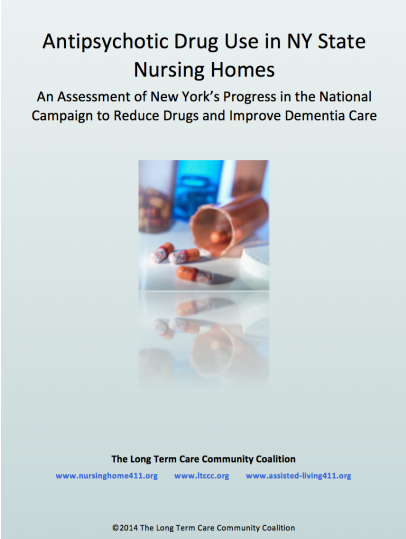
THE LTC MONITOR

Summer 2014 Long Term Care Community Coalition

Close to 20% of NY Nursing Home Residents Given Dangerous Antipsychotics

LTCCC Study Finds Little Enforcement of Minimum Standards of Care, Though NY Failed to Achieve National Goal to Reduce Chemical Restraint of Residents with Alzheimer's & Other Dementia

Inappropriate antipsychotic drug use is a widespread, national problem in nursing homes. Despite the FDA's 'black box' warning against using powerful and dangerous antipsychotics on elderly patients with dementia, they are frequently used to treat symptoms of the disease, including so-called behavioral and psychological symptoms of dementia. These drugs are often used as a form of chemical restraint, stupefying residents so that they are more easy to care for. In addition to destroying social and emotional well-being, these drugs greatly increase risks of stroke, heart attack, Parkinsonism & falls.



Approximately one in five nursing home residents are given these drugs every day in New York nursing homes, though only one percent of the population will ever be diagnosed with a psychotic condition. As the U.S. Inspector General Daniel Levinson stated in 2011, "Too many [nursing homes] fail to comply with federal regulations designed to prevent overmedication, giving nursing home patients antipsychotic drugs in ways that violate federal standards for unnecessary drug use." The Inspector General concluded, "Government, taxpayers, nursing home residents, as well as their families and caregivers should be outraged – and seek solutions."

In response to the Inspector General's report and advocacy by nursing home resident representatives, including LTCCC, the federal Centers for Medicare and

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U.S. Inspector General IDs Priority Issues For Nursing Homes, Other Providers

The federal Office of the Inspector General released its "Compendium of Priority Recommendations" in March. The Compendium addresses numerous issues of concern to long term care consumers. Following are some of the major points identified by LTCCC, excerpted and adapted from the OIG report, which is available at http://oig.hhs.gov.

1. **Nursing homes—Improve care planning and discharge planning.**

OIG found that Medicare paid approximately $5.1 billion for a sample of 2009 stays in which SNFs [skilled nursing facilities] did not meet quality-of-care requirements. In addition, their February 2013 report raised concerns about what Medicare is paying for (i.e., possible wasteful spending of Medicare dollars for questionable care) and demonstrated that oversight needs to be strengthened to ensure that SNFs perform appropriate care planning and discharge planning. OIG found that for 37% of stays, SNFs did not develop care plans that met requirements or did not provide services in accordance with care plans. For 31% of stays, SNFs did not meet discharge planning requirements. Additionally, their reviewers found examples of poor quality care related to wound care, medication management and therapy.

OIG's recommendations: Strengthen regulations on care planning and discharge planning, provide guidance to SNFs to improve care planning and discharge planning, increase surveyor efforts to identify SNFs that do not meet care planning and discharge planning requirements and to hold these SNFs accountable, link payments to meeting quality of care requirements, and

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NY Nursing Home Residents Given Dangerous Antipsychotics (Continued from cover)

Medicaid Services (CMS) began a national antipsychotic drugging initiative in March 2012. Nursing homes in New York and across the country were charged with reducing their antipsychotic drug use by 15% by the end of 2012, with additional goals to come.

Goals of the study: (1) review and assess the success of this campaign, particularly in respect to New York State's nursing home residents, and (2) assess whether enforcement actions corresponded with the scope and breadth of the antipsychotic drugging problem in New York.

Key findings: (1) Widespread use of dangerous chemical restraints persist throughout the state; (2) Nursing homes vary widely in their use of antipsychotic drugs, from under 2% to close to 50%; (3) Where one lives in NY makes a difference: the Western region had lower drugging and better enforcement of standards, while the NY City Metropolitan area had the highest drugging rates and lower enforcement; (4) Overall, state enforcement of standards for dementia care and the use of dangerous antipsychotics is minimal and largely ineffective because, even when violations are found, they are rarely identified as having caused harm to the individual who was drugged.

