champaign county HEALTH CARE CONSUMERS

Champaign County Health Care Consumers

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Grassroots organizing for health care justice and access since 1977.

October 22, 2018

Richard Sewell, Vice Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761

Re: Project Number 18-026 Champaign County Nursing Home, Urbana

Dear Vice Chair Sewell,

Champaign County Health Care Consumers (CCHCC) is submitting this written response in opposition to the findings of the Illinois Health Facilities and Services Review Board regarding Project Number 18-026, Champaign County Nursing Home. *We are asking the Review Board to postpone its decision on this project to a later date, after more investigation and research can be done into the issues raised in this written response.*

The applicants are the Champaign County Board, University Rehabilitation Center C-U, LLC and University Rehab Real Estate, LLC. The Applicants propose to transfer ownership of the Champaign County Nursing Home at a cost of $11,000,000. The anticipated completion date of the sale is November 30, 2018.

Our opposition to the findings, in summary, is based on the following (supporting documents are attached as noted):

1. **Quality of Care.** *The Review Board Staff and the acquiring Applicants have failed to provide factual information about the acquiring Applicant's track record for quality of care, including Adverse Actions and violations.*

   The staff report (page 2) states that "Evidence-based assessments...will be applied regarding **capacity, quality, value, and equity**..." Evidence-based assessments were **not** conducted regarding quality of care of acquiring Applicants' existing nursing homes.

   Regarding the Background of Applicants, the application process specifically states (page 7 of staff report) that "In evaluating the qualifications, background and character of the Applicants, HFSRB shall consider whether adverse actions have been taken against the Applicants, or against any LTC facility owned or operated by the Applicants, directly or indirectly, within three years preceding the filing of the application. An LTC facility is considered 'owned or operated' by every person or entity that owns, directly or indirectly, an ownership interest."

   On this basis, the Review Board Staff should have inquired about, or required Mr. Rothner to provide information regarding Adverse Actions against nursing homes owned and/or operated

by his companies, including Extended Care Clinical, LLC, Altitude Health Services, Inc., as well as Atied Associates

Instead, the Review Board Staff accepted at face value the 8/15/18 signed certification from Mr. William Rothner that no adverse action had been taken against his newly-created companies, University Rehabilitation Center C-U, LLC and University Rehab Real Estate, LLC, which is co-owned by Atied Associates.

In fact, it would be impossible for Adverse Action to have been taken against these companies (University Rehabilitation Center C-U, LLC and University Rehab Real Estate, LLC) because they did not exist prior to August 17, 2018 (according to IL Certificates of Good Standing).

Information regarding Adverse Actions against other nursing homes owned by Mr. Rothner and his companies, as well as by Atied Associates (the co-owners of the newly-created University Rehabilitation Center C-U, LLC and University Rehab Real Estate, LLC) should have been requested and/or investigated.

In fact, these entities have had Adverse Actions against them, including Type A and Type AA violations.

For details on Adverse Actions, please see the following:

- Attachment A: Type A or Type AA Violations
- Attachment B: IDPH Quarterly Reports for Extended Care Clinical, LLC facilities
- Attachment C: Adverse Actions by Government Agencies Against Atied-owned Nursing Homes in Illinois

2. **Expected changes in quality of care based on changes to staffing levels.** *A background review of the Staffing Levels of Extended Care Clinical, LLC and Atied Associates, LLC nursing homes indicates that, under the ownership of the acquiring Applicants, Champaign County Nursing Home residents can expect a decrease in staffing levels at the nursing home. Staffing levels in nursing homes are associated with quality of care.*

Champaign County Nursing Home is rated Above Average for staffing.

More than half of the 16 Illinois (non-psychiatric) nursing homes owned by Extended Care Clinical, LLC homes are Below Average or Much Below Average.
9 (or about 55%) were Below Average or Much Below Average; 4 (or 25%) were Average; and 3 (or about 20%) were Above Average.

The vast majority of the 18 nursing homes in Illinois owned by Atied Associates, LLC are Below Average or Much Below Average for staffing.
14 (or 78%) were Below Average or Much Below Average; only 2 (or 12%) were Average; none were Above Average or Much Above Average. 2 could not be found.

For details on Staffing Levels, please see:

- Attachment D: Nursing Home Staffing

3. **Stated ownership of Champaign County Nursing Home not the same as approved by County Board action.** *There are significant discrepancies and confusion surrounding the Champaign County Board's action to sell the Champaign County Nursing Home to a specified bidder, compared to the entity listed in the Purchase Agreement, and even the entities listed as*

acquiring co-applicants. And there is a failure by the Review Board Staff to obtain ownership information for some of these entities.

It is unclear whether the Purchase Agreement and the Application are consistent with the actions taken by the County Board to sell the nursing home to a specified buyer:

• On May 24, 2018, the County Board voted to sell the nursing home to the sole bidder who responded to the RFP. The Resolution that the County Board adopted for the sale of the home - Resolution No. 2018-141 - specified that the county would be selling the CCNH to **Extended Care Clinical, LLC and Altitude Health Services, Inc.**

• On May 9, 2018, the Champaign County Board held a Special Meeting where Mr. William Rothner and two other representatives representing Extended Care Clinical, LLC and Altitude Health Services, Inc. would answer questions about their bid to own the Champaign County Nursing Home.

• However, the Purchase Agreement is between is with Altitude Acquisitions, LLC, but it is not listed as a co-applicant on the Certificate of Need.

• Review Board staff inquired about this, given that University Rehab Real Estate, LLC and University Rehabilitation Center of CU, LLC were the entities listed in the Certificate of Need application.

• Review Board Staff were told that "Altitude Acquisitions, LLC is a placeholder entity and will go away at closing."

• Staff Report on Page 7 states that "... Atlitude Acquisitions, LLC is a "placeholder" and does not meet the requirements of 77 ILAC1130.220 – Necessary Party to an Application for Permit."

• Mr. William Rothner provided signed certifications dated August 15, 2018 regarding the newly created companies, University Rehabilitation Center C-U, LLC and University Rehab Real Estate, LLC, which are co-owned by Atied Associates. *However, these companies did not yet exist.* The Certificates of Good Standing for these companies indicate that they were created on August 17, 2018.

• Review Board Staff failed to acquire, and Mr. Rothner failed to produce ownership information regarding Atied Associates, LLC and Altitude Acquisitions.

• In several places, the Review Board Staff Report wrongly states that "The Champaign County Board approved the sale of the nursing home to University Rehabilitation Center C-U, LLC, who has expertise in value engineering and can implement programs designed to improve quality and reduce costs..." *The County Board did not approve the sale to this entity, and this entity does not have expertise in these matters, because it was not in existence at the time the sale was approved.*

4. **Champaign County Board did not do due diligence in obtaining independent valuation of nursing home prior to issuing RFP for its sale.** The Applicants and the Review Board Staff state that two entities conducted "valuations" of the nursing home – Evans Senior Investments and Marcus & Millichap – which resulted in the asking price of $11 million. *An*

opinion from a national expert on health care valuations was obtained and disputed the notion that these were "independent valuations using sound methodologies."

CCHCC does not believe that the Champaign County Board did its due diligence in valuing the nursing home, and in setting the $11 million price.

