



January 27, 2026

Dr. Mehmet Oz, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244

Re: 90 FR 55687, Medicare and Medicaid Programs;
Repeal of Minimum Staffing Standards for Long-Term Care
Facilities, CMS-3442-IFC

Dear Dr. Oz:

The National Consumer Voice for Quality Long-Term Care (Consumer Voice) submits the following comments in strong opposition to the interim final rule (90 FR 55687) published on December 3, 2025, in which the Centers for Medicare and Medicaid Services (CMS) proposes to rescind large portions of the nursing home minimum staffing rule finalized in May 2024. Consumer Voice is the leading national voice representing consumers on issues related to long-term care, helping ensure consumers are empowered to advocate for themselves. We are a primary source of information and tools for consumers, families, caregivers, advocates, and ombudsmen to help ensure quality care for the individual.

The minimum staffing standard for nursing homes, finalized in May 2024, is the most significant increase in protections for nursing home residents in decades. It is estimated to save at least 13,000 lives annuallyⁱ and will result in a substantial increase in the quality of life for nursing home residents. Its rescission will be catastrophic for nursing home residents, their families, and nursing home workers.

The minimum staffing standard resulted from a lengthy, evidence-based regulatory process. It relied on decades of research showing that nursing homes with higher staffing levels have better health outcomes. There was an opportunity for public comment, with more than 40,000 comments submitted. Notably, the staffing standard recognized the challenges some nursing homes face in hiring staff by allowing lengthy implementation periods and significant opportunities for exemptions.

CMS cites several reasons for its action to rescind the staffing standard, but focuses particularly on Congress's recent suspension of its implementation until 2034. From this action, CMS concludes it must rescind the staffing standard. However, if Congress wanted the staffing standard rescinded, it could have. Instead, it postponed its implementation. In keeping with Congress's intent, CMS should issue a rule simply updating the implementation dates set

by Congress. As further documented in our comments below, the additional justifications CMS provides for rescinding the staffing standard do not hold water.

Notably, the interim final rule does not address the benefits of the staffing standard to residents. CMS ignores the impact the staffing standard will have to improve the quality of care and quality of life for hundreds of thousands of residents, instead focusing on red herring arguments that are easily refuted. Most importantly, CMS offers no plan or alternative to address the nursing home staffing crisis, despite its statutory duty to ensure nursing homes have sufficient staff. CMS is now returning to the status quo, a status quo that resulted in tens of thousands of nursing home deaths during the COVID-19 pandemicⁱⁱ and has resulted in years of residents suffering and dying due to inadequate staffing.

We urge CMS to rescind the interim final rule and stand with the hundreds of thousands of nursing home residents, their families, and workers by implementing the staffing requirements.

Inadequate Staffing Drives Poor Health Outcomes and Resident Deaths

It is irrefutable that nursing homes with more staff have fewer resident deaths and negative health outcomes than their counterparts. During the COVID-19 pandemic, nursing homes with higher staffing levels had fewer resident infections and deaths.ⁱⁱⁱ Additionally, nursing homes with higher Registered Nurse staffing levels have:

- Increased functional improvement;^{iv v vi}
- Reduced incontinence;^{vii}
- Reduced urinary tract infections and catheterization;^{viii ix x xi}
- Reductions in pain,^{xii} pressure ulcers, weight loss and dehydration,^{xiii xiv xv xvi} use of antipsychotics,^{xvii xviii} restraint use,^{xix xx xxi} infections,^{xxii xxiii} falls,^{xxiv xxv} rehospitalization and emergency department use,^{xxvi xxvii xxviii xxix} missed care,^{xxx xxxi} adverse outcomes,^{xxxii} and mortality rates.^{xxxiii xxxiv}
- Higher staffing levels are strongly associated with fewer deficiencies.^{xxxv xxxvi xxxvii}

CMS's own study^{xxxviii}, commissioned as part of the regulatory process, documented increased positive health outcomes and less omitted care as staffing levels increased. Notably, CMS does not challenge the factual finding that higher staffing levels lead to better health outcomes.

Last year, Consumer Voice released a report in which 120 nursing home residents described what it is like to live in an understaffed nursing home.^{xxxix} Here are some quotes from residents describing what it is like to live in a nursing home with inadequate staff:

- "Some residents have not had a shower in months, told there is not enough staffing."
- "No showers for weeks, meds constantly late or skipped, call lights not answered for hours."
- "I often go 12-hour shifts without seeing a single staff member."
- "I've waited up to three hours for help, and that's just one of many everyday occasions."
- "Lots of falls from not being monitored!"

- “Meals are late, 45 to 90 minutes. They have missed giving me meals sometimes.”
- “Aides say they have too many people to take care of. I have to wait.”
- “So far, I haven’t been out of bed for three days.”
- “I have been left in bed all day without being touched for any care.”
- “I never get out of bed. Most staff don’t know how to use the Hoyer lift, so they don’t want to hurt me.”

