



The National  
**CONSUMER VOICE**  
for Quality Long-Term Care  
formerly NCCNHR

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Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Room 445-G, Hubert H. Humphrey Building  
Washington, DC 20201

Delivered by Hand

**Attention: CMS-2435-P;** Medicare and Medicaid Programs  
Civil Monetary Penalties for Nursing Homes

The National Consumer Voice for Quality Long-Term Care (formerly NCCNHR) and the undersigned organizations appreciate the opportunity to comment on implementation of one of the most important provisions in many years to improve nursing home compliance. In our daily work and activities, we are engaged with people who are dependent on the laws you enforce and the regulations you promulgate to protect their or their loved ones' safety, health, dignity, and quality of life. We strongly commend you for meeting the intent of Congress in the Affordable Care Act (Pub. L. 111-148) to rectify a serious problem that our constituents experience and that the Government Accountability Office, Office of Inspector General, and other investigators have repeatedly identified—the ability of many nursing home providers to delay or avoid civil monetary penalties for serious violations that harm residents or place them at imminent risk of injury. The ability of nursing homes to delay payment of CMPs while pursuing meritless appeals has undermined the effectiveness of an immediate sanction intended to motivate providers to attain and maintain compliance and thus to avoid the more draconian sanction of termination from Medicare and Medicaid; when the sanction is undercut by delays, noncompliance is encouraged. In the first major nursing home reform legislation passed since 1987, Congress sought to correct a weakness in existing law that hampers the deterrent effect of CMPs and undermines the government's authority to sanction noncompliance.<sup>1</sup>

**Although our comments include recommendations to strengthen the proposed regulations, we also want to express our strongest possible support for the July 12 Notice of Proposed Rulemaking and urge you to move forward with the requirements you proposed.**

<sup>1</sup> In a 2007 report requested by Senator Charles E. Grassley, sponsor of the CMP reforms in the ACA, the GAO noted that "payment of homes of federally imposed CMPs is deferred if they appeal deficiencies, a process that can take years, diminishing the immediacy of the sanction and further undermining the sanction's deterrent effect." *Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents*, Government Accountability Office, March 2007, page 52. A 2005 OIG report found that the collection of CMPs in appealed cases took an average of 420 days, and "consequently, nursing homes are insulated from the repercussions of enforcement by well over a year." The OIG said "that as of March 2004, the facilities associated with 36 of the 44 uncollected CMPs [included in the study] were out of compliance during an inspection following the enforcement cycle when the unpaid CMP was imposed." *Nursing Home Enforcement: Collection of Civil Monetary Penalties*, HHS Office of Inspector General, July 2005, page 6.

*The National Consumer Voice for Quality Long-Term Care (formerly NCCNHR) is a 501(c)(3) nonprofit membership organization founded in 1975 by Elma L. Holder that advocates for quality care and quality of life for consumers in all long-term-care settings.*

Representatives of the nursing home industry have labeled the enforcement system as punitive and called for rewriting existing law, including requiring state inspectors to consult and collaborate with those they are charged with regulating. However, since 1998, numerous government reports, private research studies, and media investigations have demonstrated that serious deficiencies are overlooked, undercited, and downgraded, and that penalties are frequently negligible (“the cost of doing business”) or never enforced. Some of these problems have been traced by the GAO and others to “external pressure” from providers, who sometimes use politicians as intermediaries to try to coerce state licensing and certification agencies to discard or downgrade deficiencies or penalties.<sup>2</sup>

While providers argue that administrative appeals judges’ upholding of 90 percent of deficiencies is proof that the system is stacked against them, an examination of cases shows shocking neglect and abuse that resulted, in some cases, in minimal penalties. The Center for Medicare Advocacy regularly reviews and summarizes ALJ decisions in its monthly newsletter, *Enforcement*. The following cases are from the July issue:

