THE LTC MONITOR

Winter 2014-15 Long Term Care Community Coalition

Nursing Home Family Member Launches *Last Stop* Documentary Project & Website

By Laurie Kash

The documentary project and website, Last Stop (http://laststopmovie.com/) is about the many for whom a nursing home is, indeed, their last stop. The completion of our life's journey can and should be one of meaning and dignity, not isolation and loneliness, warehoused and cut off from the world.

In traditional society, elders held unique authority. In modern society, our elders are viewed as expendable, especially when they become ill, disoriented or unable to care for themselves. Institutional "nursing care" is the nightmare world where all of this plays out, often at its worst. The Last Stop documentary project was conceived after my mother was paralyzed from the chest down from medical malpractice and nursing home neglect. [See "*My Mother's Nursing Home Nightmare*" article from the LTCCC Monitor Spring 2013 issue!! [http://www.ltccc.org/newsletter/documents/ltccc_spring2013_web.pdf] Her indomitable will and amazing spirit helped her prevail for three additional years.

In those three years I was witness to many of the realities of institutional "care." I met many family members, advocates, nursing home patients, and also some commendable nurses and aides. Their frustration and outrage, as well as their commitment – along with potential solutions – will be featured in this documentary, with interviews eliciting these perspectives, along with my mother's story.

LTCCC Presents Submission to United Nations on Widespread Restraint of U.S. Nursing Home Residents

In September 2014, LTCCC filed a submission for the United Nation's Universal Periodic Review of the United States on the widespread use of antipsychotic drugs as chemical restraints of residents with Alzheimer's Disease and other dementia in U.S. nursing homes. The submission raises concerns relating to: cruel, inhuman and degrading treatment; abuse and neglect of vulnerable populations (both nursing home residents in general and elderly individuals with Alzheimer's Disease or other dementia in particular); and denial of the rights to be informed of and consent to treatment.

Every nation's human rights record comes up for periodic review by the U.N. The review for the United States will take place the spring of 2015. Following is the summary of LTCCC's submission. The full text of the submission is available at http://www.nursinghome411.org/?articleid=10085.

I. SUMMARY

1. The 1987 U.S. Nursing Home Reform Law[1] and its implementing regulations set forth strong standards for the care of nursing home residents in the United States. Under the law, each resident must be provided the care he or she needs, as an individual, to attain and maintain his or her highest practicable physical, emotional and psychosocial well being. There are explicit safeguards to prevent physical and chemical

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Submission to United Nations (Continued from cover)

restraint use and unnecessary drugging of nursing home residents. However, despite these longstanding requirements, and a U.S. Food and Drug Administration (FDA)[1] "black box warning" against use of antipsychotic drugs on the elderly, approximately one in five U.S. nursing home residents are administered antipsychotic drugs every day. These drugs are essentially 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. There is a strong correlation between antipsychotic drugging and mortality for the elderly. This correlation increases the longer an individual is drugged.

2. This submission raises concerns relating to cruel, inhuman and degrading treatment; abuse and neglect of vulnerable populations (both nursing home residents in general and elderly individuals with Alzheimer's Disease or other dementia in particular); and denial of the rights to be informed of and consent to treatment.

3. Our findings and concerns are based on the results of numerous studies, including many conducted over the years by (or for) the United States government, as well as our own studies on inappropriate antipsychotic drugging rates and the widespread and persistent failures of the government to prevent this drugging and uphold longstanding standards for nursing home resident care. In addition, our concerns are informed by numerous cases (both legal cases and anecdotal reports from families and the grassroots organizations with which we work) from across the country that substantiate the pervasiveness of this problem and the significant harm it causes to thousands of nursing home residents and their families every year.

4. Our recommendations are fundamentally simple: the United State government should enforce longstanding standards of care and treatment of nursing home residents and, particularly, of the numerous residents suffering from Alzheimer's Disease or other forms of dementia.

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Please call Sara Rosenberg at 212-385-0355 or email sara@ltccc.org for newsletter support & sponsorship opportunities.

LTCCC HOLDS SIXTH ANNUAL BENEFIT

On October 22, LTCCC held its annual cocktail party. This year we were proud to honor Dr. Mary Jane Koren and celebrate her longstanding leadership in our country's efforts to improve nursing home care. We also paid tribute to advocate and long-time friend of LTCCC Ann Berson. Thank you to everyone who joined us for the evening, and those who could not attend but generously supported the program. Visit www.facebook.com/LTCCC for more pictures.

Thank you to this year's sponsors!

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We would like to thank the Alzheimer's Association, NYC, for hosting the party and Blondie's Treehouse Inc. for providing the floral arrangements.

