

“(The hallways)...reeked of urine”ⁱ

- State of Illinois Health Inspector

“It hurts like hell”ⁱⁱ

- Resident, in response to Health Inspector questions regarding open untreated pressure sores

“(She) was observed to have her eyes tightly closed and had facial grimacing. (She) begged staff, **“Please don’t touch me.”**ⁱⁱⁱ

- State of Illinois Health Inspector’s observation of resident’s untreated inward rotation of leg

“I told (the administrator) that we needed more staff to monitor and that **I did not feel safe** but (the administrator) just cut my hours down”^{iv}

- Nurse at Gem Healthcare facility

Lerner No Gem

How Michael Lerner and Gem Healthcare continue to fail Illinois seniors

- ✓ Failure to keep residents clean and groomed
- ✓ Failure to identify, treat and prevent pressure sores
 - ✓ Failure to call 911 in a timely manner
 - ✓ Failure to have a plan for emergency services
- ✓ Failure to adequately staff and monitor a confused resident resulted in resident’s death

EXECUTIVE SUMMARY

Based in Chicago, Illinois, Michael Lerner is the primary owner of four Illinois nursing homes with a history of numerous patient care violations, Forest Hill Health and Rehab in East Moline, Galesburg Terrace in Galesburg, Regal Health and Rehab in Oak Lawn and Camelot Terrace in Streator. Michael Lerner is also the primary operator of these facilities through Gem Healthcare Management, Inc, for which Lerner serves as the company's President and Secretary. Over the last several years, these facilities managed by Gem Healthcare Management, Inc have accumulated numerous care violations.

While under the management of Gem Healthcare, the Illinois State Department of Public Health have found residents of these homes suffered sexual abuse¹, debilitating health issues^{vi} and even death^{vii}. While Gem Healthcare's President Michael Lerner and related companies receive public dollars from these facilities, frontline caregivers at these homes receive poverty level wages. These low wages and poor management in turn contribute to troubling turnover rates at Gem homes. At Lerner's Galesburg Terrace facility, 68% of Certified Nursing Assistants (CNA), the workers who provide the majority of direct care to residents, have been there less than one year and 77% have been there less than two years. Among the staff at Galesburg Terrace, there is just one full-time nursing assistant who has been caring for residents there for more than three years.^{viii}

This report will examine how Gem Healthcare's questionable management of public healthcare dollars has resulted in dramatic health outcomes experienced by nursing home residents in Gem's care. The State of Illinois has a responsibility and an obligation to protect the residents dependent on these nursing homes. With more than 280 Illinois residents^{ix} currently placed in Gem Healthcare's four facilities, the state needs to take immediate action to protect these elderly residents from the "care" provided by Michael Lerner and Gem Healthcare.

Over the last three health survey cycles, the state of Illinois documented 218 patient care and fire safety violations at Gem facilities. Of these violations, 84% were for care involving actual and/or potential harm to residents. Two Gem facilities, Forest Hill Health and Rehab and Regal Health and Rehab, reported more than twice the state average number of deficiencies over the last three survey cycles.^x

Today, we have submitted a request to the State Department of Public Health to review the patient care at facilities owned by Michael Lerner. In the request submitted to the Department's Director, Dr. Damon T. Arnold, the following violations were cited:

- During an inspection a Gem facility, state surveyors reported, hallways **“reeked of urine”**^{xi}
- Failed to provide treatment for pressure sores.^{xii}
- Failed to follow program to prevent the spread of infection^{xiii}
- Failed to **identify and evaluate the sexual behaviors** of residents with known moderate to severe impaired cognition levels for understanding of these behaviors.^{xiv}
- **Failed to keep residents clean and groomed**^{xv}

¹ 9/18/2007 Health Survey pg 6, Forest Hill

- “**Failed to provide care to maintain cleanliness and prevent infections** for residents with urinary catheters.”^{xvi}
- Failure to adequately staff and monitor a confused resident. Subsequently, resident subsequently accidentally displaced his trach tube and died.^{xvii}
- Failed to assess, identify and provide treatment for a resident’s pain.^{xviii}
- “failure to notify the physician (in a timely manner) of a change in condition, the **failure to contact 911** in a timely manner and the failure of the facility to have a protocol regarding emergency services”^{xix}

Each of these four homes have operated under their current licenses for at least ten years, with Regal Health and Rehab in Oak Lawn operating under its current license for over sixteen years. In the last decade of management, these facilities and the residents that live there have continued to experience violations in care, declining utilization and staff turnover. This report asserts that Michael Lerner and his Gem Healthcare have had ample time and opportunity to address the continued care violations at these facilities and have been unable or unwilling to do so after over a decade of this responsibility.

