[69] Residents in nursing homes often feel lonely and isolated in their new environment and can be territorial about the limited personal space they possess. *Id.* at 8. The dissolution of previous relationships and the move into a new community are contributing factors in residents' loneliness. *See* Marian R. Banks et al., *Animal-Assisted Therapy and Loneliness in Nursing Homes: Use of Robotic Versus Living Dogs*, 9 J. AM. MED. DIRS. ASS'N 173, 173 (2008) (citing L.A. Peplau & D. Perlman, LONELINESS: A SOURCE BOOK OF CURRENT RESEARCH AND THERAPY (1982)). Higher levels of loneliness are correlated with increased likelihood of entering nursing homes. *See* Daniel W. Russell et al., *Loneliness and Nursing Home Admission Among Rural Older Adults*, 12 PSYCH. & AGING 574, 574 (1997).

[70] Marin, *supra* note 68, at 8. For the elderly, fears surrounding their social environment, such as being victims of crimes, are heightened. *See* Raymond A. Eve & Susan Brown Eve, *The Effect of Powerlessness, Fear of Social Change, and Social Integration on Fear of Crime Among the Elderly*, 9 VICTIMOLOGY 290, 290 (1984).

[71] *See supra* Part I.A.

[72] Marcus, *supra* note 12, at 10–11.

[73] *See* Palace & Reingold, *supra* note 29 (detailing how the authors' nursing facility bans smoking while allowing for other forms of marijuana to be kept on premises).

[74] A facility could confiscate marijuana claiming it hurt other resident's safety or health. *See* 42 C.F.R. § 483.10(l) ("[A] resident has the right to retain and use personal possessions . . . unless to do so would infringe upon the rights or health and safety of other residents.").

[75] *See* Eve & Brown Eve, *supra* note 70, at 290–292 (discussing the heightened sense of fear among the elderly); *see also* Marin, *supra* note 68, at 4 (describing findings that some patients perceive greater invasion of territorial and personal space).

her son stored the marijuana and snuck it in to the facility.[76] But reliance on a family member to provide medication is likely to injure the resident's sense of independence that comes from the ability to maintain privacy over personal possessions within their personal space.[77]

A resident who wishes to use marijuana in a facility that prohibits it may thus potentially face an intrusion upon their privacy in multiple ways: actual invasion of privacy if the marijuana were to be confiscated, fear of invasion if the marijuana were to be detected, or the loss of independence if the marijuana were not stored on premises. Long-term care facilities that receive federal funding and impose blanket bans on medical marijuana give insufficient weight to this loss of privacy, as well as to the losses to dignity and autonomy that arise from their prohibitions. These facilities often justify their policies by claiming federal law obliges them. The following Part will evaluate this claim and argue that the potential threat of liability instead favors permitting marijuana on premises.

II. MEDICAID AND MEDICARE REQUIREMENTS AND POTENTIAL LIABILITY

Long-term care facilities certified by Medicare or Medicaid are bound to follow both federal and state law or risk termination from the programs.[78] The Controlled Substances Act (CSA) prohibits these facilities from possessing or distributing marijuana.[79] Facilities with blanket bans on marijuana often use federal regulations as grounds for not allowing any marijuana on their premises.[80] But policies could be adopted, and have been adopted, which do not require possession or administration of marijuana by the facility and its staff.[81] Current concerns about CMS cutting funding for possession thus appear unwarranted.

The following Sections argue that by failing to adopt a policy allowing for residents to access medicinal marijuana, a long-term care facility risks potential liability under section 1983. Moreover, they show how residents might fight discharges using their state's administrative appeals process for involuntary discharges. While these claims may not prove successful in actual application, facilities should factor in potential liability and potential costs of engaging in numerous appeals, in addition to the ethical considerations described *supra*, when considering what policy to implement.

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[76] Gross, *supra* note 1.

[77] Having personal space away from the demands of others allows the resident to gain a sense of independence. *See* Yiqi Tao et al., *Privacy and Well-Being in Aged Care Facilities with a Crowded Living Environment: Case Study of Hong Kong Care and Attention Homes*, INT'L J. ENV'T. RSCH. & PUB. HEALTH, 2018, at 2.

[78] 42 U.S.C § 1396r(d)(4)(a) ("A nursing facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations. . . ."); 42 C.F.R. § 489.53(a)(1) ("CMS may terminate the agreement with any provider if . . . [i]t is not complying with the provisions of title XVIII . . . of this chapter or with the provisions of this agreement.").