Recommendations: The study includes recommendations for each of the key agencies responsible for protecting nursing home residents and ensuring the integrity of the Medicaid system, which pays for the large majority of nursing home long term care. It includes specific steps that the state and federal oversight agencies (the NY Department of Health and federal Centers for Medicare and Medicaid Services) can take to better identify and effectively crack down on harmful and illegal nursing home drugging practices.

The full report includes information on every nursing home in New York and identifies rates of drugging for the last three years, as well as relevant enforcement actions. It is available at http://www.nursinghome411.org/articles/?category=antipsychoticlaws. That website page includes interactive tables that can be used to search drugging and enforcement rates for nursing homes individually, by county and by region.

The Story of Jenny: Meet Jenny, an 80-year-old nursing home resident who suffered from dementia, hypertension, diabetes, and depression and wound up on three antipsychotic drugs. Her story, by LTCCC Board member Jeanette Sandor, is on Jeanette's blog at: http://www.voicesfrombehindthecurtains.com/blog.html.

LTCCC LONG TERM CARE COMMUNITY COALITION
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LTCCC Study Finds Ombudsman NY State Funding & Complaint Handling for NY Nursing Home Residents Among Lowest in Nation

Nursing home residents are among our most vulnerable citizens. They depend on their facilities for 24 hour a day care and monitoring, and for providing them with the good quality of life and dignity that everyone deserves and which, under federal and state laws, nursing homes are mandated to provide.

Unfortunately, too often nursing homes fail to meet these standards. For instance, a recent report from the US Inspector General assessed, for the first time ever, what happens to people who go to a nursing home for short-term rehab. The IG found that one out of three suffered harm in the facility within 35 days. This harm was the result of problems like inadequate care and monitoring, inappropriate medication management and neglect. Close to 60% of the time this harm was determined to have been preventable. Six percent of those who were harmed died as a result.

The Long Term Care Ombudsman Program (LTCOP) is charged with protecting nursing home residents by monitoring nursing homes, advocating for residents and helping to resolve problems in resident care, quality of life and dignity. While the LTCOP does not have regulatory authority (and thus cannot penalize nursing homes), LTCOPs operate in every state under statutorily mandated functions and responsibilities delineated in the Older Americans Act. **More than any other entity, LTCOPs have the advantage of being "on the scene"** and, as the law mandates, should have a strong voice in representing the needs of residents to policy makers and advocating for systemic change as well as handling individual problems and complaints. Despite the fact that federal law requires that LTCOPs are to be strong and independent, in reality many of the programs in New York State are not permitted or are otherwise unable to carry out many of their statutorily defined functions.

See, ***Nursing Home Penalties Drop 33% in 2013 as New Federal Study Finds One in Three Harmed in Nursing Home Rehab – Majority Preventable***, for more information on the Inspector General's Report. Available at http://www.nursinghome411.org/?articleid=10079.

We undertook this study to assess the strength and viability of the LTCOP to carry out its mission and to find out, from the ombudsmen themselves, what challenges they face. As detailed in the report, we identified a number of significant issues that appear to undermine the strength, independence and viability of the NY State program:

- From 2007 – 2012, nursing home complaints handled by NYS ombudsmen *fell* over 80% and the number of nursing home problems that reached a "satisfactory resolution" *fell* over 85%.
- In 2012, approx. 10% of US nursing home residents had a problem handled by the LTCOP. In NY State, the number was only 3%.
- State funding for the NYS Ombudsman Program, comparatively low, literally flat-lined over the last decade.
- Only about 50% of the ombudsmen surveyed indicated that they are aware of, and participate in, the following two ombudsman activities delineated in the Older Americans Act: speaking to policymakers or advocating for systemic change.
- More than one-third felt that their (or their office's) ability to handle problems has changed in recent years.
- When asked to identify their top three challenges, 90% chose a category that related to being explicitly or implicitly prevented from performing certain activities by the state office, their sponsoring organization or their local program office.
- Lack of time or resources was the biggest single challenge cited by ombudsmen, followed closely by a perceived lack of clarity in the law relating to ombudsmen activities.

The full report is available at http://www.nursinghome411.org/?articleid=10080. It includes graphs and discussions of all relevant findings as well as recommendations for both the LTCOP and for the new managed care ombudsman program that the state will be launching this year.