- The Departmental Appeals Board upheld CMPs totaling \$11,100 against an Iowa facility cited for several nutrition-related deficiencies. In one case, the facility discontinued a supplement ordered by a resident’s physician even though she was at risk of malnutrition, observed by staff eating less than half of her food at meals, and losing a significant amount of weight. In spite of the resident’s decline in nutritional status, the facility variously claimed that she was “near her ideal body weight” and “exercising her right not to eat.”
- An Oregon nursing home lost its appeal of a citation for failure to assess a resident with a below-the-knee amputation for six days, during which time his surgical wound became bleeding and infected and the resident was confused and in pain. It was almost two weeks before the resident was readmitted to the hospital for treatment of a MRSA infection and amputation of his leg above the knee. The facility, which was fined \$1,500, argued that the resident did not suffer actual harm. (The facility had “a significant history of noncompliance.”)
- An ALJ sustained \$764,750 in penalties against a Kentucky facility for failing to take meaningful steps to protect debilitated residents from an alert, oriented, and relatively large and robust resident who had a long history of sexually aggressive behavior and engaged in verbal, physical, and sexual abuse of the facility’s residents for many months. The facility argued that no one was harmed by the man’s actions.

Any examination of the history of noncompliance in our country’s nursing homes will lead to the conclusion that we have waited far too long for this law and these regulations.

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<sup>2</sup> “State agency officials from two states—State A and an additional fifth state—reported that state legislators or industry representatives had appeared on-site during nursing home surveys. Although in some cases the legislators just observed the survey process, officials from these two states explained that third parties also have interfered with the process by questioning or intimidating surveyors. The state agency director from the fifth state commented on our questionnaire that the nursing home industry sent legal staff on-site during surveys to interfere with the survey process. Similarly, officials from State A told us that during one survey, a home’s lawyer was on-site reviewing nursing home documentation before surveyors were given access to these documents. Officials from State A also told us that state legislators have attended surveys to question surveyors about their work and whether state agency executives were coercing them to find deficiencies. We discussed this issue with the CMS regional officials responsible for State A, who acknowledged that this type of interference had occurred.” *Nursing Homes: Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment*, GAO, November 2009.

### **A. Proposed Establishment of an Escrow Account for Civil Monetary Penalties**

We concur with CMS's interpretation of Congress's intent in this section: To address the findings of the GAO and OIG that the time-lapse between identification of noncompliance and the collection of CMPs "diminishes the immediacy of the enforcement response, insulates the facility from the repercussions of enforcement, and may undermine the sanction's deterrent effect."

**Comment:** We fully agree with CMS's reasoning in this section to require per day CMPs to be effective and continue to accrue from the date that noncompliance is determined until the completion of the IIDR process. We agree that if per day penalties did not continue to accrue during IIDR, there would not be any CMP funds to collect when deficiencies were upheld during the IIDR process, and the financial incentives for facilities to correct noncompliance would be lost.

### **B. Proposed Reduction of a Civil Monetary Penalty by 50 Percent for Self-Reporting and Prompt Correction of Noncompliance**

We concur with CMS's interpretation of its authority under the ACA to reduce civil monetary penalties when facilities self-report and correct noncompliance within 10 days. Although the statutory language is confusing, we concur that a commonsense interpretation of the law requires that the reduction occur only under the conditions CMS proposes:

- The facility must report the violation before it is identified by CMS, the state, or a complainant who is not an official of the facility.
- The correction must occur within 10 calendar days of the date the facility identified the violation.

We agree that since the facility has acknowledged noncompliance, it should waive its right to a hearing to receive the reduction. We also agree that a facility that receives a 50 percent reduction for self-reporting should not be entitled to the additional 35 percent reduction it would usually receive for waiving a hearing.

Congress, of course, provided that CMPs cannot be reduced for self-reporting noncompliance that results in immediate jeopardy, constitutes a pattern of harm or widespread harm to residents, or resulted in a resident's death, or that is a repeat deficiency ("deficiencies in the same regulatory grouping of requirements found at the last survey").

**Recommendation:** While we are not opposed to providing the maximum 50 percent reduction in a CMP as an incentive to self-report noncompliance and correct deficiencies promptly, we strongly urge CMS to identify conditions under which a CMP might not be reduced by the full amount—for example, when deficiencies are related to systemic policies or problems in the parent company; when the facility is a Special Focus Facility; or when the facility has had numerous repeat deficiencies in other regulatory groupings.

**Recommendation:** We strongly urge you to define the corrective action a facility must take to receive a 50 percent reduction, including demonstrating that it has evaluated why noncompliance occurred and has taken effective steps to ensure that it will not occur again. For example, firing a nursing assistant

for injuring a resident is not a correction if injury was the result of poor supervision, lack of training, understaffing on the aide's shift, or failure to address previous complaints about her performance.