[79] 21 U.S.C. § 841(a)(1) ("[I]t shall be unlawful for any person knowingly or intentionally to manufacture, distribute, or dispense, or possess with intent to manufacture, distribute, or dispense, a controlled substance."). Marijuana is currently classified as a schedule one controlled substance. 21 U.S.C. § 812 (c)(1)(c)(10).

[80] *See* Gross, *supra* note 1; *see also* Erickson, *supra* note 7.

[81] *See* Marcus, *supra* note 12 at 9–10 (saying that federal law does not require hospitals to prevent inpatients from bringing marijuana on premises); *see also* Palace & Reingold, *supra* note 29, at 94–97 (describing a facility that has implemented a policy allowing for marijuana use on premises, while remaining compliant with federal law).

A. Potential Private Right of Action Under Section 1983

Residents who have been discharged for using medicinal marijuana should consider bringing a section 1983 claim,[82] which "imposes liability on anyone who, under color of state law, deprives a person of any rights, privileges, or immunities secured by the Constitution and laws."[83] In *Blessing v. Freestone*, the Supreme Court determined whether a particular statutory provision gives rise to a federal right by looking at three factors: (1) whether Congress intended that the provision in question benefit the plaintiff; (2) whether the plaintiff demonstrated that the right protected by the statute is not so vague and amorphous that its enforcement would strain judicial competence; and (3) whether the statute unambiguously imposes a binding obligation on the states.[84] The Supreme Court later added a requirement to the first prong that the statute contain explicit language creating rights.[85] Once this test is satisfied, section 1983 is presumed to enforce the right in question.[86]

The Court has held that a variety of constitutional rights can be enforced using section 1983. Many of these rights originate in the Fourteenth Amendment. For example, both procedural due process and substantive due process are enforceable under section 1983.[87] The Bill of Rights is also enforceable under the Fourteenth Amendment, as the Due Process Clause incorporates these rights and makes them applicable to the states.[88] With statutory claims under section 1983, the analysis depends on whether the statute is a rights-creating statute or a spending statute.

A mere spending statute will not give rise to an action under section 1983.[89] In *Pennhurst State School and Hospital v. Halderman*,[90] the Court described the rationale for this distinction: "In legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by

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[82] One veteran's affair agency with eight residential facilities in California has a policy of immediately discharging the resident from the home if they use marijuana. Libby Denkmann, *Can Veterans be Penalized for Using Pot? Answer is Hazy,* KPCC LOCAL NEWS (Jan. 8, 2018), https://www.scpr.org/news/2018/01/08/79589/california-veterans-who-use-marijuana-are-caught-i/ [https://perma.cc/BAG8-MSVC].

[83] Blessing v. Freestone, 520 U.S. 329, 340 (1997) (quoting 42 U.S.C. § 1983).

[84] *Id.* at 340-341 (1997) (citing *Wright v. Roanoke Redevelopment & Hous. Auth.,* 479 U.S. 418, 430–432 (1987)).

[85] Gonzaga Univ. v. Doe, 536 U.S. 273, 283 (2002) ("We now reject the notion that our cases permit anything short of an unambiguously conferred right to support a cause of action brought under § 1983").

[86] *Id.* at 284.

[87] *See* Cleveland Bd. of Educ. v. Loudermill*,* 470 U.S. 532, 541 (1985) ("The point is straightforward: the Due Process Clause provides that certain substantive rights – life, liberty, and property – cannot be deprived except pursuant to constitutionally adequate procedures."); Cnty. of Sacramento v. Lewis, 523 U.S. 833, 854 (1998) (holding that a situation involving a high-speed chase where there was no intent to physically harm a suspect or worsen their legal plight was not redressible under section 1983 because there was not a violation of substantive due process).

[88] McDonald v. City of Chicago*,* 561 U.S. 742, 763–764 (2010) (explaining that in selective incorporation, the Court inquires "whether a particular Bills of Rights guarantee is fundamental to our scheme of ordered liberty and justice").

[89] *See Gonzaga,* 536 U.S. at 279-82 (2002) ("[W]e have never before held, and decline to do so here, that spending legislation drafted in terms resembling those of FERPA can confer enforceable rights.").