Last Stop (Continued from cover)

Background

The Last Stop video and website are works in progress, for which I am currently raising money. They illustrate my mother's heroic journey as a disabled survivor of institutional neglect. The website also poignantly recounts first hand, in the *Personal Stories* section, others who have also suffered in nursing homes. Such was my mother's story, a story of terrible institutional neglect *that could have been prevented*. This is how and why I became committed to nursing home reform. I seek an audience for these stories because I believe that it is essential to expose rampant nursing home neglect and abuse and to advocate effectively for bona fide reform.

What Happened to My Mother

My mother experienced an acute delirium from a head injury, at the age of 86, and entered the Jewish Home of Rochester, NY (JHR) to stabilize. She rapidly improved, and was about to return to her home to resume her active, independent life.

However, three weeks into her rehabilitation, an evening nurse failed to conduct a required catheterization and my mother was discovered hours later on the floor, on her back, in a pool of urine. Over the next two weeks, she progressively lost all mobility. The evidence of a resulting catastrophic spinal injury was overwhelming. Tragically, my mother was neglected at every level of care. Our family pled for an emergency room visit, but our repeated pleas were dismissed by the facility. Instead of receiving necessary and critical medical treatment, my mother was referred to a psychiatrist.

A brief neurological examination by my brother-in-law, a heart surgeon, determined that, following two weeks of neglect when medical action was still possible and necessary, my mother had become paralyzed from the chest down. The emergency room visit finally happened at that time but by then her injury was no longer reversible. My mother spent the remaining three years of her life confined to the nursing home, in a wheelchair, without autonomy or independence.

The NY State Department of Health (NYSDOH) investigated. Their findings trivialized the institutional neglect that caused my mother's paralysis, stating: "The issue involved not following a physician's order to catheterize a resident. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy."

The Need for Accountability

Our family's legal action sought accountability and justice. We sought public discussion concerning nursing home practices throughout the nation. What happened to our mother was documented in extensive court documents and medical records. We hoped to model the pursuit of necessary legal action when the oversight agencies have failed. Legal action is often the only way to shine a light because the agencies can or will not. LTCCC's report, *Using Law and Regulation to Protect Nursing Home Residents When Their Government Fails Them*, provides useful information on how to do this (http://www.nursinghome411.org/?articleid=10008).

Our family's story shows the potential for concerted action to expose neglect and implement change. My mother's catastrophe did not happen in a vacuum. She is a flesh and blood example of systems that are failing and which, I believe, must be held accountable. What our family was able to accomplish on an individual level, proving terrible harm, needs to be communicated to the society at large. **Our goal is to ensure appropriate and effective oversight to address harm when it occurs and to move the system in the direction that such harm becomes rare, rather than commonplace.**

We need vehicles of change for those most vulnerable in our society, now so often forgotten and victimized. Truth commissions may be one remedy to tell the stories of grave injustices and to create real and lasting reform. Please join me in this vital process of awakening consciousness and spurring action at http://laststopmovie.com/.

Last Stop was accepted for the RCTV Output 2014 Film Festival and screened before a live audience at the Cinema Theater in April of 2014.

Selected Enforcement Actions of the Medicaid Fraud Control Unit in the NY State Attorney General's Office: 6/16/14 - 9/15/14

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: Following is a portion of MFCU actions for the quarter. For the full list of actions reported to us by the agency go to http://www.ltccc.org/enforcements/archives.shtml.