Under the Nursing Home Care Act, the Illinois Department of Public Health has the ability and responsibility to appoint a receiver to control a nursing home when “...a threat to the health, safety or welfare of a resident (exists) that the facility is unwilling or unable to correct”.^{xx} With years of violations in care documented at the nursing homes “managed” by Michael Lerner, this report asserts that Illinois citizens in Gem Healthcare’s care face this threat now.

Because of the history of patient care deficiencies experienced by residents of Gem Healthcare’s facilities, this report recommends the following:

- An immediate investigation by the Illinois Department of Public Health to document that an emergency exists at the following Gem Healthcare managed facilities under the ownership of Michael Lerner; Camelot Terrace, Forest Hill Health and Rehab, Galesburg Terrace and Regal Health and Rehab
- The immediate appointment by the Illinois Department of a receiver to assume control of these facilities until this emergency no longer exists.

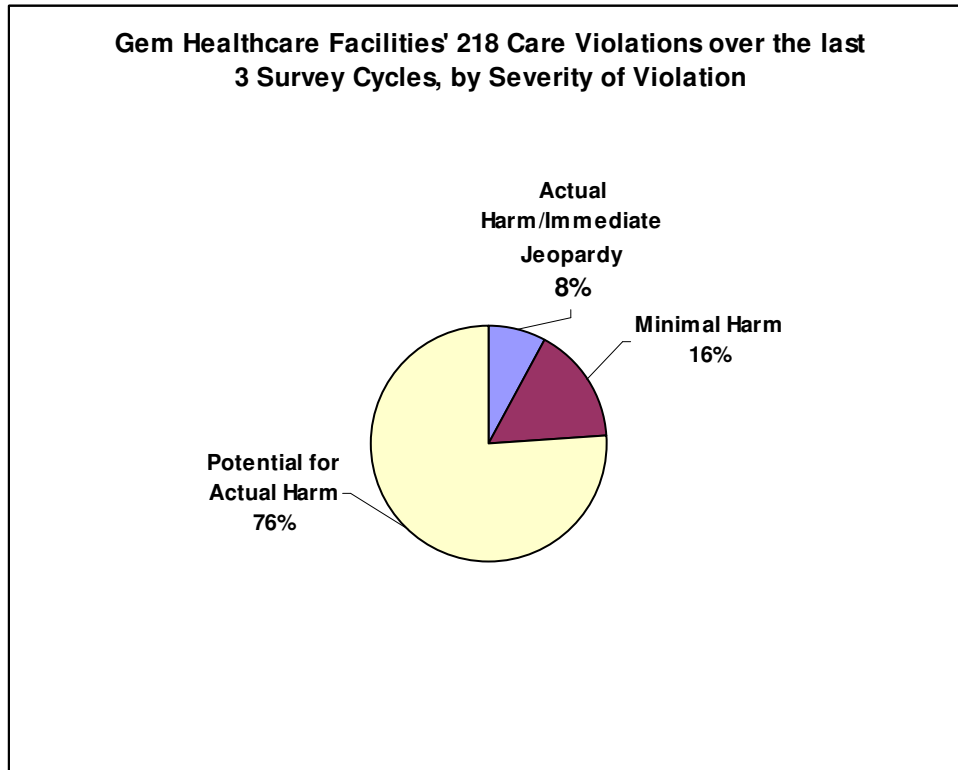
GEM Healthcare Facilities Record of Patient Care

In 2007 and 2008, the Illinois Department of Public Health recorded 77 violations of patient care and fire safety reported at Gem facilities. Over 88% of these violations were for cases where potential or actual harm existed for the residents living there. Of these violations, nearly 30% took place in the first few months of 2008, with only two of four Gem facilities with data yet available through the federal government’s medicare.gov website. If this number of violations have taken place at only two Gem facilities in the last few months, what kinds of care violations can the residents of Gem Healthcare expect to suffer in the coming months?

Over the last three health survey cycles administered by the Illinois Department of Public Health:

- The four Gem Healthcare facilities each reported higher than the state average number of deficiencies over a three year period.