Save the Date! LTCCC's Annual Event will be held on October 22.

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OIG Priorities (Continued from cover)

follow up on the SNFs that failed to meet care planning and discharge planning requirements and that provided poor quality of care.

2. Nursing homes—Address harm to patients, questionable resident hospitalizations, & inappropriate drug use.

A February 2014 OIG report revealed that about 33 percent of Medicare beneficiaries experienced adverse or temporary-harm events during their SNF stays. Fifty-nine percent of the adverse events and temporary-harm events were clearly or likely preventable and resulted, for example, from substandard treatment, inadequate resident monitoring, and failure or delay of necessary care. [For more information on this important study see LTCCC's press release and resources, ***Nursing Home Penalties Drop 33% in 2013 as New Federal Study Finds One in Three Harmed in Nursing Home Rehab – Majority Preventable***. Available at http://www.nursinghome411.org/?articleid=10079.]

A November 2013 report found that nursing home residents went to hospitals for a wide range of conditions, with septicemia the most common. Rates of Medicare resident hospitalizations varied widely across nursing homes with some states having higher rates of resident hospitalizations than others. A May 2011 report questioned safeguards against unnecessary atypical antipsychotic drugs used for residents of nursing homes. OIG found that 95 percent of claims for such drugs were for elderly nursing home residents diagnosed with conditions for which the drugs' use was not approved by FDA or were for residents diagnosed with dementia, the condition specified in a Food and Drug Administration (FDA) warning about such drugs.

OIG Recommendations: CMS should Include potential events and information about resident harm in its quality guidance to nursing homes and instruct nursing home surveyors to review facility practices for identifying and reducing adverse events. CMS should explore alternative methods for the survey and certification process to promote compliance with established federal standards regarding unnecessary drug use in nursing homes. [See the cover story on nursing home antipsychotic drugging for more information, or visit our **Antipsychotic Drugs & Dementia Care** page at www.nursinghome411.org for more information and resources.]

3. Nursing homes—Improve emergency preparedness and response.

OIG recommends that CMS revise federal regulations by identifying and including in its regulations requirements for specific elements of emergency plans and training, update the State Operations Manual to provide detailed guidance for surveyors assessing compliance with federal regulations for nursing home emergency planning and training, promote use of the emergency preparedness checklists for nursing homes, state long-term-care ombudsman programs and Medicaid state agencies. The Administration for Community Living (ACL) should develop model policies and procedures to protect resident health, safety, welfare, and rights during & after disasters. [NOTE: The LTC Ombudsman Program is part of the ACL.]

4. Hospices—Ensure compliance with Medicare Conditions of Participation.

OIG found that 17% of state-surveyed hospices had not been recertified within the preceding six years, with some hospices experiencing longer intervals since their most recent survey. In 12 States, more than 25% of hospices had not been recertified within the last six years. Such findings raise concerns about whether CMS and state agencies can ensure that hospices comply with Medicare Conditions of Participation and quality-of-care requirements.

5. Address Medicaid managed care fraud and abuse concerns.

OIG asked Medicaid managed care entities (MCEs), states, and CMS to identify their major concerns regarding fraud and abuse. The primary concern centered on providers billing for services not rendered. Other concerns included providers rendering services that are not medically necessary and billing for higher levels of services than were provided (upcoding); questionable beneficiary eligibility; and prescription drug abuse by beneficiaries.

In addition to their fee-for-service programs, states may contract with different types of MCEs to provide health care services on a statewide or a community basis. Managed care's capitated payments create incentives for providers to render fewer services to beneficiaries.

Selected Enforcement Actions of the Medicaid Fraud Control Unit in the NY State Attorney General's Office: 12/16/13 - 3/15/14

The Medicaid Fraud Control Unit (MFCU) prosecutes cases of Medicaid fraud and patient abuse in nursing homes. To report fraud, abuse or neglect go to http://www.ag.ny.gov/comments-mfcu or call (800) 771-7755. Note: A sentence of "conditional discharge" means if similar act is committed during the time period defendant can be brought back to court.