[90] 451 U.S. 1, 28 (1981) (finding no private right of action under the Developmentally Disabled Assistance and Bill of Rights Act of 1975).

the Federal Government to terminate funds to the State."[91] Similarly, *Suter et al. v Artist M.* found that the Adoption Assistance and Child Welfare Act did not give any individual discernible rights and therefore was not enforceable under section 1983.[92] The Court in *Suter* stated:

> Careful examination of the language . . . does not unambiguously confer an enforceable right upon the Act's beneficiaries. The term "reasonable efforts" in this context is at least as plausibly read to impose only a rather generalized duty on the state to be enforced not by private individuals, but by the Secretary in the manner [of reducing or eliminating payments].[93]

Because there was no "specific, individually enforceable right" created by the statute, there was no basis for a section 1983 claim.[94]

In order to bring a statutory claim under section 1983, the statute must be a "rights-creating statute."[95] When deciding whether a federal statute creates a right actionable under section 1983, the Supreme Court has held that the text, structure, and legislative history should be examined to determine whether the *Blessing* factors are met.[96] The Court in *Gonzaga* described the type of statutory language necessary to be considered rights-creating:

> We [] reject the notion that our cases permit anything short of an unambiguously conferred right to support a cause of action brought under section 1983. Section 1983 provides a remedy only for the deprivation of "rights" privileges or immunities secured by the Constitution and laws" of the United States. Accordingly, it is *rights*, not the broader or vaguer "benefits" or "interests," that may be enforced under the authority of that section.[97]

When a resident brings a section 1983 claim against a Medicaid or Medicare facility, some courts have found that the requirements for certified facilities meet the *Blessing* factors.[98] Residents' rights include "the right to choose a personal attending physician," "to participate in planning [their]

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[91] *Id.*

[92] 503 U.S. 347, 360 (1992).

[93] *Id.* at 363.

[94] Gonzaga Univ., 536 U.S. at 281 (describing the holding of *Sueter et al. v. Artist M).*

[95] *Id.* at 284-85 ("Once a plaintiff demonstrates that a statute confers an individual right, the right is presumptively enforceable by § 1983. But the initial inquiry – determining whether a statute confers any right at all – is no different from the initial inquiry in an implied right of action case, the express purpose of which is to determine whether or not a statute 'confer[s] rights on a particular class of persons.'") (quoting *California v. Sierra Club,* 451 U.S. 287, 294 (1981).

[96] *Id.* at 285-86.

[97] *Id.* at 283.

[98] *See* Grammer v. John J. Kane Reg'l Centers-Glen Hazel, 570 F.3d 520, 527–28 (3d Cir. 2009); *see also* Concourse Rehab. & Nursing Ctr. Inc. v. Whalen*,* 249 F.3d 136, 144 (2d Cir. 2001). However, some district courts in other jurisdictions have *not* found section 1396r to confer a right to the resident. *See* Sanguinetti v. Avalon Health Care, Inc.*,* No. 1:12-CV-0038, 2012 WL 2521536, at *5 (E.D. Cal. June 28, 2012); Hawkins v. Cty. of Bent, Colo.*,* 800 F. Supp. 2d 1162, 1167-68 (D. Colo. 2011). Given this split, a nursing home should consider its jurisdiction when factoring in potential liability under section 1983.

care and treatment," and "the right to privacy with regard to accommodations [and] medical treatments."[99] In *Grammer v. John J. Kane Reg'l Centers-Glen Hazel*, the Third Circuit found the Medicaid statute created a right for the residents enforceable under section 1983.[100] The Court evaluated each of the three factors set forth in Blessing and found the following: "[1] [a]s both a Medicaid recipient and a nursing home resident, Grammer's mother was an intended beneficiary of 42 U.S.C. § 1396r . . . [2] The various rights are clearly delineated by the provisions at issue . . . [and 3] the language unambiguously binds the states and the nursing homes as indicated by the repeated use of 'must.'"[101]

Courts have not yet considered these rights in the context of a nursing home resident who has been discharged for marijuana use. If a resident either faces discharge because they used medicinal marijuana on the premises or experiences increased pain and suffering due to a facility's marijuana prohibition, they may viably argue that any injury caused was due to a violation of their rights to participate in planning their care and treatment, to choose their attending physician, and to privacy. The argument presented here is so far untested in the courts and would rest on a finding that a resident's rights to plan their own care and treatment, to choose their own physician, and to maintain their privacy incorporate the right for that care and treatment *not* to be impeded by a facility's policies. Even as the argument remains unproven, residents should consider raising the legal claim as it could result in damages and incentivize changes in current policies.

