to US Educated Nurses (USENs) is limited. This study uses 2018 National Sample Survey of Registered Nurses data to compare income, work hours, job satisfaction, and human capital, defined as personal characteristics (knowledge, work experience) and behaviors (job mobility), of FENS and USENs working full-time in LTC. A human capital score, consisting of highest nursing education, skill certifications, state licensures, years of experience, multi-state employment history, and multi-lingual status was constructed. Covariates included nurse demographics, direct care role, and ability to practice to full scope. Covariate-adjusted group differences in employment outcomes and human capital were compared using ANCOVA and logistic regression. Mediation analyses explored whether human capital explained FEN vs USEN differences. FENs earned higher hourly wages (p=0.0169), worked fewer hours annually (p=0.0163), and reported greater human capital (p<.0001) compared to USENs. FENs and USENs, however, had similar annual salaries (p=0.3101) and job satisfaction (p=0.1674). Human capital mediated FEN vs USEN effects on hourly wages but not annual work hours. FENs' higher levels of human capital partially account for FEN vs USEN differences in hourly wages. Application of the human capital concept advanced our ability to examine differences in employment outcomes and highlight aspects of the value that FENs contribute to LTC settings.

INDICATORS OF ELDER MISTREATMENT: CORRELATES AMONG VETERANS RECEIVING CARE IN THE VETERANS HEALTH ADMINISTRATION

Jenefer Jedele,[1] Cameron Griffin,[2] and Julie Weitlauf,[3] *1. Veterans Health Administration, Ann Arbor, Michigan, United States, 2. VA, Ann Arbor, Michigan, United States, 3. VAPAHCS/Stanford, Palo Alto, California, United States*

Among community-dwelling adults ages 65 and older, approximately 11% have experienced elder mistreatment (EM), including physical, emotional or sexual abuse, neglect, or financial exploitation. EM research typically focuses on this age group; however, Veterans receiving Veterans Health Administration (VHA) care have increased earlier morbidity, which may accelerate the impacts of EM. Using a cohort of all VHA Veterans 50 years and older with VHA use in 2018-2020, we examined correlates of EM. ICD-10 codes from clinical encounters identified Veterans with indications of EM (n=4,427). A 10% sample of Veterans without indications of EM was selected for comparison (n=530,535). Logistic regression compared EM+ Veterans to the comparison sample and assessed overall demographic and clinical differences as well as differences by age, i.e. 50-64 versus 65 and older. Overall, female gender (OR=5.3, 95% CI=4.3-6.5), non-white race/ethnicity (OR=1.7, CI=1.5-1.9), dementia (OR=3.0, CI=2.6-3.5), PTSD (OR=2.0, CI=1.6-2.5), anxiety (OR=1.3, CI=1.0-1.5), military service connected disability status (OR=1.3, CI=1.1-1.5), and higher Elixhauser medical morbidity scores (OR=1.1, CI=1.1-1.1) were associated with EM. Prior year ER visits (OR=28.0, CI=23.6-33.4), inpatient stays (OR=14.0, CI=11.5-17.0), and mental health visits (OR=26.1, CI=22.2-30.6) also predicted EM+ status. Forty-six percent of VHA Veterans with indicators of EM were aged 50-64. For these Veterans, female gender, PTSD, service connection, and mental health visits were associated with increased risk of EM compared to Veterans 65+. Findings highlight clinical correlates of EMs among Veterans in VHA care. Increased awareness of EM risk factors is warranted and may inform VHA efforts for EM prevention, detection and intervention.