Nursing Home	Location	Defendant	Narrative	Sentence
Betsy Ross Rehabilitation Center	Oneida	Reynolds, Judith, Registered Nurse	Resident of facility was noted with copious amounts of blood in foley catheter and tubing. Defendant improperly attempted to flush resident's catheter with 60 ml of normal saline when she knew that the catheter had been dislodged. Defendant waited approximately 30 minutes then flushed resident's catheter 3 more times using 60 ml of normal saline with no return each time. When defendant finally attempted to do what she should have done from the beginning, which is to change the catheter, she was unable to stop the bleeding.	2/3/2014: Three years probation and 300 hours of community service.
Blossom South Nursing Home	Monroe	Beckhorn, Cindy, Director of Nursing	Beckhorn, the former Director of Nursing at Blossom South Nursing Home, filled in numerous blank entries on patient medication administration records and treatment administration records with false and forged initials during a Department of Health survey inspection of the above-named home.	1/14/2014: Conditional discharge with 40 hours of community service.
Blossom South Nursing Home	Monroe	Rowe (Goodman), Sheryl, Licensed Practical Nurse	Rowe, a former nurse manager at Blossom South Nursing Home, filled in numerous blank entries on patient medication administration records and treatment administration records with false and forged initials during a Department of Health survey inspection of the above-named home.	1/14/2014: Conditional discharge with 40 hours of community service.
Bridgeview Nursing Home	Queens	Mante-Adu, Esther	The defendant, while working as a Certified Nurse Aide at the Bridgeview Nursing Home, struck a resident in the head several times and was verbally abusive to the resident. The Defendant was found guilty after a jury trial on January 27, 2014 of Endangering the Welfare of an Incompetent or Physically Disabled Person, an A Misdemeanor, and Wilful Violation of Health Laws, an unclassified misdemeanor.	3/12/2014: Three years of probation with participation in a court-ordered anger management counseling program, and a requirement that the defendant be precluded from engaging in private employment as a home health aide.
Chemung County Health Center	Chemung	Chaffee, Michael, Licensed Practical Nurse	Chaffee failed to perform a blood sugar test on nursing home patient but recorded a reading in the patient's medical record indicating the test had been performed. A resulting facility audit disclosed that there were approximately 25 falsely documented blood sugar levels for 14 different residents attributable to Chaffee.	3/6/2014: One-year conditional discharge. Signed a consent order from the Office of Professional Discipline agreeing to a two month suspension of his nursing license, probation supervision by OPD for one year and a $500 fine imposed by the NYS Education Department.
The Hamptons Center for Rehabilitation	Suffolk	Ohakam, Ray, Certified Nurse Aide	Defendant, a CNA, transferred a resident alone, without using a Hoyer lift, in violation of the resident's care plan that required a two person Hoyer lift transfer. Several hours later staff members on the following shift reported finding extensive bruising on the resident and an x-ray revealed a fractured clavicle, subarachnoid bleed and subdural hematoma. When asked during the facility's investigation, the defendant falsely stated that a specific aide assisted with the transfer. That aide denied assisting and the video recording revealed that no other aide entered the room and a Hoyer lift was never brought to the room. When confronted, the aide admitted to conducting an unassisted transfer, but denied dropping or injuring the resident.	2/10/2014: Three years probation, surrender of CNA certificate and signed agreement precluding future employment caring for incompetent, elderly, infirm or disabled people until at a minimum 12/31/2015.
Heritage Health Care Center	Oneida	Narbone, Debra, Licenced Practical Nurse	The defendant stole prescription narcotic pain medication from residents of the nursing facility.	1/17/2014: Three years probation.
Hudson Park Rehabilitation and Nursing Center	Rensselaer	Francis, Sarina, Certified Nurse Aide	Sarina Francis, CNA, grabbed resident Jones' left arm when the resident attempted to hit her. According to witness CNA Stacy Hill, Jones then twisted the left arm of Jones behind her back, yanked the resident's incontinent brief out from under her, and smacked resident Jones in the face with it. Accused CNA then took resident Jones hand and proceeded to make Jones hit herself in the face. Ms. Jones sustained a broken arm, acute oblique fracture of the distal ulna metaphysis.	3/10/2014: Thirty Days of jail and five-years probation. Defendant previously surrendered her CNA certificate.
Orzac Center for Extended Care	Nassau	Delem, Princema, Certified Nurse Aide	Defendant, a CNA, transferred a resident alone using a Hoyer lift, in violation of the resident's care plan that required a two person Hoyer lift transfer. The Hoyer lift tipped over and the resident fell to the floor and sustained a bump on his head. The defendant gave a false statement during the facility's investigation denying that the resident fell or received any injury.	1/9/2014: One year conditional discharge. Conditions were $750 fine, surrender of CNA certification, and signed agreement precluding future employment involving caring for incompetent, elderly, infirm or disabled people for a minimum of three years.
St. Catherine Laboure Health Care Center	Erie	Miller, Sally, Registered Nurse	Miller stole hydrocodone from facility and falsified delivery sheet to cover up theft.	1/15/2014: One-year conditional discharge; condition requiring the defendant to surrender her RN license.