Nursing Home	Location	Defendant	Narrative	Sentence
Amsterdam at Harborside/Enriched Housing	Nassau	Benodin, Stephanie, Personal Care Assistant	Defendant stole a check from a resident's checkbook, forged it and used it to steal money from the resident's account.	9/5/2014: Sixty-days Jail and three-year's Probation.
Beechwood Homes	Erie	Harris, Onjelque, Certified Nurse Aide	Caused skin burn by improper incontinent care.	7/30/2014: One-year Conditional Discharge, 25 hours of Community Service and a $205.00 surcharge. She also executed an Affidavit of Surrender of her CNA Certificate.
Blossom North Nursing and Rehab Center	Monroe	Acevedo, Elizabeth, Certified Nurse Aide	Hidden camera revealed that a highly vulnerable resident of the facility was neglected in that numerous health care professionals failed to properly provide ordered care and treatment to the resident.	6/26/2014: One-year Conditional Discharge.
Blossom North Nursing and Rehab Center	Monroe	Dahal, Binita, Registered Nurse	Hidden camera revealed that a highly vulnerable resident of the facility was neglected in that numerous health care professional failed to properly provide ordered care and treatment to the resident.	6/26/2014: One-year Conditional Discharge and 24 hours of Community Service. Signed a Consent Order from the Dept. of Education (suspension, probation and fine).
Blossom North Nursing and Rehab Center	Monroe	Holmes, Christy, Certified Nurse Aide	Hidden camera revealed that a highly vulnerable resident of the facility was neglected in that numerous health care professionals failed to properly provide ordered care and treatment to the resident.	7/17/2014: Sixty-four hours of Community Service and surrendered her license.
Blossom North Nursing and Rehab Center	Monroe	Jenkins, Junetta, Licensed Practical Nurse	Hidden camera revealed that a highly vulnerable resident of the facility was neglected in that numerous health care professionals failed to properly provide ordered care and treatment to the resident.	7/17/2014: Three-year's Probation and 140 hours of Community Service.
Blossom North Nursing and Rehab Center	Monroe	Stevenson, Krista, Certified Nurse Aide	Hidden camera revealed that a highly vulnerable resident of the facility was neglected in that numerous health care professionals failed to properly provide ordered care and treatment to the resident.	7/17/2014:Three-year's Probation and 64 hours of Community Service.
Blossom North Nursing and Rehab Center	Monroe	Anderson, Champagne, Licensed Practical Nurse	Hidden camera revealed that a highly vulnerable resident of the facility was neglected in that numerous health care professionals failed to properly provide ordered care and treatment to the resident.	8/14/2014: Three-year's Probation.
Golden Hill Healthcare Center	Ulster	Smithmyer, Patricia, Registered Nurse	Defendant was supervising RN at Golden Hill Care Center. Resident, who had directive requesting CPR, stopped breathing while defendant was in room but the she did not commence CPR. Defendant claimed that she was not in the room.	7/17/2014: One-year Conditional Discharge, 150 hours of Community Service to be completed in 90 days and surrendered nursing license.
Harding Nursing Home	Oneida	Jones, Joianne, Licensed Practical Nurse	The defendant stole oxycodone tablets that had been earmarked to be wasted. She documented that the oxycodone had been wasted to cover-up her theft and possession of the oxycodone.	7/24/2014: One-year Conditional Discharge and continue participation in SPAN program and treatment until released. Defendant to provide regular proof of participation to the Court.
Highland Health Care Center	Allegany	Alvarez, John, Administrator	Administrator falsified fire drill records	7/1/2014: One-year conditional discharge, $200 fine, and a $205 surcharge.
Highpointe on Michigan f/n/a Deaconess SNF	Erie	Kozlowski, Cynthia, Licensed Practical Nurse	Hidden camera revealed that staff failed to follow care plan of resident with advanced stage Huntington's Chorea and falsified documentation to cover-up their neglect.	6/18/2014: One-year Conditional Discharge and 100 hours of Community Service to include her appearance at an in-service training as needed upon request of MFCU to provide a "scared straight" presentation. The defendant was also required to pay a $200 surcharge and provide a DNA sample.
Highpointe on Michigan f/n/a Deaconess SNF	Erie	Clegatt, Hazel, Certified Nurse Aide	Hidden camera revealed that staff failed to follow care plan of resident with advanced stage Huntington's Chorea and falsified documentation to cover-up their neglect.	7/2/2014: One-year Conditional Discharge and 100 hours of Community Service to include her appearance at an in-service training as needed upon request of MFCU to provide a "scared straight" presentation. The defendant was also required to pay a $200 surcharge and provide a DNA sample.
Highpointe on Michigan f/n/a Deaconess SNF	Erie	Glass, Margaret, Certified Nurse Aide	Hidden camera revealed that staff failed to follow care plan of resident with advanced stage Huntington's Chorea and falsified documentation to cover-up their neglect.	7/2/2014: One-year Conditional Discharge and 100 hours of Community Service to include her appearance at an in-service training as needed upon request of MFCU to provide a "scared straight" presentation. The defendant was also required to pay a $200 surcharge and provide a DNA sample.
Highpointe on Michigan f/n/a Deaconess SNF	Erie	Harrell, Rubetta, Certified Nurse Aide	Hidden camera revealed that staff failed to follow care plan of resident with advanced stage Huntington's Chorea and falsified documentation to cover-up their neglect.	7/2/2014: One-year Conditional Discharge and 100 hours of Community Service to include her appearance at an in-service training as needed upon request of MFCU to provide a "scared straight" presentation. The defendant was also required to pay a $200 surcharge and provide a DNA sample.
Highpointe on Michigan f/n/a Deaconess SNF	Erie	Henderson, Kenissa, Certified Nurse Aide	Hidden camera revealed that staff failed to follow care plan of resident with advanced stage Huntington's Chorea and falsified documentation to cover-up their neglect.	7/2/2014: One-year Conditional Discharge and 100 hours of Community Service to include her appearance at an in-service training as needed upon request of MFCU to provide a "scared straight" presentation. The defendant was also required to pay a $200 surcharge and provide a DNA sample.
Highpointe on Michigan f/n/a Deaconess SNF	Erie	Robinson, Mariah, Certified Nurse Aide	Hidden camera revealed that staff failed to follow care plan of resident with advanced stage Huntington's Chorea and falsified documentation to cover-up their neglect.	7/2/2014: One-year Conditional Discharge and 100 hours of Community Service to include her appearance at an in-service training as needed upon request of MFCU to provide a "scared straight" presentation. The defendant was also required to pay a $200 surcharge and provide a DNA sample.
Highpointe on Michigan f/n/a Deaconess SNF	Erie	Stevens, Shateeka, Licensed Practical Nurse	Hidden camera revealed that staff failed to follow care plan of resident with advanced stage Huntington's Chorea and falsified documentation to cover-up their neglect.	7/2/2014: One-year Conditional Discharge and 100 hours of Community Service to include her appearance at an in-service training as needed upon request of MFCU to provide a "scared straight" presentation. The defendant was also required to pay a $200 surcharge and provide a DNA sample.
Highpointe on Michigan f/n/a Deaconess SNF	Erie	Stuart, Amanda, Certified Nurse Aide	Hidden camera revealed that staff failed to follow care plan of resident with advanced stage Huntington's Chorea and falsified documentation to cover-up their neglect.	7/2/2014: One-year Conditional Discharge and 100 hours of Community Service to include her appearance at an in-service training as needed upon request of MFCU to provide a "scared straight" presentation. The defendant was also required to pay a $200 surcharge and provide a DNA sample.

