

ILLINOIS STATE POLICE
INVESTIGATIVE REPORT

File #	Reporting Date(s)	Reporting Agent(s)	ID #	Lead No.
00X0369	10/23/00	RAY A. LEWIS/RON BARANOWSKI	2269	

Title	Case Agent:	ID #	Dist./Off.	Typed by:	Date
MICHAEL REINSTEIN	R. A. LEWIS	#2269	MFCU-CHGO	rl	11/20/00

Purpose
INTERVIEW OF [REDACTED]

On October 23, 2000, Illinois State Police Special Agent Ray A. Lewis and United States Postal Investigator Ronald Baranowski, interviewed [REDACTED] at her residence located at [REDACTED] Chicago, Illinois, TX: [REDACTED]. The purpose of the interview was to determine what information [REDACTED] could provide regarding the allegation Psychiatrist Dr. Michael Reinstein may have falsely billed Medicare and Medicaid for medical services he did not provide.

[REDACTED] was employed at Maxwell Manor Nursing Home located at 4737 S. Drexel Ave., Chicago, Illinois from 1990 until the facility was closed by the Illinois Department of Public Health and the Illinois Department of Public Aid in June 2000. [REDACTED] related her job title was Social Services Specialist and her job functions included but, was not limited to assisting patients with basic every day needs, conducting group and individual sessions in order to report on their mental and physical health. [REDACTED] stated she conducted seminars on Stress, Finances, Grooming, Social Skills and Motivation Management. Each session was conducted daily and they lasted approximately thirty minutes. [REDACTED] reported to Social Service Supervisor Adetunji Olayiwola for the past three years. [REDACTED] stated all the social service specialists consumed a lot of time with each patient individually.

[REDACTED] stated, Dr. Michael Reinstein was the facility's assigned psychiatrist and he was responsible for the psychiatric care for the majority of the patients at Maxwell Manor. Dr. Reinstein only came to the nursing home on Wednesdays and he almost never conducted individual or group therapy sessions with patients. [REDACTED] stated, Dr. Reinstein usually arrived at the facility approximately 9:00 a.m. and he would leave at approximately 10:00 a.m.

While Dr. Reinstein was at the facility, he spent most of his time talking with the facility's License Practical Nurses (LPN) at the nurse's station. The nurses he talked to were Delores Matthew, Bobby Townsend, Gladys Jones and Hattie Moss. These LPNs would provide Dr. Reinstein with the mental condition of patients and he would enter that information into the patient's medical chart.

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The Maxwell Manor facility has seven floors and patients were on floors two through six with approximately 45 patients per floor. Each floor had a nurse station and when Dr. Reinstein was at the facility he spent approximately five to fifteen minutes at each station.

█████ stated many patients complained to the nurses, the social workers and the management at Maxwell Manor about not being able to meet with Dr. Reinstein. Patients who had never seen Dr. Reinstein were prescribed medications from the information that was listed on the patient's evaluation form. Evaluation forms were required to be completed by the patient's assigned psychiatrist initially when the patient entered the facility and three times a year thereafter. ██████ stated the facility's Psychiatry Rehabilitation Service Coordinators (PRSC) completed evaluation forms. According to ██████, the owner and the office manager Ms. McClinton and Ms. Garret ordered the PRSCs to complete the form as part of their job function. ██████ stated she witnessed Dr. Reinstein signing the already completed evaluation forms.

█████ stated many patients also complained about taking the medication Clozaril. The drug caused several patients to hallucinate, loss of bladder control, loss of sex drives, it gave them the "trembles" and headaches that were associated with dizziness. Most of the patients had no choice in what medications they had to take. Patients who did not take Clozaril were not issued passes that allowed them to leave the facility unsupervised.

█████ stated she had many conversations with Dr. Reinstein about how many patients who had bad physical reactions to Clozaril. Dr. Reinstein very seldom reduced or changed the dose. Grier advised Dr. Reinstein failed to meet with family members of patients who wanted to discuss the mental condition and the effect of Clozaril. LPN's only discussed patients conditions with family members.

Dr. Reinstein ordered blood tests for all patients who were taking Clozaril. Each patient was given at least one test per week. ██████ stated an unknown named pharmacist at times accompanied Dr. Reinstein and would provide cigarettes to patients. According to ██████, this was one of the ways that Dr. Reinstein used to get patients to agree to continue to take Clozaril. ██████ advised, Dr. Reinstein usually came to the facility alone, however in December of 1999 Ginny Robinson, W/F accompanied Dr. Reinstein to the facility. Robinson made rounds to each floor and talked to the most unruly and troubled patients who complained about the mental and physical reactions Clozaril was causing to them. Robinson was attempting to convince patients the importance of taking the drug. Robinson also introduced a new drug, Trileptal, to the patients and offered them the option between Trileptal and Clozaril.