Federal Civil Money Penalties[1] Against NY Nursing Homes: 12/01/13 - 2/28/14[2]

Federal CMPs are one of a number of remedies that the state and federal governments can use when a nursing home fails to meet minimum standards. Typically, when a nursing home is found to be failing to provide the quality of care, quality of life and/or other conditions that it promises to provide in order to receive Medicaid or Medicare money other remedies, such as requiring a "plan of correction," are implemented first.

Name of Home	Location	Survey Date[3]	Amount
Chemung County Health Center	Elmira	10/4/13	$3,900 [4]
Edna Tina Wilson Living Center	Rochester	10/25/13	$4,550 [4]
Glengariff Health Care Center	Glen Cove	8/8/13	$22,490 [4]
Indian River Rehab and Nursing Center	Granville	7/15/13	$273,100
Lutheran Retirement Home	Jamestown	9/27/13	$6,370 [4]
New Gouverneur Hospital SNF	New York	8/23/13	$5,980 [4]
Pine Haven Home	Philmont	8/2/13	$6,500 [4]
Rosewood Heights Health Center	Syracuse	6/20/13	$6,500 [4]
St. Lukes Home	Utica	8/30/13	$53,400
Sullivan County Adult Care Center	Liberty	5/23/13	$5,200 [4]
Teresian Home Nursing Home Co	Albany	11/25/13	$39,000

[1] Civil Money Penalties (CMPs) – a federal monetary sanction against nursing homes that fail to comply with minimum standards.
[2] As reported by CMS. For further details contact the CMS FOIA Officer at 212-616-2220.
[3] Date of initial survey. In some instances the facility may have been revisited.
[4] Amount reflects a 35% reduction as the facility waived its right to Appeal as permitted under law.

Special Focus Facilities in New York State: As of March 20, 2014

The federal Special Focus Facility (SFF) Program was created to address the widespread problem of nursing homes that have persistent, serious problems. Once a facility is selected for inclusion in the Program it receives special attention from the state, including at least twice as many surveys as normal (approximately two per year). The goal is that within 18-24 months of being in the Program a facility will either: (1) develop long term solutions to its persistent problems or (2) be terminated from the Medicare and Medicaid programs. Termination usually means that a facility is sold to a new operator or closed. Due to resource limitations, only 136 nursing home across the country are selected for participation in the SFF Program at any given time, though many more would "qualify" due to their poor care.

Important Notes: (1) In 2013 CMS significantly curtailed the SFF Program due to federal sequestration. Thus, there are now even more nursing homes that qualify to be an SFF because of their extremely poor record, but are not. **LTCCC recommends that consumers consider any facility with a one star overall rating on Nursing Home Compare (www.medicare.gov/nursinghomecompare) to be the equivalent of an SFF, amongst the worst in the country**. (2) Numbers in parentheses below indicate the number of months a facility has been an SFF. An asterisk means the facility is a repeat SFF.

Update: CMS announced in April 2014 that, effective immediately, states can resume selection of new SFFs. Thus we can expect an increase in SFFs in New York and nationally.

In addition, though Blossom South still appears on the CMS list (and below) it has been removed from the Medicare and Medicaid programs and closed. See the Spring issue of the *Monitor* and the *Democrat & Chronicle* for more information.

Facilities Newly Identified as a SFF	Facilities That Have Shown Improvement	Facilities That Have Not Improved	Facilities That Have Recently Graduated from the SFF Program	Facilities No Longer Participating in the Medicare and Medicaid Program
None	Rosewood Heights Health Center (24)*	Blossom South Nursing And Rehabilitation Center (34) *	Pleasant Valley (20)	None
			Van Duyn Home And Hospital (25)	
			Wingate at Beacon (11)	

Selected Actions of the NYS Office of the Medicaid Inspector General: 9/16/13 - 12/15/13

The Office of the Medicaid Inspector General (OMIG) works to protect NY State citizens residing in long term care facilities by making sure that those responsible for their care do not engage in abusive and fraudulent activities. This is done through OMIG's working to ensure that those who are enrolled as providers in the Medicaid program are properly vetted; investigating allegations of fraud and abuse within long term care facilities; and excluding providers who have abused their positions as caregivers. In addition to conducting their own investigations, OMIG makes determinations to exclude based on other agency actions, including the State Education Department (SED), the Medicaid Fraud Control Unit (MFCU), and Human Health Services (HHS). A single provider can receive multiple exclusions, based on different indictments and convictions. This multiple exclusion process works to protect residents of long term care facilities, because it ensures that even if one type of exclusion is overturned, the abusive provider is still banned from receiving Medicaid funds based on other convictions.