Federal Civil Money Penalties[1] Against NY Nursing Homes: 6/1/14 - 9/30/14[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
Absolut Center For Nursing & Rehab Aurora Park	East Aurora	1/30/2014	$15,210.00 [4]
Alice Hyde Medical Center SNF	Malone	11/25/2013	$38,740.00 [4]
Avon Nursing Home	Avon	9/6/2013	$9,500.00
Hudson Park Rehab and Nursing Center	Albany	9/20/2013	$48,600.00
Kaaterskill Care Skilled Nursing And Rehab	Catskill	11/3/2013	$19,890.00 [4]
Livingston Hills Nursing & Rehabilitation Center	Livingston	2/11/2014	$38,512.50 [4]
Rosewood Rehabilitation & Nursing Center	Rensselaer	11/15/2013	$13,715.00 [4]

[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 212-616-2439.
[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 October 1, 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 a small number of nursing homes 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) Because the SFF Program is so limited, 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.

Newly Identified as a SFF	Shown Improvement	Not Improved	Recently Graduated from the SFF Program	No Longer Participating in the Medicare and Medicaid Program
None	Rosewood Heights Health Center (30)*	None	None	None

Please Support LTCCC This Holiday Season

DONATE TO OUR ANNUAL APPEAL: 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 www.ltccc.org/about/support.shtml. All donations are 100% tax-deductible. Any amount is truly appreciated!

SHOP & SUPPORT LTCCC: Go to smile.amazon.com and choose LTCCC as your charity or go to www.igive.com/ltccc to shop at 100s of stores, from Macy's to Brooks Brothers to Walgreens, even travel sites like Expedia.com. All shopping is secure and donations are made at no cost to you.

Selected Actions of the NYS Office of the Medicaid Inspector General: 6/15/14 - 9/15/14

What is the Office of the Medicaid Inspector General (OMIG) & what does it do?

OMIG investigates allegations of fraud within long term care facilities, works to ensure that those who are enrolled as providers in the Medicaid program are properly vetted and excludes 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).

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.

To report suspicion of fraud to the OMIG go to http://www.omig.ny.gov/consumers.