• *An e-mail from James Unland, a foremost national expert on healthcare valuations, was shared with the Champaign County Board and concludes that the methods used by the brokerage firms Marcus & Millichap, and Evans Senior Investments for arriving at a sale price for the Champaign County Nursing Home do* ***not*** *constitute "independent valuations". Mr. Unland also states that the absence of certain information indicates that the County has not done its due diligence regarding the County Nursing Home.*

• See Attachment E: E-mail sent to Champaign County Board Members with expert opinion regarding independent health care valuations and whether or not Champaign County's materials from brokerage firms constitute an "independent valuation".

Excerpts: "The materials that you sent were neither 'independent' valuations nor valuations using what I would consider to be sound methodologies. For "brokerage" firms to do a valuation is an inherent conflict of interest."

"I have not yet seen a valuation according to proper standards nor have I seen a truly independent valuation."

"If such information has not been developed, the absence of this kind of vital information would indicate to me that the county needs to do much more work in order to meet its due diligence responsibility and, I would think, its fiduciary duty to the County's taxpayers in respect to assessing the nursing home's relative present and future viability and in determining its future."

James Unland's resume can be viewed here: http://freepdfhosting.com/42abe272bb.pdf

• In addition to the lack of a proper independent valuation, the price tag of $11 million was arrived at prior to the County's hiring of SAK, a nursing home management firm that specializes in turning around distressed nursing homes. The $11 million sale price was set at a time when the nursing home was performing more poorly than it was after SAK began managing the home.

5. **Alternatives to the Proposed Project.** *This section of the Report fails to consider an alternative that the County Board did discuss at its meetings: the possibility of re-issuing another RFP and possibly changing the conditions for the sale in order to attract a more suitable buyer.*

Given the above issues (and there are many more issues, but the above are the most significant), *we are asking the Review Board to postpone its decision on this project to a later date, after more investigation and research can be done into the issues raised in this written response.*

Thank you for your consideration. If you have questions or need more information, please feel free to contact me by phone at 217-352-6533 or by e-mail at claudia@shout.net.

Sincerely,

Claudia Lennhoff

Claudia Lennhoff, Executive Director

Attachment A: Type A or Type AA Violations

Criterion 1125.520 – Background of Applicants, states that "HFSRB shall consider whether adverse actions have been taken against the Applicants, or against any LTC facility owned or operated by the Applicants, directly or indirectly, within three years preceding the filing of the application. An LTC facility is considered "owned or operated" by every person or entity that owns, directly or indirectly, an ownership interest.

Section 1125.140 (and Section 1130.140) of the Administrative Code defines Adverse Action as follows: *"Adverse Action" means a disciplinary action taken by Department of Public Health, Centers for Medicare and Medicaid Services (CMMS), or any other State or federal agency against a person or entity that owns and/or operates a licensed or Medicare or Medicaid certified LTC facility in the State of Illinois. These actions include, but are not limited to, all Type A and Type AA violations.*

Definitions:

Type A violation: a violation of the Act or rules which creates a condition or occurrence relating to the operation of a facility that (i) creates a substantial probability that the risk of death or serious mental or physical harm, to a resident will result there from or (ii) has resulted in actual physical or mental harm to a resident.

Type AA violation: a violation of the Act or rules which creates a condition or occurrence relating to the operation of a facility that proximately causes a resident's death.

Summary of research on Type A and Type AA violations for Acquiring Applicants of Project 18-026:

There are currently at least 10 nursing homes owned by William "Avi" Rothner, Extended Care Clinical, LLC, or Atied Associates, LLC that have Type A or Type AA violations within three years preceding the filing of the Certificate of Need Application for the Champaign County Nursing Home (Project 18-026).

Listing of Violations:

Salem Village Nursing and Rehab
Violation: Type A
Survey Date: 05-06-2016
IDPH VIolation Report: http://dph.illinois.gov/sites/default/files/publications/NH16-C0266-05-06-16-Salem-Village-Nursing-Rehab-100716.pdf
IDPH Quarterly Report (Page 21) http://www.dph.illinois.gov/sites/default/files/publications/July-Sept-2016-QRPT.pdf
Ownership: William Rothner Accumulation Trust, among other Rothner Accumulation Trusts
Cost Report (6-Supplemental)
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2016LTCCostReports/salem_village_nursing_rehab_2016_0044057.pdf

Chateau Nursing and Rehabilitation Center
Violation: Type A
Survey Date: 10-18-2017

IDPH Violation Report: http://dph.illinois.gov/sites/default/files/publications/NH17-C0515-10-18-17-Chateau-Nrsg%26RehabCtr.pdf
IDPH Quarterly Report (Page9)
http://www.dph.illinois.gov/sites/default/files/publications/Oct-Dec-2017-QRPT.pdf
Ownership: Extended Care Consulting, LLC under Rothner Health Venture G II, LLC
Cost Report (6A, 6-Supplemental):
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/chateau_nsg_rehab_ctr_2017_0046177.pdf

Countryside Nursing and Rehabilitation Center
Violation: Type A
Survey Date:09-21-2016
IDPH Violation Report: http://dph.illinois.gov/sites/default/files/publications/NH16-C0483-09-21-16-Countryside-Nrsg&RehabCtr-010917.pdf
IDPH Quarterly Report (Page 7) http://www.dph.illinois.gov/sites/default/files/publications/Oct-Dec-%202016-QRPT-010917.pdf
Ownership: Countryside Nursing and Rehabilitation Center, LLC (Eric Rothner, Rothner Family Grandchildren Trust, N & S Rothner Family Trust)
Cost Report (6A, 6-Suplemmental):
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2016LTCCostReports/countryside_nrsg_rehab_ctr_2016_0050708.pdf

Pontiac Healthcare and Rehab
Violation: Type A
Survey Date:09-16-2016
IDPH Violation Report: http://dph.illinois.gov/sites/default/files/publications/NH16-C0451-09-16-16-Pontiac-HealthcareandRehab-010917.pdf
IDPH Quarterly Report (Page 26)
http://www.dph.illinois.gov/sites/default/files/publications/Oct-Dec-%202016-QRPT-010917.pdf
Ownership: Atied Associates
Cost Report (6-Supplemental):
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2016LTCCostReports/pontiac_healthcare_and_rehab_2016_0053264.pdf

Pearl Pavilion
Violation: Type A
Survey Date: 01-31-2017
IDPH Violation Report: http://dph.illinois.gov/sites/default/files/publications/NH-17-S0099-01-31-17-Pearl-Pavilion-041017.pdf
IDPH Quarterly Report (Page 29) http://www.dph.illinois.gov/sites/default/files/publications/Jan-March-2017-QRPT-041017.pdf
Ownership: Atied Associates, LLC
Cost Report (6-Supplemental):
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/pearl_pavilion_2017_0053603.pdf

Forest City Rehab and Nursing Center

Violation: Type A
Survey Date: 07-18-2017
IDPH Violation Report: http://dph.illinois.gov/sites/default/files/publications/NH-17-C0395-07-18-17-Forest-City-Rehab-and-Nursing-Center-102317.pdf
IDPH Quarterly Report (Page 9) http://www.dph.illinois.gov/sites/default/files/publications/July-Sept-2017-QRPT-102317.pdf
Ownership: Atied Associates, LLC
Cost Report (6-Supplemental):
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/forest_city_nsg_rehab_ctr_2017_0052803.pdf