- Over the last three health survey cycles, the state of Illinois documented 218 patient care and fire safety violations at Gem facilities. Of those violations, 84% were involving actual or potential harm to residents.
- Two Gem facilities, Forest Hill and Regal, reported more than twice the state average number of deficiencies over a three year period.
- Forest Hill Health and Rehab reported 87 violations of patient care, more than three times the state average number of deficiencies over this same three year period.

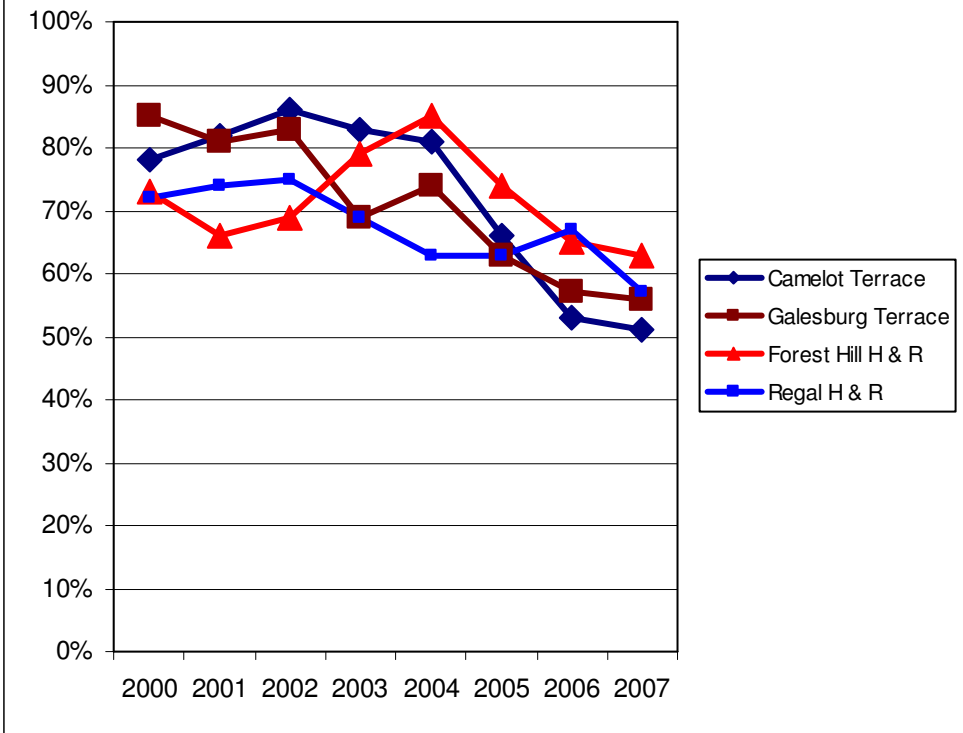


Declining Occupancy Leaves Public Aid Residents Behind ^{xxi}

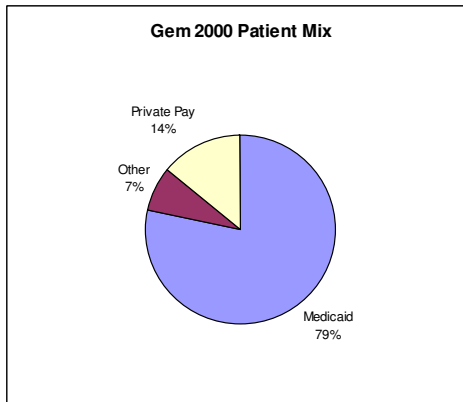
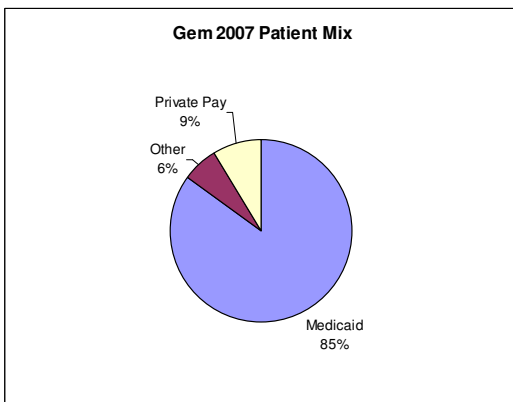
While Gem Healthcare’s nursing homes have accumulated these disturbing violations of residents’ care, the occupancy of the homes has steeply declined. In 2007, the four homes were licensed by the State of Illinois to provide 490 skilled nursing beds, while only 286 residents were reportedly living in the four facilities.^{xxii}

Collectively, the four homes had an 57% occupancy in 2007, down from 61% in 2006, and 67% in 2005. This was lower than the state average occupancy of 84% for 2006 and 2005.