LIVING IN THE NEW NORMAL: EFFECT OF RESIDENTIAL SETTING ON PERCEPTION OF A MEANINGFUL LIFE AMONG OLDER WOMEN

Judith Scott,[1] Helen Graham,[1] Ann Mayo,[2] and Melissa Benton,[1] *1. University of Colorado Colorado Springs, Colorado Springs, Colorado, United States, 2. University of San Diego, San Diego, California, United States*

Perception of a meaningful life is related to depression, anxiety, and general well-being. The sense that one's life is meaningful influences overall quality of life, which influences aging well. It is not clear whether differences in residential setting influence perception of a meaningful life. This study evaluated the effect of residential setting (community versus assisted living) on perception of a meaningful life in 48 older (79.7 ± 1.0 years) women living in the community (n=24) or assisted living (n=24) who were pair matched by age. They completed a one-time questionnaire regarding self-rated health and whether life has meaning. Both questions were scored on a 5-point scale with 0 indicating poor health or no life meaning and 4 indicating excellent health or strong life meaning. There were no significant differences in age between women in community living (CL) and assisted living (AL) (78.0 ± 09 vs. 81.5 ± 1.6 years, respectively; p=0.7). Both groups also reported similar self-rated health scores (CL: 2.4 ± 0.2; AL: 2.2 ± 0.2; p=0.4), indicating good-very good health. However, there were significant differences between groups in their perception of a meaningful life. Women in CL reported significantly lower scores compared to women in AL (2.9 ± 0.2 vs. 3.6 ± 0.1; p=0.006), indicating that women in CL perceived a less meaningful life. Based on our findings, it appears that the supportive infrastructure provided by AL residential settings may promote quality of life and successful aging by enhancing the perception of a more meaningful life.

NURSING HOME FACTORS AND THEIR IMPACT ON COVID-19 CASES: A STUDY OF WISCONSIN STATE

Mohammed Abahussain,[1] Priya Nambisan,[2] Colleen Galambos,[2] Bo Zhang,[2] and Elizabeth Bukowy,[3] *1. University of Wisconsin- Milwaukee, Wauwatosa, Wisconsin, United States, 2. University of Wisconsin-Milwaukee, Milwaukee, Wisconsin, United States, 3. Medical College of Wisconsin, Wauwatosa, Wisconsin, United States*

COVID-19 has been devastating for Nursing Homes (NHs). The concentration of older adults with underlying chronic conditions inevitably made the setting highly vulnerable leading to high rates of mortality for residents. However, some nursing homes fared better than others. This study examines several quality measures and organizational factors to understand whether these factors are associated with COVID-19 cases in Wisconsin. We combined three datasets from Centers for Medicare & Medicaid Services (CMS) – the Star Rating dataset, Provider Information dataset and COVID-19 Nursing Home dataset. Data used

is from the period of Jan 1 – Oct 25, 2020 for the state of Wisconsin. The analysis includes 331 free-standing NHs with no missing values from the data sets. The variables used were self-reported information on nursing home ratings, staff shortage, staff reported hours, occupancy rate, number of beds and ownership. Of the 331 NHs examined, shortages were reported of 25.4%, 31.1%, 3.2% and 15.6% of licensed nurse staff (25.4%), nurse aides (31.1%), clinical staff, (3.2%) and other staff (15.6%) Additionally, there was a significant ($p<.05$) positive correlation between number of beds and COVID-19 cases, and there was no statistically significant association between occupancy rate and COVID-19 cases. NHs with better star ratings were also found to have less COVID-19 cases. Interestingly, private NHs had significantly higher COVID-19 cases than for-profit and government owned NHs, a finding that is congruent with other studies in this area. Recommendations for practice will be discussed.

POTENTIAL SOURCES OF RACIAL AND ETHNIC DISPARITIES IN NURSING HOME INFLUENZA VACCINATION

Melissa Riester,[1] Elliott Bosco,[1] Barbara Bardenheier,[2] Patience Moyo,[3] Rosa Baier,[1] Melissa Eliot,[1] and Andrew Zullo,[1] *1. Brown University, Providence, Rhode Island, United States, 2. Brown University School of Public Health, Smithfield, Rhode Island, United States, 3. Brown University School of Public Health, Providence, Rhode Island, United States*