Spring Creek Nursing and Rehab Center
Violation: Type A
Survey Date: 11-08-2017
IDPH Violation Report: http://dph.illinois.gov/sites/default/files/publications/NH17-S0572-11-08-17-Spring-Creek-Nrsg%26Rehab.pdf
IDPH Quarterly Report (Page 40) http://www.dph.illinois.gov/sites/default/files/publications/Oct-Dec-2017-QRPT.pdf
Ownership: Extended Care Consulting, LLC under William Rothner Accumulation Trust (and other Rothner Accumulation Trusts)
Cost Report (6A, 6-Supplemental):
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/spring_creek_nsg_rehab_ctr_2017_0052613.pdf

Grasmere Place
Violation: Type A
Survey Date: 11-01-2017
IDPH Violation Report: http://dph.illinois.gov/sites/default/files/publications/NH18-C0010-11-01-17-GrasmerePlace.pdf
IDPH Quarterly Report (Page 8) http://www.dph.illinois.gov/sites/default/files/publications/Quarter-Jan-Mar-2018-QRPT.pdf
Ownership: Extended Care Consulting, LLC under William Rothner, William Rothner Accumulation Trust (and other Rothner Accumulation Trusts)
Cost Report (6A, 6-Supplemental):
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/grasmere_place_2017_0054213.pdf

Bridgeway Senior Living
Violation: Type A
Survey Date: 03-01-2018
IDPH Violation Report: http://dph.illinois.gov/sites/default/files/publications/NH18-S0152-03-01-18-Bridgeway-Senior-Living.pdf
IDPH Quarterly Report (Page 9) http://www.dph.illinois.gov/sites/default/files/publications/Quarter-April-June-2018-QRPT.pdf
Ownership: Atied Associates
Cost Report (6-Supplemental)
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/bridgeway_senior_lvg_2017_0053363.pdf

The Parc at Joliet
Violation: Type A
Survey Date: 03-15-2018
IDPH Violation Report: http://dph.illinois.gov/sites/default/files/publications/NH18-C0153-03-15-18-Parc-atJoliet-The.pdf
IDPH Quarterly Report (Page 33) http://www.dph.illinois.gov/sites/default/files/publications/Quarter-April-June-2018-QRPT.pdf
Ownership: (Extended Care Consulting,LLC under Charles Slagle. Charles Slagle also has ownership with Spring Creek Nursing and Rehab Center along with other Rothner Trust)
Cost Report (6A, 6-Supplemental)
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/parc_at_joliet_2017_0052571.pdf

Attachment B:
IDPH Quarterly Reports on Safety Violations for Extended Care Clinical, LLC Facilities Within Three Years Prior to Filing Application

Description of research - overview:

Reviewed IDPH Nursing Home Violations Quarterly reports for the period of 2015-2018, starting with the most recent first, for 14 of Extended Care Clinical (EEC), LLC's Illinois locations. Additional Illinois facilities owned by William "Avi" Rothner, and Eric Rothner were also included in this research.

A listing of ECC's locations can be seen here:
http://extendedcarellc.com/media/pdf/ECC-Facilities_Map-2016.pdf

The IDPH Nursing Home Violations Quarterly reports can be found here:
http://www.dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/violator-quarterly-reports

2018 – 1st Quarter

Grasmere Place
Survey Date – 11/01/2017
A fine of $12, 500.00
DOCKET NUMBER:NH 18-C0010
http://dph.illinois.gov/sites/default/files/publications/NH18-C0010-11-01-17-GrasmerePlace.pdf

The facility failed to follow the drug test policy and conduct a drug test, they failed to carry out physician orders regarding care, medications, and an appointment for patient with high risk pregnancy. They also failed to follow CPR policy and standards to provide effective CPR, failed to provide psychiatric rehab services. The facility director of nursing failed to review physician's orders for one resident and failed to provide prenatal care for 2 pregnant women. *Failures contributed to fetal demise of unborn child and overdose resulting in death of the pregnant resident. It was noted that failure to provide effective CPR has the potential to affect all 178 residents. CPR was done on a patient who was sitting on a toilet, rather than moving the patient to a flat surface.*

2017 – 1st Quarter

Elmwood Care
Survey Date: 01/2016
Violation Amended/Affirmed, Fine Assessment Reduced and/or Notice of Conditional License Withdrawn
DOCKET NUMBER: NH 16-S0069

- No information on incident available

2017 – 2nd Quarter

None

2017 – 3rd Quarter

Chateau Nursing & Rehab
Survey Date - 07/27/2017
A fine of $2,200.00.
DOCKET NUMBER: NH 17-S0367
http://dph.illinois.gov/sites/default/files/publications/NH-17-S0367-07-27-17-Chateau-Nrsh-%26-Rehab-Center-102317.pdf

Facility failed to follow fall prevention policy and failed to supervise and monitor residents. Facility also failed to notify resident's physician of the severe pain followed by the accident. Resident had sustained neck fractures due to lack of supervision. There was also a resident with fractured humerus who complained about pain for 5 days straight and nursing staff failed to let a doctor know. Another resident had a laceration in the back of head after a fall. Resident had no floor mats in bedroom despite the extensive history of falls. Resident with seven prior documented falls was found under the sink with a laceration to the head.

Timber Point Health Care Center
Survey Date: 06/22/2017
A fine of 2,200.00
DOCKET NUMBER: NH 17-C0332
http://dph.illinois.gov/sites/default/files/publications/NH-17-C0332-06-22-17-Timber-Point-Healthcare-Center-102317.pdf

The facility failed to provide the physician ordered scheduled medication for a resident. This failure resulted in the resident having increased negative behaviors, increased nervousness, and an altered mental state. This required emergency treatment for drug withdrawal. Medication Administration Record dated from 5/1/17 to 6/19/17 indicates that the resident did not receive scheduled doses of medication from 6/4/17 to 6/13/17 and 5/1/17 through 5/4/17 because facility was out of the medication. *The resident was prescribed Ativan, to be taken every 8 hours. Staff failed to dispense the medication, and the facility ran out of the medication on several occasions. This resulted in agitation and altered mental state, as well as withdrawal from benzodiazepine.*

2017- 4th Quarter

Chateau Nursing & Rehab
Survey Date- 10/18/2017
A fine of $25,000.000.
DOCKET NUMBER: NH 17-C0515
http://dph.illinois.gov/sites/default/files/publications/NH17-C0515-10-18-17-Chateau-Nrsg%26RehabCtr.pdf

Facility failed to follow fall prevention policies and failed to supervise high risk for falls resident. This resulted in a resident sustaining lacerations and abrasions to the right forehead and cheekbone. He also had a tear above the right eyebrow and underwent spinal surgery. The same resident had multiple falls and injuries due to inadequate fall prevention policies and precautions. Resident fell of the bed and sustained 2 skin tears to the right arm, measuring 5.0 centimeters and 1.0 cm long. An MRI scan showed that resident had a spinal cord injury at the level of C3,C4, and C5 with unstable fractures to the anterior and posterior columns. On October 17, 2017, the neurosurgeon who saw the resident through the ER said resident had swelling in the neck, spinal cord, and bones and these were not from old injuries. *The neurosurgeon stated that the resident should have been sent to the hospital after the first fall that happened in the facility. Resident's motor skills were highly affected as a result of the fall and spinal injury from the fall, including resident's ability to open and close mouth, which affected ability to eat.*

Survey Date: 10/26/2017
A fine of 2,200.00
DOCKET NUMBER: NH 17-S0558
http://dph.illinois.gov/sites/default/files/publications/NH17-S0558-10-26-17-Generations-atNeighbors.pdf

Facility failed to respond to a patient's medication request. This resulted in the resident experiencing pain, insomnia, and crying. Woman was alert and began crying when talking about her experiences in the past weekend as she explained how the facility ran out of her pain medication. The woman explained they ran out of morphine for the second time in a couple of months and how it has been a nightmare. She explains being up all night and experiencing excruciating pain as well as depression. *Records indicate that resident's physician was* ***not*** *notified when morphine supply ran out. Documentation indicates multiple times when dosage of morphine was not given to resident.*

Wheaton Care Center
Survey Date- 08/31/2017
A fine of $2,200.00.
DOCKET NUMBER: NH 17-S0441
http://dph.illinois.gov/sites/default/files/publications/NH17-S0441-08-31-17-Wheaton-CareCenter.pdf

Kitchen staff used a propane gas grill inside the kitchen of the facility because the facility had the gas temporarily shut off and this impeded the facility's ability to provide residents with hot meals. Using the propane grill indoors in an unvented area could have had the potential to cause a fire and put all the residents at risk. The manufacturer of the propane tank stated that the propane tank should not be used indoors.
The facility also failed to ensure that the dietetic service supervisor was qualified for his position. The supervisor had not completed a Dietary Managers Association or approved managers course. Records indicated he had not completed a 90 hour dietary managers course.