B. Fighting a Potential Discharge

Long-term care facilities certified by Medicaid or Medicare are required to meet both federal standards and state standards. States that wish to participate in Medicaid appoint a single state agency to assure that federal requirements are met and that the state's procedures are at least as stringent as those established by the federal government.[102]

Residents in certified facilities have procedural protections that prevent discharge without good cause.[103] Federal law permits involuntary discharge in only six circumstances where it is considered necessary or appropriate. These circumstances arise when: (1) the facility cannot meet the resident's welfare needs, (2) the resident no longer needs care, (3) the safety of other individuals in the facility is endangered, (4) the health of individuals in the facility is endangered, (5) the resident has failed to pay after reasonable and appropriate notice, or (6) the facility ceases to operate.[104] The nursing facility must notify the resident of the discharge,[105] and every state must provide a fair mechanism for a resident to appeal the facility's decision.[106]

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99 42 U.S.C. § 1396r(c)(1)(A)(i)–(iv).

100 *Grammer,* 570 F.3d at 527–32 .

101 *Id.*

102 *See* 42 U.S.C. § 1396a(a)(5) (mandating that a state plan for medical assistance provide for the establishment or designation of a single state agency to administer or supervise the administration of the plan); 42 C.F.R. § 483.204 (requiring the state to provide a hearing and appeals system for matters regarding discharge, transfer, readmission screening, and annual resident review determinations).

103 A "discharge" is defined as a move from a nursing facility to a non-institutional setting. 42 C.F.R. § 483.202.

104 42 U.S.C.A. § 1395i-3(c)(2).

105 *Id.*

106 42 U.S.C.A. § 1395i-3(e)(3).

The standard of proof required for a facility to prove that a discharge was necessary, following the federal standards, depends on state requirements.[107] Some states have required a standard of proof as high as clear and convincing evidence.[108] The typical standard of proof, though, is substantial evidence.[109]

If a resident is to be discharged, federal law provides that the care facility notify not only the resident but also a family member or legal representative (as defined under state law).[110] By mandating that the resident receive notice, the law maintains some respect for the resident's autonomy while also recognizing the limited capacity of some residents to represent themselves and enforce their rights.[111]

The most common justification for resident discharges are behavioral problems, such as acting aggressively in ways that pose a risk to either their own safety or other residents' safety.[112] Kathleen Knepper has discussed the justifications most often used by nursing homes to discharge residents:

> Somewhat ironically, while agitation increases the likelihood that an individual will be placed in a facility for long-term care, it also may increase the likelihood that the facility will seek to transfer or discharge the resident. A nursing home's desire to relocate a resident who demonstrates agitation will evidence the facility's lack of success in responding effectively to these behaviors.[113]

In discharging residents for behavioral issues, courts have held that facilities first must develop an adequate care plan and provide appropriate services.[114] In the *Matter of the Involuntary Discharge or Transfer of J.S.*, for example, a resident with schizophrenia was uncooperative with caregivers, refused treatment, and neglected her personal hygiene and nutrition.[115] However, because the facility did not attempt to establish and implement an adequate care plan for the resident, the court found that transfer or discharge was improper and should be viewed as a last resort.[116]

One facility successfully met its burden of proof for a discharge when a resident struck and verbally abused other residents.[117] The resident also, to quote the court's quizzical phrase,

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107 *See, e.g.*, Edgewater at Waterman Vill. v. Youngren, 803 So. 2d 900, 901 (Fla. Dist. Ct. App. 2002) (finding the standard of proof based on federal law was clear and convincing evidence of taking proper action).

108 *See, e.g.*, *id.*

109 Kathleen Knepper, *Involuntary Transfers and Discharges of Nursing Home Residents Under Federal and State Law*, 17 J. LEGAL MED. 215, 223 (1996).

110 *Id.* at 231-32.

111 *Id.* (explaining that permitting family members to act on the resident's behalf raises ethical concerns about autonomy, however, in some circumstances, residents may be incapable of exercising their rights, which necessitates family member intervention.).

112 *Id.* at 245-46.

113 *Id.* at 247.

114 *Id.* at 267-69 (explaining several cases where discharges were denied due to inadequate services and care plans).

115 512 N.W.2d 604, 607-08 (Minn. App. 1994)

116 *Id.* at 607-08, 612.