Nowhere in the interim final rule does CMS mention the suffering that occurs in understaffed homes, how individuals are dehumanized and neglected. In fact, CMS barely mentions nursing home residents in the interim final rule, instead focusing solely on nursing homes and ignoring the significant benefit hundreds of thousands of nursing home residents would experience under the minimum staffing standard.

The Staffing Standard Is Modest and Will Have its Greatest Impact on the Country’s Most Poorly Staffed Nursing Homes

The staffing standard's minimums are modest. The overall 3.48 hours per resident per day (HPRD) is less than the national average.^{xi} To illustrate, a 2001 staffing study commissioned by CMS^{xii} found that residents required at least 4.1 HPRD to avoid an increased risk of harm. The May 2024 staffing standard is 37 minutes less than the 2001 study. The staffing standard is designed to raise staffing in chronically understaffed homes. These homes have, on average, poorer health outcomes and lower quality ratings.^{xiii}

Critically, the staffing standard will reduce CNAs' workloads, enabling them to care for all residents and provide better care. The chart below illustrates the significant impact the staffing standard will have on CNA workloads in nursing homes in the lowest staffing quartile. Current CNA-to-resident ratios are almost two times higher than recommended levels in these facilities.^{xiiii} Overall, caseloads will be reduced by 30% for CNAs, increasing their ability to provide person-centered care that meets the quality standards mandated by federal and state regulations.

Nursing Homes in the Bottom Quartile of CNA Staffing		
Shift	Current Ratio	New Staffing Ratio
Morning	13 to 1 (.63 HPRD)	9 to 1 (.93 HPRD)
Evening	13 to 1 (.63 HPRD)	9 to 1 (.93 HPRD)
Night	21 to 1 (.39 HPRD)	14 to 1 (.59 HPRD)

CMS's Reasons for Rescinding the Staffing Standard Are Not Supported by Evidence

CMS offers several justifications for rescinding the minimum staffing standard. First, it states that because Congress postponed the implementation of the staffing standard until September 30, 2034 (Public Law 119-21), it must rescind the staffing standard for regulatory clarity. Second, it cites concerns regarding hiring challenges for nursing homes, with a particular focus on rural and tribal communities. Third, it cites recent federal district court decisions finding that parts of the staffing standard exceed CMS's authority. Lastly, it claims the staffing standard is one-size-fits-all. These reasons are not supported by evidence, nor do they require that CMS rescind the staffing standard.

Congress's Recent Action Postponing Implementation of the Staffing Standard Until 2034 Does Not Require CMS to Rescind the Staffing Standard

As noted previously, if Congress had wanted to rescind the minimum staffing standard, it could have done so. Instead, Congress postponed the implementation of the staffing standard until 2034. CMS claims that this postponement necessitates rescinding the staffing standard for regulatory clarity.^{xliiv} If CMS's concern is regulatory clarity, it should simply issue a staffing standard that reflects Congress's will to implement the minimum staffing standard in 2034. Instead, CMS is taking the extreme step of controverting Congress's intent and rescinding the staffing standard.

CMS's Concerns Regarding Hiring Challenges Are Not Supported by Evidence and Are Addressed by the Staffing Standard

CMS cites hiring challenges as next reason for rescinding the staffing standard, specifically focusing on tribal and rural areas.^{xliv} Since the staffing standard was announced, much has been made of hiring challenges some nursing homes face, particularly rural nursing homes, despite CMS's own data showing rural and non-rural homes staff almost identically.^{xlvi} While some facilities, whether urban or rural, may face hiring challenges, the minimum staffing standard offers significant opportunities for facilities to obtain exemptions. Facilities located in areas where there are not enough staff to hire will be able to obtain one-year exemptions, with there being no limit on the number of exemption renewals a facility may obtain. CMS does not even mention these exemptions in the interim final rule, completely ignoring them. Lastly, the May 2024 standard included generous implementation periods, which are now even more generous following a 10-year implementation postponement by Congress.

Importantly, CMS ignores the real factors that influence staffing levels, ownership type, facility size, proportion of Medicaid residents, whether a facility is free-standing or hospital-based, and whether a facility is a Special Focus Facility or on the candidate list.^{xlvii} CMS's staffing study documented that thousands of nursing homes are providing, on average, daily care to residents that far exceeds the staffing standard. These facilities are located all over the country but tend to be non-profit, smaller in size, hospital-based, and have a smaller proportion of

Medicaid residents. These factors far exceed the predictability of staffing levels over geographic location.^{xlviii}

Inexplicably, CMS ignores the real driver of nursing home staffing challenges: turnover. According to CMS data, the average nursing home in the United States has to replace half its staff each year,^{xlix} with some studies suggesting the average is over 100%.^l Nursing homes can hire staff, but they are not retaining them. It is well documented that low wages and benefits, inadequate training, poor management, limited career advancement, and excessive workloads drive high staff turnover in nursing homes.^{li} Poor job quality has plagued nursing home workers for years, yet the nursing home industry has done little to address these underlying problems.