2016 - 1st Quarter

Elmwood Care
Survey Date: 01/21/2016
A fine of 2,200.00
DOCKET NUMBER: NH 16-S0069
- No information available on incident.

2016- 2nd Quarter
None

2016 -3rd Quarter
None

2016 - 4th Quarter

Briar Place
Survey Date: 08/31/2016
A fine of 2,200.00
DOCKET NUMBER: NH 16-S0458
http://dph.illinois.gov/sites/default/files/publications/NH16-S0458-08-31-16-BriarPlace-010917.pdf

There was neglect and failure to observe a resident. The tub room was unsupervised and the resident was found undressed, floating face down in the tub. There was also blood in the water streaming from the mouth and resident was unresponsive. Blood was coming out of the resident's nose during compressions. The resident was later pronounced dead at the facility. *The resident was to shower 2x's a week with supervision until the next review. However, a resident stated that there were no locks on any shower/tub rooms at any time of the day. Additionally, staff would occasionally check tubs/showers, but didn't check all the time. Similarly, another resident states that he gets his own linens from the linen room even though he's not supposed to because the nurses are busy. Moreover, he states staff has never checked on him when he's bathing.*

Countryside Nursing and Rehab Center
Survey Date: 09/21/2016
A fine of $25,000.00
DOCKET NUMBER: NH 16-C0483http://dph.illinois.gov/sites/default/files/publications/NH16-C0483-09-21-16-Countryside-Nrsg&RehabCtr-010917.pdf

They failed to demonstrate adequate supervision to a patient with dementia wandering into another resident's room. This resulted in a resident being physically assaulted. A resident went into another resident's room where resident 1 became aggressive, hitting the other resident in the mouth. There was scratches on the back, neck, and breast of the resident who was sexually assaulted.

2015- 1st Quarter

The Estates of Hyde Park
Survey date 2/09/15
A fine of $2,200.00
DOCKET NUMBER: NH 15-C0116
http://www.dph.illinois.gov/sites/default/files/resources/NH15-C0116-2-9-15-Estates-of-HydePark.pdf

Failure to provide adequate fall prevention policies. A resident was found on the floor with multiple skin tears. Another resident required 2 people for mobility and was only seeing 1 person each time. Also, the bed had no rails. Resident fell against the radiator cover causing the cover to become dislodged and this resulted in multiple skin tears. The resident also had a bed alarm in place but it did not alarm. Another resident was receiving incontinence care by only one CNA when instructions in the MDS specifically indicated a two person assistance for bed mobility.

Prairie Manor Nursing Home and Rehab Center
Survey Date: 12/14/14
A fine of $2,200.00
DOCKET NUMBER : NH-15C0006
http://www.dph.illinois.gov/sites/default/files/resources/NH15-C0006-121414-Prairie-Manor-Nsg-and-Rehab.pdf

The facility failed to perform a proper and safe mechanical lift for 3 or 4 residents. The lack of adequate precautions resulted in slipping and sustaining a fractured arm for a resident. The nurse aide reported performing the transfer by herself when it should have been completed by two, consequently, the resident started complaining of left shoulder pain. The physician stated that the resident fractured her left arm during the transfer earlier that day, but did not receive a call from the nurse until later that night.

Grasmere Place

Survey date: 1/1/15/15

DOCKET NUMBER: NH 15-C0040

NH 15-S0041

http://www.dph.illinois.gov/sites/default/files/resources/NH15-C0040-S0041-1-15-15-Grasmere-Place.pdf

Staff failed to follow policies and procedures for infection control. The facility failed to properly sanitize blood glucose equipment. They failed to remove expired stock medication, expired medications, and medication of discharged patients, posing a great risk. There was also failure to take temperature of the food and recording it. Failure to record proper food temperature can result in uncooked food or foodborne-illness. There was also pots and pans washed improperly with food residue. The call system was faulty, having pull cords higher than 6 inches from the floor.

2015- 2nd Quarter

The Estates of Hyde Park
Survey Date: 4/14/15
No Fine
DOCKET NUMBER: NH-15S0201
http://www.idph.state.il.us/about/nursing_homes_violations15/2nd_Quarter/15-S0201%20NH%204-15-15%20Estates%20of%20Hyde%20Park.pdf

The facility failed to provide water at a temperature of at least 100 degrees Fahrenheit at all times for residents.

2015 - 3rd Quarter

Grasmere Place
Survey Date: 8/5/15
No fine

DOCKET NUMBER: 15-C0357

- No information on the incident available

Timber Point Health Care Center
Survey Date: 6/25/2015
No Fine
Docket Number: 15-S0316
http://www.dph.illinois.gov/sites/default/files/publications/Nursing_Home_Quarterly_Reports/2015_Q3/15-S0316%20NH%20Timber%20Point%20Healthcare%20Center%206-25-15.pdf

The facility failed to report a fall and the resident had an injury to the head and a broken leg.

Tri-State Nursing & Rehab Center

Survey Date:
No fine
DOCKET NUMBER: 15-S0303
http://www.dph.illinois.gov/sites/default/files/publications/Nursing_Home_Quarterly_Reports/2015_Q3/15-S0303%20NH%20Tri-State%20Nursing%20%26%20Rehab%20Ctr%206-4-15.pdf

Facility failed to perform a safe mechanical lift transfer, resulting in a left forearm wedged underneath the wheelchair armrest while being raised by the lift, caused a laceration of 5 cm and 1.5 cm deep.

2015 - 4th Quarter

Tri-State Nursing & Rehab Center
Survey Date: 06/04/2015
Violation Amended/Affirmed, Fine Assessment Reduced and/or Notice of Conditional License Withdrawn.
DOCKET NUMBER: NH 15-S0303

-No information on incident available

Rainbow Beach Care Center
Survey Date: 09/08/2015
No fine
DOCKET NUMBER: NH 15-C0429
http://dph.illinois.gov/sites/default/files/publications/NH15-C0429-09-08-15-Rainbow-Beach-Care-Center.PDF

Multiple patients were given inadequate individualized treatment plans for serious mental illness.

Attachment C:
Adverse Actions By Government Agencies Against Atied-owned Nursing Homes in Illinois

William Rothner provided a signed certification dated August 15, 2018 stating that "no adverse action as defined in 77 IAC 1130.140 has been taken against any nursing home owned or operated by University Rehabilitation Center of C-U, LLC, an Illinois limited liability company, in the State of Illinois during the three year prior period to filing this application".