Nursing Home	Defendant	Location	Narrative	OMIG Exclusions Based Upon:
Focus Rehabilitation and Nursing Center	Michelle Brown, CNA	Utica	Ms. Brown was kicked by a resident who had dementia. Ms. Brown responded by slapping and punching the resident, and then sprayed the resident in the face with a bottle of peri-wash.	HHS Exclusion 1/20/14 & MFCU Conviction 11/27/2013
Maplewood Health Care and Rehabilitation Center	Krysta Davis, LPN	Canton	Ms. Davis removed pills from a blister pack, and placed them in a cup. She did not however provide the prescription medication to the intended patients; although she signed the facility Medication Administration Record (MAR) indicating that she had provided the residents with the medications.	HHS Exclusion 6/19/2014 & MFCU Conviction 3/04/2014 & MFCU Indictment 9/25/2013
Mills Pond Nursing and Rehabilitation Center	Pauline Tonsingh, CNA	Mills Pond	Ms. Tonsingh left a disabled resident alone on the toilet, in violation of the resident's care plan. The resident fell sideways and Ms. Tonsingh found her with her face against the railing next to the toilet. Instead of getting an RN's immediate assistance, Ms. Tonsingh continued with morning care, dressed the resident and brought her into the dining room, where other staff observed that the elderly woman had a swollen, bruised eye with blood tinged discharge. The resident sustained a fractured orbital and extensive bruising on the rest of her body. Ms. Tonsingh initially asserted that she found the patient that way earlier in the morning.	HHS Exclusion 6/19/2014 & MFCU Conviction 1/27/2014 & MFCU Indictment 3/10/2013
Park Ridge Living Center	Groven Glenn, CNA	Greece	Mr. Glenn threw a chicken bone at an 83 year old resident, and then wheeled her wheelchair into a closed door, leading to bruising and abrasions on the woman's body.	HHS Exclusion 05/20/2014 & MFCU Conviction 2/24/2014 & MFCU Indictment 07/28/2013
The Pines at Catskill Center for Nursing and Rehabilitation	Jacqueline Brown, LPN	Catskill	Ms. Brown took Oxycontin pills for her own use that were prescribed to a resident. She then destroyed the facility narcotic sheet.	MFCU Conviction 2/03/2014 & MFCU Indictment 7/24/2013
St. Ann's Home	Ericha Brown, CNA	Rochester	Ms. Brown posted a video on Facebook that she took with her iPhone of a 92 year old patient suffering with dementia. The video showed the elderly resident being harassed, teased and having her hair pulled.	HHS Exclusion 6/19/2014 & MFCU Conviction 3/4/2014
Springs Nursing and Rehabilitation Center	Janice Giudilli, RN	Troy	Ms. Giudilli failed to make changes in the medication orders for a resident, causing the patient to receive insulin in an amount in excess of what was necessary to maintain a safe and appropriate blood glucose level. The resident subsequently needed to be hospitalized.	MFCU Conviction 2/03/2014
Van Rensselaer Manor Nursing and Rehabilitation Facility	Cynthia Uzzo, LPN	Troy	Ms. Uzzo administered insulin to a resident when she should not have done so based on the sugar level readings. After learning that the resident then had a hypoglycemic episode, Ms. Uzzo altered the resident's medical records to cover her mistake and requested that her nursing supervisor not report the incident.	MFCU Conviction 2/24/2014

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✪ ✪ ✪ ✪ ✪ **The LTC Monitor – Winter 2014-15** ✪ ✪ ✪ ✪ ✪

Enclosed is our quarterly newsletter on nursing home care, dementia care and other LTC issues. Visit www.ltccc.org for all of our reports, educational resources & action alerts.

Now is the time for LTCCC's Annual Appeal: Please consider supporting our work to improve care, dignity & quality of life for residents in nursing homes and assisted living in 2015. See page 6 for details.

New Policy Brief: *Improving Nursing Home Care: Consumer Priorities for CMS*

The Coalition for Quality Care (CQC), a national coalition of state and regional LTC consumer groups, has issued a policy brief on nursing home quality and oversight. The brief presents specific recommendations on how to address longstanding and pervasive nursing home problems, including: high rates of abuse and neglect; inadequate care and monitoring; and the resulting suffering - both physical and mental - of elderly and disabled residents across the U.S. It was written by LTCCC's executive director, Richard Mollot, on behalf of CQC, with input from its members. Key recommendations focus on:

A. RESTORE FAITH IN NURSING HOME OVERSIGHT

1. Basic Survey Agency Improvements and Safeguards are Needed
2. Strengthen Survey Expectations, Guidance & Performance
3. Improve Quality & Quantity of Survey Staff – State Agencies & CMS Regional Offices

B. IMPROVE PUBLIC INFORMATION ON NURSING HOME QUALITY & SAFETY

1. Improve Staffing Information on Nursing Home Compare
2. Improve Other Information on Nursing Home Compare

C. ADDITIONAL RECOMMENDATIONS TO IMPROVE QUALITY & RESTORE CONFIDENCE

1. Use of Civil Money Penalties (CMPs)
2. Focus CMS Resources on Core Activities

The brief is available on CQC's website, www.coalitionqualitycare.org & LTCCC's website, www.nursinghome411.org.