**Recommendation:** CMS should assure that citations have been appropriately cited and CMPs appropriately assessed before reducing the amount of the CMP. This recommendation is supported by federal look-behind surveys' frequent identification of state survey agencies' underciting of deficiencies and by the attitude of provider representatives' themselves that they should be allowed to correct deficiencies without penalty. For example, according to the Des Moines Register, the Iowa legislature this year "eliminated fines for self-corrected violations, such as failure to meet basic fire safety regulations and failure to provide adequate nutrition for residents. The bill passed the Senate without a dissenting vote after industry lobbyists characterized the violations as 'lower-level' infractions that did not 'directly impact resident care.'"<sup>3</sup>

### C. Proposed Opportunity for an Independent Informal Dispute Resolution Process

GAO's study released in December 2009 substantiated findings in previous studies that the existing informal dispute resolution process contributes to deleting deficiencies and downgrading their scope and severity. Sixteen percent of surveyors nationwide said their state's IDR process favored providers over residents; and in four states, more than 40 percent of surveyors believed IDRs favored providers. Moreover, "While only one state agency director reported that the IDR process favored nursing home operators," the report said, "three other directors acknowledged that frequent IDR hearings at least sometimes contributed to the understatement of deficiencies. For example, in some states surveyors may hesitate to cite deficiencies that they believe will be disputed by the nursing home."<sup>4</sup> The House sponsor of the bill, Rep. Henry Waxman, cited the study in the final debate before the House passed the Affordable Care Act on March 21, 2010, and specified that safeguards were necessary to ensure that IIDR is independent and safe from conflicts of interest. In addition, the House Ways and Means Committee cited the federal Office of Surface Mining Control and Reclamation Act as a model for escrow and due process.

We strongly support CMS's proposed regulations as conforming to the intent of Congress and protecting the timeliness, effectiveness, and independence of the IIDR process by requiring:

- Facilities to have the option to ask for either an IDR or an independent IDR, but not both.
- Facilities to make a timely request for an IIDR after imposition of a CMP (within 30 days) and requiring the process to be completed within 60 days.
- A written record of the procedure.
- Notification of residents, their representatives, and state ombudsmen, providing them an opportunity for written comment.
- Facilities to pay for the IIDR, based on the average time and resources needed to review a case.
- The IIDR to be conducted by the state, an entity approved by the state, or CMS (in the case of federal surveys), which has no conflict of interest.
- CMS to retain its existing authority for the survey findings and imposition of CMPs.

<sup>3</sup> "Nursing Home Inspectors Feel Lawmaker Pressure," Clark Kauffman, Des Moines Register, June 27, 2010.

<sup>4</sup> *Nursing Homes: Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment*, GAO, November 2009, page 42.

## Comments and Recommendations

**Notification of Residents, Residents' Representatives, and State Ombudsmen.** We strongly support this provision, which addresses the decades-old consumer complaint that providers have multiple opportunities to appeal deficiencies while residents, families, and citizen advocates have no formal authority in federal law to challenge a survey that overlooks or undercites noncompliance. This requirement meets, in part, a resolution passed by NCCNHR members in 2004 that called for consumers' active participation in IDRs and for a distinct IDR process for consumers to address deficiencies.

**Recommendation:** We recommend clarification of the language that “an involved resident or resident representative” be notified about the IIDR and opportunity to comment. The language is ambiguous and suggests that only residents whose care is directly at issue will be notified or permitted to comment; and it raises privacy concerns, since the resident and his or her representative would at least potentially be identified to others. Moreover, residents or family members may fear they will be retaliated against if they take advantage of the opportunity to comment.

**Recommendation:** We strongly urge that the definition of “an involved resident or resident representative” be broadened to include any resident, family member, or other resident representative with knowledge of noncompliance, as well as the resident and family councils. We also urge that you include language to ensure privacy and freedom from retaliation of those who are notified and comment.

**Facility Payment for IIDRs.** One of our greatest concerns about implementing an independent IDR system is the additional cost to an already financially overburdened survey and certification system that is struggling to ensure the safety of services that consumers and patients receive from a wide range of healthcare providers. While we support due process, we do not believe it is prudent or defensible for the government to pay for IIDRs, giving providers an incentive to file meritless challenges to deficiencies and deplete resources needed for inspections. As shown above, most deficiencies appealed to Administrative Law Judges and the Departmental Appeals Board are upheld—and for good reason.

