The Long and Winding Road: Life Care Center – Kirkland’s Journey for Justice

Readers may recall that in March 2020, Life Care Center – Kirkland (LCCK), a skilled nursing facility located in Kirkland, WA, became the epicenter of the COVID-19 outbreak in the United States. By way of brief background, LCCK’s infection control nurse reported an outbreak of an unknown respiratory infection to state officials on February 26, 2020. The County Department of Health did not return her call until the next day, after she called again.

Instead of sending a strike team to help with the increasing numbers of residents and staff succumbing to the as-yet-unknown global pandemic, a team of surveyors were sent on March 6, 2020. (The strike team arrived on March 7, 2020, more than a week after LCCK had notified county health officials.) The surveyors spent approximately 400 hours interviewing staff and reviewing thousands of pages of medical records; they never interviewed any residents.

The surveyors alleged seven separate deficiencies including infection control, which was cited at the “immediately jeopardy” level. As a consequence, the Centers for Medicare & Medicaid Services imposed a civil money penalty (CMP) of $611,325 and a Denial of Payment for New Admissions (DPNA). Separately, the State of Washington imposed “conditions” on LCCK’s license and a “Stop Admissions” order. Both enforcement actions were appealed.

Two facts are noteworthy: (1) at the time of the outbreak and survey, LCCK was designated a Five-Star facility by CMS; and (2) LCCK had an infection control survey in mid-February after it reported a resident who potentially was infected with tuberculosis. After that survey, no deficiencies were cited regarding LCCK’s infection control and prevention program. Thus, just weeks before the outbreak, surveyors had determined that LCCK’s infection control and prevention policy was in compliance with the applicable regulations.

Even before LCCK’s staff knew they were dealing with COVID-19, they had implemented a number of appropriate interventions: the dining area was closed, and residents were served meals in their rooms; disposable utensils were used; the staff were educated about the use of personal protective equipment (PPE), proper hand hygiene, and the prevention of disease transmission; and signs were posted to inform visitors they could not enter if they had symptoms such as a fever or a cough. Additionally, LCCK provided screening for respiratory infection for all visitors, vendors, and volunteers. The Centers for Disease Control and Prevention did not initially permit LCCK to test for COVID-19, which seems questionable in retrospect.

The Appeals

LCCK separately appealed the enforcement actions taken by Washington State as well as CMS. Each appeal is briefly discussed here.

Washington State Appeal

One of the seven deficiencies under appeal had to do with LCCK’s medical director. The administrative law judge (ALJ) in the state appeal addressed the allegation that LCCK failed to have the medical director implement and coordinate the residents’ care. Significantly, the medical director succumbed to COVID-19 and was home sick for about three weeks, beginning on March 3, 2020. Although the surveyors found fault with the medical director’s functions, the testimony and evidence revealed that during the entire time the medical director was out sick with COVID-19 he was available by phone and “gave competent medical advice.” Moreover, the ALJ noted, “there is no evidence that the residents did not get the care that they needed.” Thus, the deficiency related to the medical director was not upheld.

After the full evidentiary hearing, the ALJ held that Washington’s Stop Admissions order was an “abuse of discretion” although he upheld the conditions placed on LCCK’s license. In reversing the Stop Admissions order, the ALJ noted that LCCK “followed all DCC [sic] guidelines in place” at the relevant times. Further, the ALJ observed, “the Department [Washington Department of Social and Health Services] presents no evidence of what else they [LCCK staff] may have done that would have changed the outcomes for their patients,” and there was no evidence LCCK’s “management of the crisis was inadequate.” That favorable decision for LCCK was affirmed on further appeal.

CMS Appeal

Even though LCCK had a victory at the state level, it still had to contend with the $611,325 CMP and DPNA imposed by CMS at the federal level. Because much of the decision of the state ALJ was favorable and the facts were essentially identical, LCCK argued that a legal doctrine known as collateral estoppel (also referred to as issue preclusion) would apply and the CMS case should have been decided in LCCK’s favor. The federal ALJ rejected that premise and conducted a full evidentiary hearing.

The Issues

The federal ALJ addressed the following issues:

1. Whether there was a basis for the imposition of enforcement remedies (i.e., were there any deficiencies?); 2. Whether the allegation of immediate jeopardy was clearly erroneous; and 3. Whether the CMP and DPNA were reasonable sanctions.

Analysis

When deciding cases, judges weigh the evidence — both documentary and testimonial — and apply the law to the facts. Among the witnesses LCCK presented were two medical experts, Dr. Morgan Katz and Dr. Peter Hashisaki. Dr. Katz is an assistant professor of infectious diseases at Johns Hopkins University and director of antimicrobial stewardship at Johns Hopkins Bayview Hospital; he has significant experience in long-term care infection prevention and antibiotic stewardship. Dr. Hashisaki is chairman of the Infection Control Committee at Overlake Medical Center in Bellevue, WA, and has been their head of infectious diseases since 1991. The ALJ determined both experts’ testimony was “credible and entitled to greater weight than those of Dr. Schwartzman [the CMS medical expert] or the surveyors.”

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Based on all the evidence, the ALJ refused to uphold six of the seven alleged deficiencies. And he only upheld the infection control deficiency because the staff had permitted a preplanned Mardi Gras party with outside musicians to proceed on February 26, 2020, even though they maintained social distancing. (Interestingly, CMS had not alleged the Mardi Gras party as a basis for the deficiency.)

In his 136-page opinion, the ALJ criticized the survey: “While it is the right of CMS and the state survey agency [to conduct surveys] it would have been a better exercise of discretion to not create any distraction that could have adversely impacted resident care during the period of the survey … there is no evidence that the survey in this case served to protect any residents at the time it was conducted” (Life Care Center – Kirkland v. CMS, DAB CRD No. 5975 (2021), https://bit.ly/3IWRLjl). Further, the ALJ opined in a bolded statement, “However, I make no findings or determinations that the errors of Petitioner’s staff resulted in the spread of COVID-19 or the death or injury of any resident.” On the contrary, the ALJ held that “based on all the evidence presented to me” LCCK’s physicians and other staff “made a heroic effort to care for and save residents.”

Epilogue

If neither the facts nor the law support the deficiencies alleged by CMS or the resultant enforcement action, this case illustrates that an appeal may be the path to correcting that injustice and preserving reputational and other interests, along with vindicating the staff. When heroes are portrayed as villains, perhaps it is time to rethink the survey process.


The survey process is necessary and mandated by statute and regulations. But the devil is in the details, and CMS owes it to residents to make the survey process as productive as possible. One glaring lesson gleaned from this case is that there is room for improvement, especially when heroes are not recognized for the extraordinary work they perform every day.

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