Racial and ethnic disparities in influenza vaccination among nursing home (NH) residents are well-documented and have persisted over time, suggesting that new strategies are necessary to reduce disparities. We conducted a retrospective cohort study to examine the degree to which observable characteristics drove influenza vaccination disparities. We linked Minimum Data Set (MDS) assessments to facility-level data for short- and long-stay NH residents aged ≥65 years. We included residents with six-month continuous enrollment in Medicare and an MDS assessment during the influenza season (October 1, 2013 through March 31, 2014). Using nonlinear Oaxaca-Blinder decomposition, we decomposed the disparities in vaccination between White versus Black and White versus Hispanic residents. We analyzed short- and long-stay residents separately. Our study included 630,373 short-stay and 1,029,593 long-stay residents. Among short-stay residents, 67.2% of Whites, 55.1% of Blacks, and 54.5% of Hispanics were vaccinated against influenza; among long-stay residents, 84.2% of Whites, 76.7% of Blacks, and 80.8% Hispanics were vaccinated against influenza. Across the four comparisons, the crude disparity in influenza vaccination ranged from 3.4-12.7 percentage points. By equalizing 27 characteristics, these disparities could be reduced by 37.7%-59.2%. Living in a predominantly White facility and proxies for NH quality were important contributors to the disparity, although characteristics unmeasured in our data (e.g., NH staff attitudes and beliefs) contributed 40.8%-62.3% to the disparity across comparisons. Intervening on factors associated with NH quality may reduce racial/ethnic disparities in influenza vaccination. Qualitative research is essential to explore potential contributors not captured in our administrative data.

RACIAL AND ETHNIC DISPARITIES IN PAIN MANAGEMENT FOR NURSING HOME RESIDENTS: A SCOPING REVIEW

Cassandra Dictus,[1] Youngmin Cho,[2] Tamara Baker,[3] and Anna Beeber,[4] *1. School of Nursing, University of North Carolina - Chapel Hill, North Carolina, United States, 2. University of North Carolina at Chapel Hill, Chapel Hill, North Carolina, United States, 3. University of North Carolina, Chapel Hill School of Medicine, University of North Carolina at Chapel Hill (School of Medicine), North Carolina, United States, 4. University of North Carolina at Chapel Hill, UNC Chapel Hill, North Carolina, United States*

Within nursing homes, residents commonly experience pain that unfortunately goes underrecognized and undertreated, having a dramatic negative impact on residents' quality of life. Nursing homes are becoming more racially and ethnically diverse, and there is concerning evidence documenting disparities in the quality of nursing home care. In other healthcare settings, people of diverse race groups often receive less optimal pain management, but the evidence regarding racial disparities has not been synthesized for nursing homes. Thus, the purpose of this review was to investigate what is known about racial disparities related to pain management (e.g. assessment, treatment, preferences) in US nursing homes. We completed a scoping literature review using PRISMA-ScR guidelines and searching PubMed, CINHAL, and Scopus for peer-reviewed, empirical studies. Most studies were older large retrospective cohort studies of administrative data documenting that White residents were more likely than residents of diverse race groups to have pain documented and treated. Only a few studies looked at possible reasons to explain the disparities; differences were not found to be related to nursing staff racial bias nor differences in pain-related diagnoses. However, there was evidence of racial differences in resident behavior and attitudes related to pain management. None of the studies examined systemic factors related to differences among nursing homes, which has been implicated in studies looking at other outcomes including COVID-19. More research is needed which examines the causal mechanisms behind the documented racial disparities in pain management so that gaps in care can be reduced.

SPIRITUALITY AS AN ESSENTIAL ELEMENT OF PERSON-CENTERED CARE

Rachel Nathan,[1] Deborah Zuercher,[2] Steven Eveland,[3] Anjana Chacko,[3] and Raya Kheirbek,[4] *1. University of Maryland School of Medicine, University of Maryland, Maryland, United States, 2. University of Maryland Medical Center, University of Maryland, Maryland, United States, 3. University of Maryland, Baltimore, Maryland, United States, 4. University of Maryland School of Medicine, University of Maryland School of Medicine, Maryland, United States*

Data demonstrate that the majority of patients with serious or chronic illness would like their clinicians to address their spirituality but that the majority of clinicians do not provide such care. Reasons cited include lack of training. Palliative Medicine, built on the biopsychosocial-spiritual model of care, has long recognized the critical role of spirituality