Mr. Rothner also "authorizes the Health Facilities and Services Review Board ("HFSRB") and the Illinois Department of Public Health ("IDPH") access to any documents necessary to verify information submitted as prot of an application for this permit." He authorizes the HFSRB and IDPH "to obtain any additional information or documents from other government agencies which HFSRB or IDPH deem pertinent to process this application for permit."

Atied Ownership
https://www.nursinghomedatabase.com/owner/ATIED%20ASSOCIATES%20LLC

ILLINOIS

Pearl Pavilion
Atied Associates 30%
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/pearl_pavilion_2017_0053603.pdf

Resident death
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145234&SURVEYDATE=01/31/2017&INSPTYPE=CMPL

On (MONTH) 26, (YEAR) at 1:50 PM, Z1 Trauma Surgeon said R1's fall of (MONTH) 23, (YEAR) and subsequent injuries directly contributed to his death. The swelling around his spinal cord eventually impaired his ability to breathe.

Based on observation, interview, and record review the **facility failed to supervise a resident at risk for falls, failed to apply an alarm device correctly, and failed to evaluate the effectiveness of fall prevention interventions. These failures contributed to R1 having repeated falls and sustaining a fractured neck** on (MONTH) 23, (YEAR). R1 expired the same day. ...shows R1 was forgetful, confused and had impaired short and long term memory loss.

R1 ' s Progress notes showed multiple entries of R1 self-transferring and attempting to ambulate unassisted: [DATE], (YEAR) at 4:00 PM documents R1 stands up and tries to walk around and is noncompliant with his alarms.

3/28/2018 - Violations
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145234&SURVEYDATE=03/28/2018&INSPTYPE=CMPL

3/22/2018
Involuntary transfer
R1's medical record shows she was involuntarily transferred to an inpatient psychiatric hospital on (MONTH) 26, (YEAR). There is no documentation that written notification of the transfer was given to R1 or R1's representative prior to transfer. The facility was unable to provide documentation of this when requested.
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145234&SURVEYDATE=03/22/2018&INSPTYPE=CMPL

Housekeeping issues - filth
3/9/2018
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145234&SURVEYDATE=03/09/2018&INSPTYPE=CMPL
1/31/2017-fined $3,291

Other violations
https://projects.propublica.org/nursing-homes/homes/h-145234

Kensington Place and Nursing Rehab
Atied Associates - 40% ownership
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/kensington_place_nrsg_rehab_2017_0052712.pdf
Violations
https://projects.propublica.org/nursing-homes/homes/h-145829

Notes:
See October 27, 2017 CBS Chicago news story about patient who was dumped from Kensington Place at a homeless Shelter: https://www.youtube.com/watch?v=v7d8msvqhUY

Aperion Care International
Ownership: Atied Associates 35.41%
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/aperion_care_international_2017_0050187.pdf
Violations
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=146001&SURVEYDATE=03/02/2018&INSPTYPE=CMPL

Rock River Healthcare
Ownership: Atied associates 20%
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/rock_river_health_care_2017_0053231.pdf

Violations - ABUSE ISSUES Based on interview and record review the facility failed to follow their policy and procedures by not thoroughly investigating allegations of abuse, and not completing criminal background checks on residents.
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145818&SURVEYDATE=11/08/2017&INSPTYPE=STD
Shower issues - CNA's refusing to clean

https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145818&SURVEYDATE=06/28/2017&INSPTYPE=CMPL

Center Home Hispanic Elderly
Ownership: Atied Associates
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/center_home_hispanic_elderly_2017_0050989.pdf
Violations
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=146062&SURVEYDATE=01/13/2017&INSPTYPE=STD

Generations at Rock Island
Ownership - Atied Associates and Bryan Barrish, Ron Nunziato (and others)
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/generations_at_rock_island_2017_0049866.pdf
https://nursinghomerating.org/145950-ownership.htm
Violations

https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=145950&SURVEYDATE=07/20/2018&INSPTYPE=STD

https://projects.propublica.org/nursing-homes/homes/h-145950

Forest City Rehab and Nursing
Atied Associates 20%
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/forest_city_nsg_rehab_ctr_2017_0052803.pdf
Violations
https://projects.propublica.org/nursing-homes/homes/h-145937

The Estates of Hyde Park
Ownership Atied Associates 100%
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/estates_hyde_park_2017_0052837.pdf

Violations
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145828&SURVEYDATE=04/24/2018&INSPTYPE=CMPL

Doctors not seeing patients regularly

https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145828&SURVEYDATE=09/12/2017&INSPTYPE=CMPL

Complete list of violations
https://projects.propublica.org/nursing-homes/homes/h-145828

Notes:
Per Director of Nursing, corporate doesn't want to have 'documentation' on abuse investigations - no witness statements kept - when 'abuse coordinator' writes notes during interview - per corporate, notes must be destroyed.

Briar Place Nursing
Owners: Eric Rothner, 31.429%
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/briar_place_ltd_2017_0031765.pdf

Violations
https://projects.propublica.org/nursing-homes/homes/h-145784

11/02/17 survey
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145784&SURVEYDATE=11/02/2017&INSPTYPE=CMPL
On 10/24/17 at 12:56pm, E7 (CNA) stated that she is assigned to approximately 24 (2nd floor) residents thirteen (13) require extensive assistance. Surveyor inquired if there was adequate staff assigned on the 2nd floor E7 responded "No, not for us we need more."

9/22/2016 - Not enough nurses to administer meds (as a result - patients got meds late)
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145784&SURVEYDATE=09/22/2016&INSPTYPE=STD

Generations at Applewood
Ownership: 30.6% atied 11.35% bryan barrish
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/generations_at_applewood_2017_0051359.pdf
All violations
https://projects.propublica.org/nursing-homes/homes/h-145781

Park Villa and Nursing and Rehab Center
Atied Associates 40%

https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/park_villa_nsg_rehab_ctr_2017_0051417.pdf

Violations
https://projects.propublica.org/nursing-homes/homes/h-145779

3/1/2017

https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145779&SURVEYDATE=03/03/2017&INSPTYPE=STD

Paramount Oak Park (formerly Oak Park Oasis)
Atied 40% Ownership
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/park_villa_nsg_rehab_ctr_2017_0051417.pdf

Violations - a discharge
12/21/2016
Summary: R23 (has psychiatric issues - non ambulatory) Because he was 45 minutes late on pass - they discharged him. (according to policy - what was supposed to happen was that his pass be revoked) but they discharged him. He was admitted to the facility (for rehab) for a foot infection (He had his fifth toe amputated) R23 added that he believes this all stems (meaning the nursing home's attitude towards him) from the fact he received a severe burn to his thigh when a CNA gave him hot water per R23's request. (a 2nd degree burn) So for the discharge - The nursing home put three boxes of his belongings in the lobby. (and then said he was leaving by his choice - so it's not a discharge.) He had to borrow money from a resident to take a bus to the hospital. R23 is homeless and has no identification cards or medical card. Z3 stated that R23 left 2 to 3 voice messages about being very distraught, scared, not knowing what was going to happened to him or where to go and it being very cold outside.
2) Expired meds, expired syringes, expired gastrostomy tubes
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145714&SURVEYDATE=12/21/2016&INSPTYPE=STD

11/16/2017
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145714&SURVEYDATE=11/16/2017&INSPTYPE=STD