█████ stated on 10/16/00 she began employment at the Westshire Nursing Home, located at 5825 W. Cermak Road, Cicero, Illinois, as a Social Services Specialist. On 10/20/00 Dr. Reinstein came to the nursing home and put on a sales presentation on Clozaril and Trileptal to the nursing and social service staffs at Westshire. ██████ related, Dr. Reinstein attempted to convince the staffs of the benefits to the patients for taking the two drugs. ██████ stated, Dr. Reinstein passed out pamphlets on Clozaril and Trileptal. ██████ provided the reporting agents with the pamphlets that Dr. Reinstein distributed on Clozaril and Trileptal. Both pamphlets were marked as evidence and labeled ISP exhibits 1 and 2. Exhibits 1 and 2 will be maintained at the Health Care Task Force

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Office located at 4343 Commerce Court, Suite 400, Lisle, Illinois. [REDACTED] stated the presentation lasted approximately thirty minutes and after the presentation Dr. Reinstein met with a resident/patient of Westshire for approximately ten minutes.

[REDACTED] believes Dr. Reinstein is affiliated with the following hospitals and nursing homes: Bethany, Trinity, and Vancore Hospitals; Somerset Nursing Home and Madden Mental Health Center. [REDACTED] stated, Dr. Reinstein recruited patients for the listed mental health facilities. Dr. Reinstein also recruited patients for Maxwell Manor.

[REDACTED] agreed to cooperate with the investigation and will provide the reporting agents with the days and dates Dr. Reinstein is at the Westshire facility. [REDACTED] will discretely attempt to monitor the number of patients he treats and the type of care he is providing.

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**ILLINOIS STATE POLICE
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File #	Reporting Date(s)	Reporting Agent(s)	ID #	Lead No.
00X0369	08/09/00	RAY A. LEWIS/MIKE KUBA	2269	

Title	Case Agent:	ID #	Dist./Off.	Typed by:	Date
MICHAEL REINSTEIN	R. A. LEWIS	#2269	MFCU-CHGO	rl	8/22/00

Purpose
INTERVIEW OF ██████████

On August 9, 2000, Illinois State Police Special Agent Ray A. Lewis and Investigator Michael Kuba, interviewed Engoyema A. Fela, B/M, DOB: ██████████. ██████████ home address is ██████████ ██████████ Illinois, TX: ██████████. The purpose of the interview was to determine what information ██████████ could provide regarding the allegation that Psychiatrist Dr. Michael Reinstein may have falsely billed Medicare and Medicaid for medical services he did not provide. The interview was conducted at the ISP Chicago Medicaid Fraud Control Unit headquarters located at 8330 S. M. L. King Dr., Chicago, Illinois.

██████████ stated he has a Bachelor of Arts Degree in Psychology and Sociology from Fresno State University. ██████████ stated he was employed at the Maxwell Manor Nursing Home, located at 4737 S. Drexel Ave., Chicago, Illinois, TX: 773 268-1173, from June 1995 until the facility was closed by the Illinois Department of Public Health and the Illinois Department of Public Aid in June 2000. ██████████ related he was the facility's Psychiatry Rehabilitation Services Coordinator (PRSC). His job duties involved coordinating patient activities and services. ██████████ advised, John Tucker, Paulette Green and acting supervisor O. Tugi also worked at the facility as PRSC's. ██████████ related he worked between twelve and eighteen hours per day and usually six days a week.

██████████ stated in 1997 he quit working at Maxwell Manor and started employment at Lydia Nursing Home, located in Robbins, Illinois. ██████████ quit working at Maxwell Manor after a patient committed suicide. The management at Maxwell Manor failed to provide psychiatric care which may have caused the death and then management had a "don't care" attitude after the death. ██████████ was distraught after this incident and was upset enough to quit. ██████████ related he returned to Maxwell Manor after six months because he was asked to by the management at Maxwell Manor and he missed the patients. ██████████ stated he wanted to make a difference in the way patients were treated and cared for. According to ██████████ the management at Maxwell Manor liked the way he interacted with patients.

██████████ stated, 80 percent of the residents at Maxwell Manor were assigned to Dr. Reinstein for psychiatric care. Dr. Reinstein has been the facility's psychiatrist for more than 10 years. Most of

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the patients received little or no face to face therapy from Dr. Reinstein. Dr. Reinstein came to the facility only on Wednesdays. Dr. Reinstein usually arrived at the facility between 8:30 a.m. and 9:00 a.m., and he would be done with all his business at approximately 10:00 a.m. [REDACTED] stated many patients became agitated and rebellious because they knew they needed care and they wanted to talk with Dr. Reinstein, but were not allowed to. Security had to be called to keep order and was assigned and stationed near Dr. Reinstein while he was at the facility [REDACTED] stated the facility housed approximately 200 patients. When Dr. Reinstein did have sessions with patients he only saw five patients per visit and he would not spend more than one minute with any one patient. Most of the times he failed to have sessions with any of the patients. Many of the patients who were assigned to Dr. Reinstein did not know nor had they ever met him.