**Comment:** We would like to reiterate our strong support for CMS's proposal to require facilities to pay for IIDR and to base payments on the average cost of hearing the appeal.

**Comment:** We do not support refunding user fees to nursing homes. In its comments on the proposed regulations, the Center for Medicare Advocacy has included sound reasons for CMS to retain the fees.

**Recommendation:** Facilities should also be prohibited from charging the cost of IIDR, including consultant and attorneys' fees, to Medicare and Medicaid. Taxpayers should not be required to bear the cost of defending nursing homes against negligence and abuse.

**Conflict of Interest.** Our strongest concern about IDR is the opportunity for providers—as has been shown in some states—to attempt to exert pressure or influence on the process.<sup>5</sup> The 2009 GAO report on the underlying causes of understatement of deficiencies addressed this problem:

In isolated cases, a lack of balance with the IDR process appeared to be a result of external pressure. In one state, the state agency director reported that the nursing home industry sent association representatives to the IDR, which increased the contentiousness of the process. In another state, officials told us that a large nursing home chain worked with the state legislature to set up an alternative to the state IDR process, which has been used only by facilities in this chain. Through this alternative appeals process, both the state agency and the nursing home have legal representation, and compliance decisions are made by an adjudicator. According to agency officials in this state, the adjudicators for this alternative appeals process do not always have health care backgrounds. While CMS gives states the option to allow outside entities to conduct the IDR, the states should maintain ultimate responsibility for IDR decisions. CMS regional officials stated it would not consider the outcome of this alternative appeals process when assessing deficiencies or determining enforcement actions. Regardless, these actions may have affected surveyors' perceptions of the balance of the states' IDRs, because over twice the national average of surveyors in this state reported that their IDR process favored nursing home operators.<sup>6</sup>

**Recommendation:** To ensure that the IDR process is free of conflict of interest, we recommend that CMS specify the composition of IDR entities, similar to its requirements for survey teams. For example, IDR should be conducted by individuals with health care experience relevant to the issues that are being appealed; and the State would determine what constitutes relevant experience, subject to CMS approval.

In addition, individuals or entities would be disqualified from conducting an IDR if:

- They were employed by, or, within the past two years, had worked as an employee or as an officer, consultant, or agent for the facility or another facility with the same ownership, management, or financial interest.
- They had any financial interest or any ownership interest in the facility.
- They had an immediate family member who had a relationship with a facility.

**Recommendation:** Consumer advocates and government watchdogs have long been concerned about external pressure on surveyors that either directly or indirectly results in underciting deficiencies. We recommend that CMS adopt two recommendations that were in the November 2009 GAO report and apply it to the IDR as well as the survey process:

Establish expectations through guidance to state survey agencies to communicate and collaborate with their CMS regional offices when they experience significant pressure

<sup>5</sup> In June, the Des Moines Register published an article by staff reporter Clark Kauffman in which he reported, "State and federal officials say political pressure from lawmakers is threatening the ability of regulators to police nursing homes across the country." The article details the interference of Iowa legislators in the Iowa health department's decision-making on whether to recertify a Manor Care facility whose deficiency reports totaled 121 pages. See "Nursing Home Inspectors Feel Lawmaker Pressure," Des Moines Register, June 27, 2010.

<sup>6</sup> *Nursing Homes: Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment*, GAO, November 2009, page 45.

from legislators or the nursing home industry that may affect the survey process or surveyors' perceptions.<sup>7</sup>

Establish a hotline or other mechanism for surveyors to report external pressure on surveyors to delete or downgrade deficiencies, whether in the survey process or the informal dispute resolution process.<sup>8</sup>

#### ***D. Acceptable Uses of Civil Monetary Penalties***

We commend CMS for its decision to use its discretionary authority to retain half of Title XVIII CMPs to benefit residents and to reserve the right to approve the programs that are funded. Your action is in keeping with a resolution passed unanimously by the Consumer Voice (then NCCNHR)'s membership in 2006 that called for "dedicating as much [CMP] funding as possible for projects and programs undertaken to improve resident care and quality of life in innovative ways." The recommendations were based on a national study by the Long Term Care Community Coalition and University of California/San Francisco<sup>9</sup> in which the Consumer Voice assisted; and they represent the views and experiences of groups and individuals across the United States who benefit residents through their advocacy for better care and residents' rights.