Medications given late.
Insulin never ordered - so they borrowed from another patient's med.
Dirty broken meat slicer, etc, etc
Signatures missing on controlled substances log sheet
Loose hand rails, chipped paint, buckled floor tile (essential. outdated maintenance)
8/19/2016 - $3,000 fine
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145714&SURVEYDATE=08/19/2016&INSPTYPE=CMPL
Another involuntary discharge

All violations
https://projects.propublica.org/nursing-homes/homes/h-145714

Rushville Nursing and Rehab
(40%) Sherwin Ray 60
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/rushville_nsg_rehab_ctr_2017_0053637.pdf
Violations
https://projects.propublica.org/nursing-homes/homes/h-145488

Generations at Neighbors
Ownership: Atied 36.28%
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/generations_at_neighbors_2017_0049973.pdf

Violations
https://projects.propublica.org/nursing-homes/homes/h-145440

11/18/2016 -
1) staff has poor hygiene - did not change soiled gloves
2) No back up water supply in case of a disaster. Stated they had a vendor 130 miles that would supply back up water - they called while the surveyor was there - no answer.
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145440&SURVEYDATE=11/18/2016&INSPTYPE=STD

2/8/18
1) Patient receiving solid foods when she is on a pureed diet
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145440&SURVEYDATE=02/08/2018&INSPTYPE=CMPL

Bridgeway Senior Living
Atied Associates - 40%
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/bridgeway_senior_lvg_2017_0053363.pdf

Violations
4/19/2018
1) Holes in walls that looked like gnaw marks
2) Red and black ants and mice everywhere
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145420&SURVEYDATE=04/19/2018&INSPTYPE=CMPL

1/16/2018
1)Residents not getting groomed with nail care and facial hair. Jagged nails with blackish colored substance underneath nails.
2) A resident high risk for pressure ulcers sat in a urine soaked diaper and dry stool. failed to reposition her for almost 4 hours
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145420&SURVEYDATE=01/16/2018&INSPTYPE=STD

River View Rehab Center
Owership: Atied Associates 33.3%
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/river_view_rehab_ctr_2017_0052795.pdf

7/19/18 - violations

3) R45's physician progress notes [REDACTED]. Record showed the condition of R45's legs as bilaterally extremely swollen, redness, bleeding, scaly, bleeding, weeping, discolored and with different sizes of new blisters present
https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=145308&SURVEYDATE=07/19/2018&INSPTYPE=STD

3/26/18 - violations
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145308&SURVEYDATE=03/26/2018&INSPTYPE=CMPL
Violations: In this facility, a resident only gets showers twice a week.
1:53 PM, R4 was laying in bed and R4 had an extremely foul body and urine odor emitting from his body. The odor could be smelled outside of R4's room in the main hallway of the facility. Facility Bath and Skin Report Sheet, dated as of (MONTH) 21, (YEAR), shows R4 was only offered a shower on (MONTH) 7 and 14, (YEAR) with no refusals documented on the report.

2. Facility bath and skin report sheet, dated as of (MONTH) 21, (YEAR), shows R9 was cognitively impaired and required the physical assistance of one staff for bathing received only three of her six scheduled showers with no refusals documented on the report.

3. shows R3's cognition was moderately impaired and R3 was totally dependent on two staff for bathing assistance. On (MONTH) 21, (YEAR) at 1:44 PM, R3 was lying in his bed and stated he feels disgusting when he does not receive his scheduled showers. Facility bath and skin report sheet, dated as of (MONTH) 21, (YEAR), shows R3 was only offered three of his six scheduled showers with no refusals documented
on the report.

4. The fish being served to residents appeared gray with a very dark black/brown center line on each piece. The fish also appeared very dry.
The ham was rubbery.

5.The ham appeared dark red-brown and dry. The ham tasted overcooked and had a rubbery texture. Even the food service director stated the fish and ham were not up to the quality that he would like to serve to the residents.

12/21/2017 VIOLATIONS
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145308&SURVEYDATE=12/21/2017&INSPTYPE=CMPL
1..On 12/20/17 at 11:05 am, R2 stated I don't get enough to eat in the facility. On 12/20/17 at 11:06 AM, R1 stated I don't get enough to eat. R1 added The food is bad, they don't give 2nd's. On 12/20/17 at 11:07 AM, R4 stated I don't get enough to eat.

2. On 12/20/17 at 12:55 pm, R12 stated I do not get enough to eat. R12 stated staff tells me to come back and when I come back, staff states there is no more.

Multiple other residents claimed of the same issue. IDPH says "Minimal harm"

8/24/2017 VIOATIONS
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145308&SURVEYDATE=08/24/2017&INSPTYPE=STD
1.) stated at 2pm R2 , who had a motorized wheel chair with oxygen tubing attached to his tracheotomy. asked for staff assistance to be transferred from his chair to his bed where his blow call

light would be available for R2's use. R2's blow call light was not attached to R2's wheel chair and R2 had no call light system, or method of calling staff for assistance, in place while in his wheelchair. Z1 stated she was waiting to leave until facility staff transferred R2 back to bed because R2 had no way of calling staff for help and R2 could not motorize out of his room while his tracheotomy was connected to his oxygen. Z1 was concerned if R2 needed. E2 had no response when asked how R2 would call for help while connected to his oxygen and in his wheelchair if Z1 were not present. R2 would not be able to call for or retrieve staff help. At 2:49 PM during continuous observation, Z1 approached the nursing station to again request staff assistance to transfer R2 to his bed. At 3:13 PM, no staff had entered R2's room and Z1 returned to the nursing station to request assistance for R2. At 3:39 PM, Z1 again approached the nursing station, requested assistance to transfer R2 back to bed, and stated she did not want to leave R2 until he was back in bed. At 3:47 PM, he was taken to his room.

5.) R21 stated I'm a person too, you know! I feel degraded like I'm not worth it! R21 stated she sits in her wheel chair or recliner chair, with her incontinence brief soaked with urine and her pants wet, for four to five hours without staff coming to change her brief. R21 stated she is not changed from 10:00 AM, when she is gotten up from bed and transferred to her wheelchair, until 2:00 PM when she is transferred from her wheelchair to her recliner chair. R21 stated she then sits in the chair from 2:00 PM until 8:30 PM and her brief is changed at 8:30 PM when staff put her to bed. R21 stated she knows when her brief is wet, but she gave up calling for assistance because I could call, but I would sit and wait the whole time until 2:00 PM, and it would just aggravate me! R21 stated the staff tell her they have no time to change her brief any sooner than 2:00 PM. R21 stated she knew staff were feeding other residents and they would not come until after they were freed up from lunch. R21 stated if she wants to attend bingo at 6:30 PM and she asks the staff to transfer and change her earlier than 8:30 PM,
R21 stated the staff complain to her about her request and resist changing her brief because it is during dinner time and they have people to feed. R21 stated this is her usual routine for the staff. R21 stated, It's worse to call and know they know you need help and they don't come . How do you know I haven't fallen and I am laying here thirty minutes? That's what scares me! R21 also stated the staff tell R21 that they cannot help R21 because they have to go assist other residents. R21 stated the staff tell R21 they cannot help R21 with all she requests because the staff tell R21 they have to go and help other residents and they do not have time for R21. R21 stated, I'm an important person too!