Gem Healthcare Facilities Declining Occupancy 2000-2007



As a group, the facilities have experienced a decline in the number of residents using private funds to finance their stay. Between 2000 and 2007, Gem facilities saw a decrease in their percentage of these more lucrative private paying residents and an increase in the percentage of residents paying for services through public Medicaid dollars.



Low Staffing Levels Leads to Poor Patient Outcomes

In January of 2007, Gem Healthcare's Regal Health and Rehab was cited by State Health Inspectors for failure to adequately staff and monitor a confused resident, provide hemodialysis to a resident and failure to administer medication to another resident.

"...the facility failed to provide supervision and staff monitoring for 1 resident in the sample with an identified neuro impairment. Subsequently, (resident) manually removed his trach tube and expired. (Resident's) death was documented by the medical examiner to be an accidental death by self affliction (self extubation due to displacement of trach tube).

(Resident 2) and (Resident 7) expired shortly after the omission of medications and the lack of treatment and care."^{xxiii}

Subsequent interviews with the nurse caring for the resident who accidentally displaced his trach tube revealed the following, **"I told (the administrator) that we needed more staff to monitor and that I did not feel safe but (the administrator) just cut my hours down."**^{xxiv}

A December 2001 report to Congress by the US Department of Health and Human Services put forth a minimum of 3.55 hours of direct care per resident per day as a quality care threshold.^{xxv} In 2002, a Center for Medicaid and Medicare Services funded report, *"Nursing Home Staffing Standards"*, cautioned against allowing staffing levels to fall below 2.75 hours per day. This report warned that staffing levels this low could result in serious harm to nursing home residents.^{xxvi} The state of Illinois requires, at a minimum, 2.5 nursing hours per resident per day for skilled nursing facilities.^{xxvii} Although 3 out of 4 Gem facilities meets Illinois minimum level of hours of nursing care per resident, ratios at Forest Hill and Camelot Terrace continue to fall short of the minimum hours of care suggested by *"Nursing Home Staffing Standards"* to avoid serious harm to residents. All Gem facilities report lower than minimum required hours of direct care per resident per day to provide quality care as recommended by the U.S. Department of Health and Human Services (HHS) in their 2001 report.



Specific Violations at Gem Homes (2007-2008)

Camelot Terrace

- During an inspection, state surveyors reported, hallways **“reeked of urine”**^{xxxviii}
- Failed to provide treatment for pressure sores. During an interview with a resident, state surveyors reported, “(Resident) complained of his buttock **burning and hurting**. (Resident) stated that they used to put dressings on his bottom, but they no longer do that.”^{xxxix}
- Failed to give insulin and inhaler treatments resulting in a **40% medication error**.^{xxx}
- Failed to quarantine a resident with methicillin resistant staph infection^{xxxxi}

Forest Hill Health & Rehab

- During an inspection, state surveyors reported that **strong urine odors** were “...noted throughout the day”.^{xxxii}
- After falling out of a wheelchair and receiving a head injury, a resident was rushed to the ER where it was also discovered she was severely dehydrated. The Emergency Room Physician suggested the resident had **not been receiving adequate fluids for 2 or more weeks**.^{xxxiii}
- Failed to **identify and evaluate the sexual behaviors** of residents with known moderate to severe impaired cognition levels for understanding of these behaviors.^{xxxiv}
- Failure to provide adequate activities for residents on the Alzheimer’s unit^{xxxv}
- **Failed to keep residents clean and groomed**^{xxxvi}

Galesburg Terrace

- Failed to monitor a resident’s dialysis shunt site. “(Resident) had been found with a **“pool” of blood around her arm** and “a significant amount of blood on the bed around her left upper arm.”^{xxxvii}
- “(Resident) receive(d) antipsychotic medication, without indication for use, without informed consent, and without necessary monitoring of behaviors.”^{xxxviii}
- “Based on observation and interview, the facility failed to provide the required 80 square feet per bed in 13 multi-bed resident rooms of a total of 47 resident rooms.”^{xxxix}