[REDACTED] stated psychiatric evaluations (blank copy attached) were completed on each patient. Evaluations were filled out initially when patients entered the facility, every quarter of the year and at times when the patient's mental condition had changed or appeared to be changing. The psychiatric evaluations are supposed to be completed by the patient's assigned psychiatrist after face to face sessions [REDACTED] stated the PRSC's would complete the evaluations and Dr. Reinstein signed them. [REDACTED] related the Director of Social Services, Mr. Akins, ordered the PRSC's to complete the evaluations. Akins was aware the PRSC's did not have the education nor the training to complete the psychiatric evaluations. [REDACTED] stated he witnessed Dr. Reinstein signing blank evaluations with only the name of the patient printed on the forms. Many times the PRSC's forged Dr. Reinstein's name on the evaluations. [REDACTED] stated, he signed his own name on the evaluations he completed but, someone in management erased his signature and would stamp or sign Dr. Reinstein's name.

[REDACTED] stated, Dr. Reinstein spent most of his time while he was at the facility signing evaluation forms. Usually he would sign between 20 and 30 forms at each visit. Dr. Reinstein compiled a list of names from the forms he signed, [REDACTED] believed this is how he billed Medicaid/Medicare. Dr. Reinstein rarely discussed the psychiatry condition of the patient with the staff at Maxwell Manor. Between 1990 and 1995 the Illinois Department of Public Health issued a warning to Maxwell Manor's management about allowing staff to complete patients' psychiatric evaluations. Fela stated he told the other PRSC's that it was Dr. Reinstein's job to fill out the evaluation forms.

[REDACTED] advised Maxwell Manor management established a Care Program Group that consisted of LPN's, RN's, Social Workers, and PRSCs. The purpose was to discuss the needs, physical and mental condition of each patient. Dr. Reinstein never met with the Program Care Group or reviewed the group's reports on the condition of patients. According to [REDACTED], Dr. Reinstein on occasions would ask him [REDACTED] about the mental and physical condition of some of the patients. [REDACTED] believed that Dr. Reinstein may have entered this information into patient charts.

Dr. Reinstein was known at the facility jokingly as the "Clozaril King." Clozaril is a drug most commonly prescribed for mentally impaired patients. Dr. Reinstein was accompanied most of the time by a pharmacist. [REDACTED] could not recall the pharmacist name nor the name of the pharmacy he worked at. Dr. Reinstein prescribed Clozaril most of the time, and in [REDACTED] opinion, when it was not necessary. Many patients complained to [REDACTED] that the drug made them act and feel sick after taking it. Patients related they lost control of his/her bladder or it (Clorzaril) made them hallucinate.

Since the patients were required to take the drug and were not scheduled to see Dr. Reinstein the patients became agitated or depressed. LPN's and RN's would recommend and order medication for patients and Dr. Reinstein signed the medication order without ever examining the patient. Usually unruly or rebellious patients had their medication (Clozaril) increased. This was one way of maintaining control over patients.

Patients who showed they could function away from the facility were given "passes." This allowed patients to leave the facility for short periods of time to take care of personal business, visit friends and family members. In order for the passes to be issued patients had to agree to take Clozaril. Dr. Reinstein also solicited patients this way. He promised that he would issue them passes if he became their psychiatrist.

██████████ stated the only time Dr. Reinstein looked at or wrote in the patient's charts was to note the change of medication and this information was obtained from the LPN's and RN's. Dr. Reinstein never monitored the behavior of the patients after changing or adjusting their medication.

Dr. Reinstein was not accompanied by his own staff when he visited the facility. Dr. Maxim Chasanov, who shares office space with Dr. Reinstein located at 4755 N. Kenmore, Chicago, Illinois, substituted for Dr. Reinstein occasionally when he did not show up. According to ██████████ Dr. Chasanov attempted to meet with the patients but, the patients were so agitated about only now being able to meet with a psychiatrist many were threatening. Dr. Chasanov after about six months refused to return to Maxwell Manor because he feared for his safety. No other psychiatrist visited any patient at Maxwell Manor.

Three months before Maxwell Manor was to be closed, Dr. Reinstein came to the facility with his staff to recruit patients to be placed at facilities where he was the attending psychiatrist. Dr. Reinstein and his staff were advising patients if they did not select a particular nursing home they would be homeless. Many patients thinking they had no other choices agreed to go to nursing homes that had been selected by Dr. Reinstein's staff.

██████████ could not provide any additional information and the interview was concluded.