care, meal services, transportation, and institutional services were assessed. After controlling for the level of disability, we found that those who were older-old (age 80> over), male, and low-income were less likely to use HCBS, but more likely to use institutions services ($p < 0.001$). We also found that those who lived in the city were more likely to use HCBS and transportation services ($p < 0.001$). Yet, older adults living alone were more likely to use home care and meal services but not other types of LTC services ($p < 0.001$). In conclusion, the social disparities in access to LTC services in Taiwan remains, suggesting LTC 2.0 should continue monitoring and placing the LTC equity issue on the top priority.

ADVANCE DIRECTIVES: STATE REQUIREMENTS, PRACTICES, AND PREVALENCE IN ADULT DAY SERVICES CENTERS

Jessica P. Lendon,[1] Christine Caffrey,[1] and Denys Lau[1], *1. National Center for Health Statistics, Hyattsville, Maryland, United States*

Advance directives (ADs) are documents that express a person's healthcare preferences if he/she is unable to make decisions. Adult day service centers (ADSC) may serve as an entrée to advance care planning for many people. This study examined the relationships among: 1-state requirements on ADSCs to provide information on ADs; 2-ADSC's awareness of their state requirement; 3-ADSC's practice in providing AD information; and 4-the percentage of ADSC participants with an AD. From the 2016 National Study of Long-Term Care Providers, 3,300 ADSCs reported that they maintained documentation of ADs in participants' files. Nine states required ADSCs to provide information on ADs; 22% of ADSCs were located in these states. About 24% of ADSCs did not know if their states had requirements; among the 76% of ADSCs that reported knowing, 62% were correct and 37% were incorrect. About 80% of ADSCs provided AD information to their participants, while 41% of ADSC participants had an AD on file. Regression models controlled for size, chain and profit statuses, Medicaid-licensing, medical or social care model, electronic health records use, and Census region. Having state requirements was not independently associated with ADSCs' practice of providing AD information or with the percentage of participants with an AD. Instead, ADSCs that thought their state had a requirement had greater odds of providing information on ADs, regardless of state requirements. Similarly, ADSCs that thought their state had a requirement and that provided AD information had a higher percentage of participants with an AD, independent of state requirements.

STATE VARIATION IN NURSING HOME CIVIL MONEY PENALTY ENFORCEMENT ACTIONS FOR QUALITY DEFICIENCIES

Denise L. Gammonley,[1] Xiaochuan (Sharon) Wang,[1] and Felicia Bender[1], *1. University of Central Florida, Orlando, Florida, United States*

States vary in their overall rates of nursing home deficiency citations as well as deficiencies for actual harm or jeopardy (Harrington et al., 2018). Civil Money Penalty (CMP) fines collected by the Centers for Medicare and Medicaid Services (CMS) are one enforcement action imposed to promote nursing home compliance with regulations. Collected CMP funds are redistributed to states for the sole purpose of improving nursing home resident care and quality of life through reinvestment in quality improvement projects. Using CASPER data available for US skilled nursing homes in 2015 and 2016 through the CMS QCOR database we examined the distribution of quality of care (QOC) and quality of life (QOL) deficiencies and CMP enforcement action across states. Guided by the systems framework for evaluating nursing home quality (Unruh & Wan, 2004) we further explored how contextual factors such as state spending for nursing home care, structural characteristics of facilities in states, and inadequate care processes indicated by deficiencies contribute to CMP enforcement actions and fines. Findings indicate that 27% of enforcement actions resulting in a CMP between 2015 and 2016 were imposed for a QOL deficiency while 61.7% represented QOC deficiencies. QOL deficiencies represented only 8% of the highest severity deficiency category but 81.7% of enforcement actions for QOC were for those causing immediate harm or jeopardy. QOC deficiencies are a focus of enforcement actions as they represent critical care processes influencing resident basic needs for hydration, ambulation, skin integrity and care for other special physical and behavioral needs.

ANTICIPATED NEED FOR NURSING HOME PLACEMENT AMONG LESBIAN, GAY, BISEXUAL ADULTS AGES 50-64: FINDINGS FROM THE HRS

Mekiayla Singleton,[1] Zach Gassoumis,[1] and Susan Enguidanos[2], *1. Leonard Davis School of Gerontology, University of Southern California, Los Angeles, California, United States, 2. University of Southern California, Los Angeles, California, United States*

By 2030, the population of LGBTQ older adults is expected to exceed 6 million. Yet little is known about the expected use of nursing homes (NH) among LGBTQ older adults. Prior research has found NHs lack cultural sensitivity, and that LGBTQ NH residents are going "back into the closet" and not disclosing their sexual orientation due to discrimination and quality of care concerns. Using data from 2016 HRS, we describe bivariate differences between the LGB and heterosexual population, ages 50 to 64, and conduct a linear regression to determine the impact of LGB status on self-reported chance of moving to a NH in the future. Compared with the heterosexual population (n=4,049), these LGB adults (n=158) had a higher mean self-reported chance of moving to a NH ($p<.01$), fewer children ($p<.01$) and reported a slightly higher health rating ($p<.05$). LGB adults ages 50-64 also were more likely to be unmarried (71%, $p< .001$), white (59%, $p< .001$) and have a college degree (51%, $p<.001$). After controlling for sociodemographic variables, there were no significant differences between LGB and heterosexual adults' self-reported chance of moving to a NH. Although anticipated chance of moving to a NH is no different for LGB adults ages 50-64 when controlling for their sociodemographic profiles, as a group they have a higher anticipated chance than heterosexual adults. These findings support the need for improved education, training, and structural changes within long-term care settings to better serve the growing older adult LGB population.