**Recommendation.** You expect to provide guidance to permit specific categories of CMP use without pre-request approval. Therefore, we strongly recommend that you follow the Consumer Voice resolution's recommendation to "involve a wide range of stakeholders . . . in setting criteria and guidelines for the use of funds and advising on proposals for use of the funds." Building consensus among consumers, providers, frontline workers, health professionals, researchers, and others about appropriate criteria will improve buy-in, cooperation, and participation and provide better assurance that programs meet resident needs. Convening a stakeholder workgroup, such as the one scheduled on the Nursing Home Compare review, would provide those with an interest in the success of CMP-funded programs an opportunity to discuss and agree on what activities, for example, would contribute to meaningful, replicable, and lasting changes in the culture of nursing homes.

In the past, some activities have been funded that would have been better defined as public relations to improve the image of the facility, and some states have implemented "incentive" programs that rewarded poorly performing facilities by giving them back a portion of the CMPs that were assessed against them. Some projects pay facilities for activities for which they are already reimbursed by Medicare and Medicaid; and sometimes the returned funds have exceeded the amount the facility paid in fines. (See the comments and recommendations submitted by the Center for Medicare Advocacy.) It is critical to establish guidelines that providers, consumers, and other stakeholders agree will create lasting improvements to benefit residents.

<sup>7</sup> *Nursing Homes: Addressing the Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment*, GAO, November 2009, page 49.

<sup>8</sup> *Nursing Homes: Addressing the Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment*, GAO, November 2009.

<sup>9</sup> *National Report: How Federal Civil Monetary Penalties and State CMPs/Fines Can Support Good Care for Nursing Home Residents* (<http://www.nursinghome411.org/CMPPProject/index.php>)

**Recommendation:** The Consumer Voice resolution also recommends a public notice and objective review process for individual CMP-funded projects. Such a process would provide beneficiaries of funded programs and their advocates an opportunity to comment on their value and potential success.

Establish a public process, including public notice of fund availability, with a clear annual timeline for applications for funding of innovative projects and an objective review process, ensuring that the state survey and certification agency responsible for levying the CMPs retains control over how those funds are used and is accountable for how they are used. [The same would apply to CMS.]

**Recommendation:** The Consumer Voice resolution includes other recommendations that are timely and useful as you develop guidelines for the use of federal CMPs:

- Allocate sufficient funds for projects, activities, and programs so that they can make a substantial, lasting impact and potentially a widespread impact, and allocate funds for programs and projects that are practical and can be sustained and/or replicated by others after the funding has ended.
- Authorize funds for innovative projects that go beyond regulatory requirements and ordinary budget items to improve residents' quality of care and quality of life, encourage person-directed care, promote consumer advocacy and involvement, and stimulate and support the spread of "culture change."
- Target consumer-focused projects (such as work with family councils, resident councils, consumer advocacy organizations, and ombudsman programs), and establish an evaluation process for all projects, using outside evaluation experts if possible.
- Encourage programs and projects to be jointly developed with academic organizations, consumers (or their representatives), and established experts.

**Recommendation:** CMS asks whether CMP funds should be used to offset the cost of the independent informal dispute resolution. No. Funds are to be used for the benefit of residents, and as has been shown by numerous studies, informal dispute resolution is often used to eliminate or downgrade the scope and severity of deficiencies. We believe that the cost of IIDR should be underwritten by nursing homes and should not be reimbursed by Medicare or Medicaid.

**Recommendation:** CMS proposes to allow CMP funds to be used to improve the readiness and availability of temporary manager or receivership candidates—and thereby to encourage the use of this sanction—but not to pay the salaries of temporary managers. We strongly agree that paying the salaries of temporary managers or receivers would defeat the deterrent effect of using this sanction. Moreover, we believe it is important to address the lack of access to qualified temporary managers that has reduced the use of this alternative remedy, resulting in closure of facilities, disruption and crisis in the lives of residents and their families, and the premature death of some residents from transfer trauma.