6) On (MONTH) 22, (YEAR) at 3:30 PM, E1 (Administrator) described R2 as unreasonable and stated R2 wants things done only R2's way and only when R2 wants them done. On (MONTH) 21, (YEAR) at 10:30 AM, R2 stated the facility staff complain to the resident that they do not have enough staff to help position him every two hours. R2 stated that makes him feel worthless - like I don't matter. R2 stated lately he does not get turned on R2 stated he had not had his face washed in seven days and does not get a bed bath between showers. R2 stated he had worn the facility gown he was wearing for the past two to three days without it being changed. R2 stated per his schedule he was scheduled to be repositioned at 10:00 AM and he had been laying in the same position since 8:00 AM.

1/11/2017 ($25,054 fine)
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145308&SURVEYDATE=01/11/2017&INSPTYPE=CMPL
1) Abuse and staff does not do proper investigations on abuse

All violations
https://projects.propublica.org/nursing-homes/homes/h-145308

Generations at Regency
Atied 34.72% (the Barrishes are also part owners)
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/generations_at_regency_2017_0049841.pdf

2/28/18 - Violations
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145237&SURVEYDATE=02/28/2018&INSPTYPE=STD

Major hygiene issues.
Review of shower log provided by V31 showed that R95 is scheduled to get showers on Wednesday and Saturday mornings. V31 also provided surveyor with the weekly shower sheet that is to be completed by the CNA for R95 and it was blank with no indication of when R95 was bathed.

Wound dressings not being changed for four days.
On 02/25/18 at approximately 10:44 am, Resident #186 was noted in bed with V18 (Family) at the bed side feeding Resident #186. V18 pointed to the dressing on Right Medial Bicep of Resident #186 dated 2/21/18, V18 stated this should be changed every day and **today is 2/25/18 it was the same dressing since 2/21/18. Supposed to be changed daily.**

R94 is at high risk for pressure ulcer development and is dependent on staff for care. She weighed 66 pounds. R94 is lying in bed with low air loss mattress in place with a fitted sheet, draw sheet, and fabric incontinence pad in place; the bed was set to max weight of 325 pounds. R94's not supposed to have these sheets; having this sheet and pad loses the purpose of having the air mattress, if R94 needs an incontinence pad it should be the disposable one because it's thin; the bed should not be set to 325 pounds, Surveyor then asked V26 who is responsible for ensuring that the settings are correct on the low air loss mattress and she stated that the wound nurses are responsible for checking the settings once maintenance has set up the beds.

R110 is very thin in appearance with pronounced bony prominences and is dependent on staff for care . R110 is at high risk for pressure ulcer development. R110 was lying in bed with redness noted on R110's left elbow. **No staff noticed it.**

R110 is on hospice care. R110 is a at a high risk for falls. Requires a two + person assist. He only gets one.

R60 was observed lying in bed urine drainage catheter observed in place. Initially had it because of a wound. Twenty days after his wound healed, staff could not answer why he still had a urine drainage catheter. **Policy says:**
Lack of service to support continued use will result in the removal of the catheter as soon as possible but not to exceed 14 days, after a full assessment and or physician review has been completed. Evidence to support continued use will become part of the resident's clinical.

Oxygen equipment did not have dates.
Missing controlled substance signatures.
Expired insulin vials.

10/16/2017 - violations

https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145237&SURVEYDATE=10/16/2017&INSPTYPE=CMPL

1) (Z3-former nurse aide) who reported that R1
had slipped from sling during (mechanical lift) transfer. (hoyer lift requires 2 staff members - only one staff member was operating hoyer lift.Upon entrance to the room, (R1) was observed lying on the floor on left side. A laceration approximately 3 centimeters was observed to the
left temporal/orbital, with bruising and swelling. Area was cleansed and bleeding was controlled without difficulty. E22 (Treatment Nurse) applied (wound closure strip) to the lacerated area. Z1 (Primary Physician) was notified of R1's assessment and condition and was asked if E6 could send R1 to emergency room via ambulance. Z2(nurse practitioner) arrived and assessed (R1) and stated that R1 is **stable and should be transferred to bed.** R1's family arrived and R1 taken to ER. **Cause of death**: R1's certificate of death documents:Hypertensive and arteriosclerotic cardiovascular disease. Enter other significant conditions contributing to death but not resulting in the underlying condition given in part 1: Blunt force injuries due to fall. (did nursing home certificate of death match the ER's certificate of death?)

3/9/2017 violations
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145237&SURVEYDATE=03/09/2017&INSPTYPE=STD

Medication omissions and errors.
Many cases of patients not being changed and sitting in urine soaked pants.
The facility failed to follow their Abuse prevention policy by not assessing an identified offender for abuse risk, and by not implementing interventions to prevent the potential abuse of the resident/residents, for a resident identified as having a prior conviction of domestic battery. Illinois State Police report, dated (MONTH) 25, (YEAR), shows R13 was convicted of domestic battery/physical contact on (MONTH) 13, 2009 and was sentenced to eighteen months special probation on (MONTH) 4, 2009. The report also shows several convictions of illegal drug offenses including manufacturing and delivering controlled substances for which she served three years imprisonment on (MONTH) 24, 2003.

Other violations
https://projects.propublica.org/nursing-homes/homes/h-145237

Pine Crest Healthcare
Atied Associates 40%
https://www.illinois.gov/hfs/MedicalProviders/CostReports/2017%20LTC%20Cost%20Reports/pine_crest_health_care_2017_0051318.pdf

Violations
1/19/2018
https://projects.propublica.org/nursing-homes/homes/h-145220
On 1/18/18 at 9:40 AM in R6's room, R6 is up sitting in recliner-type wheelchair. **The room smells of strong urine.** R6's lips are extensively cracked and peeling. R6's legs are cracked and peeling. At 9:42 AM In R2's room, R2 is laying in the bed with his catheter bag on the floor. R2 is total assist for the majority of his needs and has limited use of extremities. R2 was calm and not moving in the bed. At 10:09 AM in R4's room, R4 is up in his recliner-type wheelchair.

R4 has a **strong foul body odor and is still unshaven. R4 opened his mouth upon request and teeth were coated with substances.**

At 1:49 PM in R2's room, R2 is in the bed all contracted with legs up to chest wearing a hospital gown. The enteral feeding pump alarm was sounding
as V7 shaved R2. V7 stated R2 does not speak and is usually as he is now. V7 asked if she should tell the nurse about the alarm sounding on the enteral pump. The bottle of enteral solution was labeled today's date and started at 10:08 AM which was confirmed earlier by V9 (Licensed Practical Nurse) at 9:47 AM and again at 2:03 PM. The pump read that 70 milliliters(ml)/hr as the rate and stop for the amount that was delivered. The enteral bottle was still full with 1000 ml of enteral feed. **Enteral feeding had not progressed for the last few hours.**

8/30/2017 - violations
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=145220&SURVEYDATE=08/30/2017&INSPTYPE=STD

Building infrastructure in need of repair

Other violations
https://projects.propublica.org/nursing-homes/homes/h-145220

Devon Gables Rehabilitation Center
Ownership: Atied Associates 48%, and rest of Rothner family has percentage stakes
https://www.nursinghomedatabase.com/home/AZ/TUCSON/85712/DEVON%20GABLES%20REHABILITATION%20CENTER

8/10/2017 - Violations
https://projects.propublica.org/nursing-homes/homes/h-035145

7/29/16 - Violations
https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=035145&SURVEYDATE=07/29/2016&INSPTYPE=STD

Medication issues.
1) Not documenting medications ordered by physician
2) Changing a physician's order

Hoyer lift issue

On (MONTH) 26, (YEAR), the resident was being assisted out of bed by two staff members via hoyer transfer when it appears a strap slipped off a loop and she fell to her right side landing on her buttocks then falling back hitting her head. The resident sustained [REDACTED]. The report indicated two staples were placed to the placed to the laceration on the resident's head and the CT scan was negative for internal injuries.