117 Nichols v. St. Luke Ctr. of Hyde Park, 800 F. Supp. 1564, 1566-69 (S.D. Ohio 1992).

"maneuver[ed] his motorized wheelchair in a menacing manner."[118] Before successfully meeting its burden in this case, the facility began a treatment course which involved changing the resident's medication, as well as confining him to his room and calling his doctor when he became agitated.[119] Because this course of treatment was unsuccessful at remediating the situation, the facility met its burden of showing the resident was a threat to other residents' safety.[120]

If a resident receives a notice of discharge for marijuana use, they should use their state's appeals process to dispute it. The use of marijuana, absent other problematic behavior, does not pose a danger to the safety or health of others in the facility comparable to physical or verbal abuse. In these situations, the facility could implement a plan to meet the resident's individual needs and respect the needs of other residents. There are not any known cases of an appeal for a discharge for marijuana, and appeals in general are relatively rare,[121] but a resident who uses either tinctures or capsules for administering their marijuana would have a compelling case that the facility failed to meet its burden of proof required for involuntary discharge.

III. CONCLUSION: PROPOSED POLICY REFORMS

Facilities should implement policies that allow for residents to keep medicinal marijuana on premises but that do not violate federal law by allowing the staff to possess or administer the marijuana themselves. This Article concludes by proposing that long-term care facilities implement the following policy with regards to on-premise marijuana use:

> 1. This policy will apply only to individuals who are eligible for medicinal marijuana and not to individuals who merely seek to use it recreationally. Although allowing for recreational use would promote resident autonomy, dignity, and privacy, the lack of a medical practitioner recommendation reduces its likely medical benefits and raises the possibility of adverse reactions from mixing marijuana with other medications.
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> 2. The marijuana cannot be administered through means that produce smoke. The pungent smell of marijuana and smoke could potentially hurt other residents' physical health or invade their right to privacy. In order to avoid potential harm to other residents, facilities should limit marijuana administration to tinctures, capsule form, and other equivalent means.

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118 *Id.* at 1566.

119 *Id.*

120 *Id.* at 1569.

121 *See, e.g.*, 41 Mo. Prac. Missouri Elder Law § 12:7 (2019) (noting the lack of published decisions in Missouri regarding involuntary discharges).

> 3. Residents will be required to purchase their marijuana from a state-certified dispensary. State-certified dispensaries are subject to various requirements that make them safer than other marijuana providers.[122] This requirement will reduce the risk that residents obtain the marijuana from other, less secure channels, whose marijuana may pose a higher likelihood of health risks.
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> 4. The facility will provide each individual a lockbox, or some device that provides an equivalent level of privacy and discretion, where the resident may store their marijuana. This lockbox will ensure that residents have the means to keep the marijuana secure assure residents that the marijuana will be kept private.
>
> 5. Lastly, a facility should inform residents that they will be required to either self-administer the marijuana or find a caregiver to administer the marijuana. Where a caregiver is involved, the facility should permit them reasonable access to the facility so that they may administer treatments according to the recommendation of the resident's physician.

In 2016, New York's Hebrew Home at Riverdale adopted a policy similar to that described above.[123] As of October 2019, the Center for Medicaid and Medicare Services had not revoked their funding.[124] Other facilities should weigh the benefits of implementing these more permissive policies – including support for residents' autonomy, dignity, and privacy interests, as well as reduced potential for civil liability – against the small risk of running afoul of federal law. Even under a risk-averse approach, long-term care facilities that fully examine the ethical and financial dimensions of regulating their residents' marijuana use should be expected to change their policies accordingly.

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[122] Some states, for example, require that certified dispensaries provide a copy of the bylaws, business plans, description of services, and processes, as well as how the dispensary will deliver the marijuana, monitor it, and ensure access is restricted before certification. *See, e.g.*, 410 Ill. Comp. Stat. Ann. 705/15-30 (West 2019) (restricting criteria on dispensaries wishing to get a license, such as requiring employee training plan, security and record-keeping plan, operating plan, etc.).

[123] Palace & Reingold, *supra* note 29, at 95-97.

[124] *Hebrew Home in Riverdale Offers Medical Marijuana Program to Elderly Resident*, NEWS 12 (Oct. 30, 2019), http://bronx.news12.com/story/41248424/hebrew-home-in-riverdale-offers-medical-marijuana-program-to-elderly-residents [https://perma.cc/TA5V-NRCY].