**Recommendation.** The ACA allows CMP funds to be used for joint training of surveyors and providers. The nursing home industry supported legislation in previous congresses to require joint training (including a provision that would have required states to place some of that training inside nursing homes regulated by the state survey agency) to "encourage collaboration between providers and

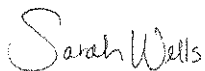
surveyors.”<sup>10</sup> While we believe that many states already provide appropriate training and information to providers about federal regulations, because of the legislative history of this provision and the inappropriate goals and requirements associated with it, we strongly recommend that the regulations clarify that such public funding:

- Can only be used for training on laws, regulations, and guidelines, not survey procedures.
- Should not be used to provide “consultation” on care practices. Public funds should not be used to underwrite companies’ normal business practices, including training their staff in how to perform their jobs.
- Should be available to any interested stakeholder. CMS itself regularly invites stakeholders—including provider associations, consumer organizations, and professional groups—to participate in its trainings on new regulatory requirements.

**Recommendation:** CMP funds should not be used to support activities or programs (for example, capital improvements) that are required by Medicare and Medicaid and already reimbursed as part of the facility’s normal reimbursement. We **oppose** the regulations’ proposal to allow funds to be used for “facilities implementing quality assurance *and performance improvement program*” as beyond the scope of the law’s intent. Facilities are required to implement so-called “QAPIs” as part of the requirements for participation in Medicare and Medicaid, and any special funding for quality assurance should be for programs and activities that go beyond the scope of that requirement.

Thank you again for your commitment to achieving effective implementation of the nursing home transparency provisions in the Affordable Care Act and for the opportunity to review and comment on these critically important regulations.

Sincerely,



Sarah F. Wells  
Executive Director

**On behalf of:**

Advocates for Basic Legal Equality, Inc.-Toledo, Ohio  
Alzheimer’s Foundation of America  
Arkansas Advocates for Nursing Home Residents  
Baltimore County Association of Senior Citizens Organizations, Inc.  
California State Long-Term Care Ombudsman  
Cape United Elders  
CareWatchers  
Center for Advocacy for the Rights and Interests of the Elderly (CARIE)-Philadelphia  
Colorado State Long-Term Care Ombudsman  
ElderCare Rights Alliance-Minnesota  
Florida Long-Term Care Ombudsman Program

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<sup>10</sup> “Smith-Lincoln Long Term Care Bill Would Help Advance Quality Improvements in Nation’s Nursing Homes,” Press Release, American Health Care Association, August 4, 2006.

Illinois Long Term Care Ombudsman Program  
Indiana Long Term Care Ombudsman Program  
Kansas Advocates for Better Care  
Kentuckians for Nursing Home Reform  
Maine Long-Term Care Ombudsman Program  
Massachusetts Advocates for Nursing Home Reform  
Michigan Long Term Care Ombudsman Program  
Minnesota Office of Ombudsman for Long-Term Care  
Missouri State Long-Term Care Ombudsman Program  
Montana State Long Term Care Ombudsman Program  
Montgomery County MD Long Term Care Ombudsman Program  
Morrow Memorial Home Family Council-Sparta, Wisconsin  
NALLTCO: National Association of Local Long Term Care Ombudsmen  
National Academy of Elder Law Attorneys  
National Association of State Long-Term Care Ombudsman Programs  
New Hampshire Office of the Long Term Care Ombudsman  
New Mexico Long Term Care Ombudsman Program  
New York State Office of the Long Term Care Ombudsman  
New York State Ombudsman Alliance  
North Dakota State Ombudsman Program  
Nursing Home Monitors-Illinois  
Ohio Office of the State Long-Term Care Ombudsman  
Nursing Home Ombudsman Agency of the Bluegrass-Kentucky  
Oklahoma Office of the State Long-Term Care Ombudsman  
Pennsylvania Long Term Care Ombudsman Program  
Resident Councils of Washington  
Rhode Island State Long Term Care Ombudsman  
TLC 4 Long Term Care Residents-Virginia  
Texas Advocates for Nursing Home Residents  
Texas Long-Term Care Ombudsman Program  
United Senior Action of Indiana  
Vermont Long Term Care Ombudsman Project  
Voices for Quality Care (LTC), Inc.-Maryland & Washington, DC  
Washington Long Term Care Ombudsman Program