Other violations
https://projects.propublica.org/nursing-homes/homes/h-035145

Attachment D:
Nursing Home Staffing

The number of staff members at nursing homes varies drastically at facilities across the country. This tool allows one to see how more than 14,000 nursing homes rate using Medicare's assessment of overall staffing.

https://www.nytimes.com/interactive/2018/07/07/health/nursing-home-map.html

There are five rating possibilities for nursing home staffing levels: Much Below Average, Below Average, Average, Above Average, and Much Above Average. There is also No Rating.

Summary of Findings:

Champaign County Nursing Home is rated Above Average for staffing.

More than half of the 16 Illinois (non-psychiatric) nursing homes owned by Extended Care Clinical, LLC homes are Below Average or Much Below Average.
9 (or about 55%) were Below Average or Much Below Average; 4 (or 25%) were Average; and 3 (or about 20%) were Above Average.

The vast majority of the 18 nursing homes in Illinois owned by Atied Associates, LLC are Below Average or Much Below Average for staffing.
14 (or 78%) were Below Average or Much Below Average; only 2 (or 12%) were Average; none were Above Average or Much Above Average. 2 could not be found.

Detailed Information

Champaign County Nursing Home
Above Average

EXTENDED CARE CLINICAL LLC Homes:

Beecher Manor Nursing & Rehab Center
Below Average

Sebo's Nursing & Rehab Center
Average

Park House Rehabilitation Center (Little Village Nursing & Rehab Center)
Much Below Average

St. James Manor & Villas
Above Average

Prairie Manor Nursing & Rehab Center
Much Below Average

Spring Mill Health Campus
Above Average

Lakewood Nursing & Rehab Center
Average

South Suburban Nursing & Rehab Center
Average

Lemont Nursing & Rehab Center
Average

Munster Med Inn (listed as Munster Meinn in tool)
Below Average

The Estates of Hyde Park
Below Average

Chateau Nursing & Rehab Center
Below Average

Dyer Nursing & Rehab Center
Above Average

Lincolnshire Health Care Center
Below Average

Tri-State Nursing & Rehab Center (Listed as Tri State Health & Rehabilitation Center)
Much Below Average

Wheaton Care Center
Below Average

Psychiatric facilities:
Rainbow Beach
Not listed

Grasmere Place
Not listed

ATIED ASSOCIATES LLC Homes:

In Illinois:

Pine Crest Health Care
Below Average

Pearl Pavilion
Below Average

Generations at Regency
Average

Riverview Rehab
Below Average

Bridgeway Senior Living

Generations at Neighbors
Below Average

Rushville Nursing & Rehab Center
Average

Oak Park Oasis (or new name, Paramaount Oak Park)
Below Average

Park Villa Nursing & Rehab Center
Below Average

Generations at Applewood
Below Average

Briar Place Nursing
N/A

Rock River Health Care
Below Average

Estates of Hyde Park, The
Below Average

Kensington Place Nursing & Rehab Center
Below Average

Forest City Rehabilitation & Nursing Center
Much Below Average

Generations at Rock Island
Below Average

Aperion Care International
Much below Average

Center Home Hispanic Elderly
Much Below Average

Ridgecrest Rehab Center
Above Average

Lancaster Rehab Center
Average

Attachment E:

E-mail sent to Champaign County Board Members with expert opinion regarding independent health care valuations and whether or not Champaign County's materials from brokerage firms constitute an "independent valuation".

Summary: James Unland, a foremost national expert on healthcare valuations concludes that the methods used by the brokerage firms Marcus & Millichap, and Evans Senior Investments for arriving at a sale price for the Champaign County Nursing Home do **not** constitute "independent valuations". Mr. Unland also states that the absence of certain information indicates that the County has not done its due diligence regarding the County Nursing Home.

Excerpts: "The materials that you sent were neither 'independent' valuations nor valuations using what I would consider to be sound methodologies. For "brokerage" firms to do a valuation is an inherent conflict of interest."

"**I have not yet seen a valuation according to proper standards** nor have I seen a truly independent valuation."

"If such information has not been developed, the absence of this kind of vital information would indicate to me that the county needs to do much more work in order to meet its due diligence responsibility and, I would think, its fiduciary duty to the County's taxpayers in respect to assessing the nursing home's relative present and future viability and in determining its future."

James Unland's resume can be viewed here: http://freepdfhosting.com/42abe272bb.pdf

E-mail Correspondence with Mr. Unland's message

From: Claudia Lennhoff
To: Champaign County Board Members
Date: 5/21/18 7:57 a.m.
Subject: County's Due Diligence and Securing an Independent Valuation of CCNH - Fwd: The Champaign County Nursing Home

Dear Champaign County Board Members and Administrative Staff,

Please find below a message from James Unland, one of our nation's foremost experts on healthcare valuations. His message is regarding the County's due diligence with regard to the valuation of the CCNH, and whether or not the efforts documented constitute an "independent valuation".

I have shared with him a number of materials regarding the CCNH, including the 5/18/18 Report and Information Packet, containing the brokerage firms' evaluations, as well as Rick Snider's e-mails.

James Unland's resume can be viewed here:

http://freepdfhosting.com/42abe272bb.pdf

Sincerely,

Claudia Lennhoff

-------- Forwarded Message --------
Subject: The Champaign County Nursing Home
Date: Sun, 20 May 2018 16:26:05 +0000 (UTC)
From: Health Capital Group <healthcapitalgroup@yahoo.com>
To: Claudia Lennhoff <claudia@shout.net>

Claudia, I took a look at the information that you sent me, as a courtesy, regarding the Champaign County Nursing Home. There is some additional information that I would like to see if it exists, and I am listing it below. If such information has not been developed, the absence of this kind of vital information would indicate to me that the county needs to do much more work in order to meet its due diligence responsibility and, I would think, its fiduciary duty to the County's taxpayers in respect to assessing the nursing home's relative present and future viability and in determining its future. Do not assume that I am convinced either way regarding whether the nursing home should be sold or should continue to be County owned. The materials that you sent were neither "independent" valuations nor valuations using what I would consider to be sound methodologies. For "brokerage" firms to do a valuation is an inherent conflict of interest. At any rate, below is what I would want to look at:

— Income/expense statements for the past full fiscal years the last 10 years and this fiscal year to date.

— Occupancy by level of service category and payer mix category for each of those same periods.

— Any written, detailed operational turnaround plans done internally and/or by independent external qualified consultants; by "independent" I mean dispassionate consultants who have **not** done prior work for either the County or the Nursing Home and who **cannot** be considered to be in a position to purchase the Home, broker the sale of the Home, enter into a management contract, etc.

— Any independent business fair market valuations that have been done according to thorough valuation standards. The documents you sent me came across as sales presentations, **not** rigorous valuations and/or business plans. **I have not yet seen a valuation according to proper standards** nor have I seen a truly independent valuation.

I look forward to hearing from you if you are able to obtain any of the above requested information.

Regards, Jim

This email is from James Unland
Professor, Health Care Business and Finance, Loyola Chicago Beazley Institute for Health Law
Editor, Journal of Health Care Finance Finance
President, The Health Capital Group
Telephone: 312-543-6962

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Claudia Lennhoff, Executive Director
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