Regal H & R

- Failed to identify **new and or recurrent pressure sores**^{xl}
- Failed to treat existing pressure ulcers with current treatment orders
- Failed to provide appropriate preventive measures to **prevent pressure ulcers**
- **A resident was observed lying in a “...pool of green drainage...”** coming from an old leg dressing.^{xli}
- “the facility staff failed to assess wounds timely and notify physician of a change in skin condition, ensure accurate treatments were completed as ordered, and ensure preventive measures were initiated for high risk residents.”^{xlii}
- “Upon observation, surveyor noted **(resident) lying in stool that had seeped through staining a lap pad and sheets**. A sacral dressing was in place undated and soiled.”^{xliii}

- “(Resident) was observed to have a **soiled dressing with foul smelling odor** to the right hip area^{xliv} ...”
- “...surveyor observed **blood on (resident’s) sheets. Surveyor observed an open area** to left hip/buttock area, and right hip area.”^{xlv}
- During an inspection on 1/23/2008, health surveyors had the following to say about a resident’s pressure sore, “There was no dressing on the wound. Surveyor asked (resident) how the wound felt and (resident) stated **it "hurts like hell."** (Resident) stated it has been a couple of days since he has had a dressing in place.”^{xlvi}
- “(Resident) was observed to have a sacral **dressing that was saturated with drainage and with stool.** The drainage had soaked through the dressing and into a very large area onto the sheet...”^{xlvii}
- “**Failed to provide care to maintain cleanliness and prevent infections** for residents with urinary catheters.”^{xlviii}
- During an interview conducted by state surveyors, a resident’s family member had the following to say, “...family member reported that she noticed strong urine odors during a recent visit to the facility. She complained of seeing a **female resident walking around "soaking wet."** She said she did not observe any staff providing assistance to this female resident. She stated that **she found her family member wet as well.**”^{xlix}
- “failure to notify the physician (in a timely manner) of a change in condition, the **failure to contact 911** in a timely manner and the failure of the facility to have a protocol regarding emergency services”^l
- Facility failed to assess, identify and provide treatment for a resident’s pain. The resident was “...**observed screaming out in pain** whenever facility staff touched her. (She) was observed to have her eyes tightly closed and had facial grimacing. **(She) begged staff, "Please just don't touch me."** (She) verbalized that she was in excruciating pain. (She) was observed to have an inward rotation of the right leg and right foot. Also, the right extremity appeared slightly shorter than the left extremity. On 3/14/07, (she) stated that she has severe leg pain. **(She) stated, "Boy does it hurt" and "Yes it really hurts."** (She) stated that she has leg pain "everyday." (She) further stated that she has had severe leg pain for the last 2 weeks.”^{li} Interviews with the Certified Nursing Assistant who assisted this resident revealed the following, “... (certified nursing assistant) stated that (resident) has daily complaints of leg and stomach pain. (CNA) further stated, **"She has complained of pain everyday since I've been working here (8 months)."** (CNA) stated that she informed the nurses of the resident's complaints of pain on several occasions.”^{lii}
- The facility failed to give a resident with cancer of the Larynx his prescribed pain medication.^{liii}
- “In a shed without doors, **5 full liquid oxygen tanks were observed stored. On the ground, surrounding the front of the shed were numerous cigarette butts** where people had been smoking.”^{liv}
- “5 red totes, labeled "Biohazardous" used to store **infectious waste was observed stored on the outside of the building** next to a plastic shed without doors.”^{lv}
- An unsupervised resident was **smoking in the basement while receiving liquid oxygen** from a portable tank per nasal cannula. The **oxygen ignited causing a fire being fed by resident’s nasal cannula that caused facial burns** to residents. Another resident in the room at the time pulled the burning nasal cannula from (resident’s) face.^{lvi}

Appendix A

Nursing Home Name	Street	City	Zip Code	# Residents
CAMELOT TERRACE	516 WEST FRECH STREET	STREATOR	61364	61
FOREST HILL HEALTH AND REHAB	4747 11TH STREET	EAST MOLINE	61244	81
GALESBURG TERRACE	1145 FRANK STREET	GALESBURG	61401	62
REGAL HEALTH AND REHAB CENTER	9525 SOUTH MAYFIELD	OAK LAWN	60453	82