Please note: In addition to the actions listed below, all of the providers which were reported as having actions taken against them by the Medicaid Fraud Control Unit in previous newsletters have been excluded by OMIG. Please see our newsletter archives at www.ltccc.org/newsletter for their names. Exclusion means that no payments will be made to or on behalf of any person for the medical care, services or supplies furnished by or under the supervision of the defendant during a period of exclusion or in violation of any condition of participation in the program. Additionally, any person who is excluded from the program cannot be involved in any activity relating to furnishing medical care, services or supplies to recipients of Medicaid for which claims are submitted to the program, or relating to claiming or receiving payment for medical care, services or supplies during the period. OMIG may take a variety of exclusion actions against a provider based upon: indictments; convictions; consent orders or HHS exclusion.

Nursing Home	Defendant	Location	Narrative	OMIG Exclusions Based Upon
Dutch Manor Nursing and Rehabilitation Center	Jodi Montenaro	Schenectady	As business office manager, Ms. Montenaro used resident funds to make unauthorized payments in the amount of $1,762 to her personal Time Warner account. A resident's son also gave Ms. Montenaro $2,688 to deposit into his mother's resident account and instead Ms. Montenaro stole the money.	MFCU Conviction: 6/23/2013
Harbour Health Multicare Center for Living	Danielle Courtney, RN	Buffalo	Ms. Courtney presented a DOH-166 Request for Approval of Disposal/Destruction of Controlled Substances Form to the NYSDOH which falsely indicated that certain quantities of controlled substances were destroyed. The controlled substances were later found intact at the facility.	MFCU Conviction: 7/24/2013
Lakeside Beikirch Care Center	John Ford, LPN	Brockport	Mr. Ford failed to change the dressing on the feeding tube of an 85- year-old woman with Parkinson's Disease and suffering from paralysis and dysphagia. Mr. Ford falsified the patient treatment administrative record by indicating he did change the dressing on six consecutive dates when he had not.	MFCU Conviction: 9/8/2013 & MFCU Indictment: 4/21/2013
Medford Multicare Center for Living	John Grayovski, CNA	Medford	Mr. Grayovski transferred an elderly resident without assistance in violation of her care plan, resulting in the resident receiving a laceration on her leg. He then covered the injury with a bootie and did not report the incident to the nurse on duty. The patient later needed sutures to close the injury. When Medford Facility investigated the injury, Mr. Grayovski falsely reported that he had transferred the resident with assistance and did not see any injury to the resident.	HHS Exclusion: 9/19/2013 & MFCU Conviction: 8/14/2013 & MFCU Indictment: 10/29/2012
Norwich Rehabilitation and Nursing Home	Kimberly Young, LPN	Norwich	Ms. Young stole fentanyl gel, a controlled substance, from two fentanyl patches, and ingested the gel orally.	HHS Exclusion: 12/19/2013 & MFCU Conviction: 6/24/2013
Sunrise Nursing Home	Johnna Scanlon-Howland	Oswego	Ms. Scanlon-Howland worked in the business office of Sunrise Nursing Home and maintained the Sunrise Nursing Home resident trust account, including making deposits and withdrawals on behalf of residents. Ms. Scanlon-Howland made false withdrawals from several residents' accounts and cashed the checks, stealing a total of $45,363 from the residents of the nursing home.	HHS Exclusion: 11/20/2013 & MFCU Conviction: 7/8/2013 & MFCU Indictment: 1/2/2013

We Need Your Help! Please Support LTCCC's Work to Improve Care, Dignity & Quality of Life for Nursing Home & Assisted Living Residents.

Please consider supporting LTCCC this year, as we continue to face significant challenges to continuing our work. You can send a check to "Long Term Care Community Coalition" at One Penn Plaza, Suite 6252, NY, NY 10119 or donate on-line at http://ltccc.org/ltccc.orgsupport.shtml.

All donations are 100% tax-deductible. Any amount is truly appreciated!

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