ⁱ 3/22/2007 Health Survey pg 5

ⁱⁱ 1/23/2008 Healthy Survey pg 13

ⁱⁱⁱ 3/21/2007 Health Survey pg 5

^{iv} 1/23/2007 Health Survey pg 7

^v 9/18/2007 Health Survey pg 6, Forest Hill

^{vi} 3/21/2007 Health Survey pg 5, Regal

^{vii} 1/23/2007, Health Survey pg 3, Regal, "...the facility failed to provide supervision and staff monitoring for 1 resident (R2) in the sample with an identified neuro impairment. Subsequently, R2 manually removed his trach tube and expired." "R2 and R7 expired shortly after the omission of medications and the lack of treatment and care."

^{viii} Seniority and Turnover information collected through ongoing contract negotiations between Michael Lerner and SEIU Healthcare Illinois/Indiana

^{ix} According to the most recent CMS data, 286 residents live at the four IL Gem Healthcare facilities.

^x CMS OSCAR data accessed 6/4/2008 from www.cms.hhs.gov. The average number of deficiencies at an Illinois' nursing home over the last three survey cycles was 26.5. Forest Hill Health and Rehab was cited for 87 deficiencies over the last three cycles while Regal Health and Rehab were cited for 72 deficiencies.

^{xi} 3/22/2007 Health Survey pg 5, Camelot Terrace

^{xii} 3/22/2007 Health Survey pg 11, Camelot Terrace

^{xiii} 3/22/2007 Health Survey pg 17, Camelot Terrace

^{xiv} 9/18/2007 Health Survey pg 6, Forest Hill

^{xv} 1/12/2007 Health Survey pg 1, Forest Hill

^{xvi} 4/26/2007 Health Survey pg 1, Regal

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- xvii 1/23/2008 Health Survey pg 6, Regal
xviii 3/21/2007 Health Survey pg 5. Regal
xix 3/21/2007 Health Survey pg 1
xx 210 ILCS 45/3-501)
xxi Based on 2000-2007 Cost Reports
xxii 2007 IL Medicaid Cost Reports and OSCAR Data Accessed 6/4/2008
xxiii 1/23/2007 Health Survey, Regal, pg 3
xxiv 1/23/2007 Health Survey pg 6
xxv Schnelle et al., “Appropriateness of Minimum Staffing Ratios in Nursing Homes, Report to Congress: Phase II Final,” Chapter 1. Center for Medicare and Medicaid Services’ Online Survey Certification and Reporting System (OSCAR).
xxvi Harrington, Charlene. “Nursing Home Staffing Standards.” Kaiser Commission on Medicaid and the Uninsured, June 2002
xxvii Title 77 of the Illinois Public Health Code, Chapter 1, Subchapter c, Section 300.1230 (L).
xxviii 3/22/2007 Health Survey pg 5
xxix 3/22/2007 Health Survey pg 11
xxx 3/22/2007 Health Survey pg 14
xxxi 3/22/2007 Health Survey pg 17
xxxii 10/23/2007 Health Survey pg 3
xxxiii 10/23/2007 Health Survey pg 3
xxxiv 9/18/2007 Health Survey pg 6
xxxv 8/20/2007 Health Survey pg 2
xxxvi 1/12/2007 Health Survey pg 1
xxxvii 3/28/2007 Health Survey pg 3-4
xxxviii 3/28/2007 Health Survey pg 7
xxxix 3/28/2007 Health Survey pg 10
xl 1/23/2008 Health Survey pg 1
xli 1/23/2008 Health Survey pg 1
xlii 1/23/2008 Health Survey pg 2
xliii 1/23/2008 Health Survey pg 6
xliv 1/23/2008 Health Survey pg 9
xlv 1/23/2008 Health Survey pg 11
xlvi 1/23/2008 Health Survey pg 13
xlvii 8/17/2007 Health Survey pg 1-2
xlviii 4/26/2007 Health Survey pg 1
xlix 4/26/2007 Health Survey pg 4
l 3/21/2007 Health Survey pg 1
li 3/21/2007 Health Survey pg 5
lii 3/21/2007 Health Survey pg 5
liii 3/21/2007 Health Survey pg 28
liv 3/21/2007 Health Survey pg 35
lv 3/21/2007 Health Survey pg 36-37
lvi 3/21/2007 Health Survey pg 38