The median wage for a CNA in the United States is \$18.80 per hour.^{lii} 42% of CNAs rely on public assistance.^{liii} As noted above, many of these CNAs are responsible for twice the number of residents as recommended. When you add to these financial burdens, impossible caseloads, and no opportunity for career advancement, it is clear why turnover is so high in nursing homes.

Poor wages and benefits are due to years of federal and state regulators failing to hold nursing homes accountable for how they used Medicare and Medicaid dollars. It is no surprise that staffing is better in non-profit homes, when financial evidence shows that for-profit homes often divert taxpayer dollars away from staffing to profits. A recent study^{liv} found that nursing homes hide or “tunnel” profits through related-party companies, through which they run over \$11 billion each year.^{lv} The study estimated that 68% of nursing home profits are hidden in these transactions.^{lvi} The same study found that if hidden profits were used instead for RN staffing, compliance with the staffing standard’s RN requirement would increase almost 50%.^{lvii}

Recent high-profile cases have documented how nursing home owners and operators profit off taxpayer dollars, while residents in their homes suffer.^{lviii} 75% of for-profit nursing homes use related parties.^{lix} While residents suffer, nursing home owners purchase 26-million-dollar mansions in Beverly Hills^{lx} and \$35 million yachts.^{lxi} Billions go unaccounted for each year, yet CMS does little to address this waste, fraud, and abuse. The burden falls heavily on nursing home workers, who are underpaid and overworked, and, in turn, on residents, who must live in understaffed nursing homes that experience untenable levels of staff turnover each year.

Rather than rescinding a staffing standard that would save 13,000 lives annually, CMS could take steps to ensure that the over \$70 billion in Medicare and Medicaid dollars paid to nursing homes annually are used for care. The minimum staffing standard will require nursing homes to use taxpayer dollars to invest in quality jobs, reduce turnover, and improve health outcomes in nursing homes.

CMS Does Not Need to Rescind the Minimum Staffing Standard Because of Federal Court Decisions

Citing recent federal court decisions that found parts of the staffing standard exceeded CMS's statutory authority, CMS claims it must rescind the staffing standard.^{lxii} Until recently, CMS rigorously defended the staffing standard, citing its authority under the Nursing Home Reform Act, which states:

It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in skilled nursing facilities under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.^{lxiii}

Federal law requires all nursing homes to provide an adequate number of nurses with appropriate training, skills, and experience to meet residents' physical, mental, and psychosocial needs.^{lxiv} Accordingly, it is CMS's "duty and responsibility" to enforce this requirement. A minimum staffing standard is one way to achieve this mandate.

CMS could have appealed these district court decisions. Instead, it chose not to defend its regulatory authority. As a result, CMS created the very situation it now cites as grounds for repealing the standard.

CMS Erroneously Cites Nursing Home Lobbying Industry's Talking Point "One-Size-Fits-All" as a Reason the Standard Must Be Rescinded

Since the standard was first introduced, lobbyists for the nursing home industry have touted a minimum staffing standard as "one-size-fits-all". Until recently, CMS easily refuted this talking point by pointing to the standard itself, which makes clear that this is a minimum standard, not a goal, and that many residents will need more care. CMS also directly referenced federal law which, even with the new staffing standard, still required all nursing homes to have nursing staff "sufficient to meet the nursing needs of its residents."^{lxv} Now, CMS adopts the industry talking point and ignores the multitude of evidence that this standard is not "one-size-fits-all".

CMS states that the standard is "one-size-fits-all" because it implements a standard "without accounting for differences in labor supply, overall acuity of the facility's resident population, or available resources."^{lxvi} Yet all of these assertions are belied by the standard itself. A minimum staffing standard is based on clinical evidence of health outcomes associated with staffing. Labor supply is extraneous to this calculation. Nevertheless, the staffing standard specifically provides for exemptions based on labor supply. Additionally, the facility assessment requirements, issued as part of the standard, require nursing homes to gauge the overall acuity of the resident population and provide adequate staff to meet the needs.

The staffing standard provides exemptions based on a facility's location and takes into account "labor supply" in those areas. When CMS finalized the staffing standard, it noted that under its exemption framework, thousands of facilities would receive some exemption from the standard, with the highest concentration being in rural areas.^{lxvii}

In addition to generous exemption opportunities, CMS specifically phased in implementation, with the most generous compliance requirements for rural facilities. These compliance requirements are now much more generous as a result of Congress's decision to postpone implementation until 2034. This postponement gives facilities 10 years to meet the modest requirements outlined in the minimum staffing standard, and even then, facilities with labor challenges can obtain exemptions.

CMS's claim that the standard is one-size-fits-all ignores the standard itself. Throughout the final staffing standard issued in May 2024, CMS made clear that the standard is a floor, below which the risk of harm to nursing home residents increases. Below is language from the staffing standard emphasizing that the standard is a floor, and facilities must meet the needs of all residents by assessing acuity:

"(W) hen assessing the sufficiency of a facility's staffing, it is important to note that any numeric minimum staffing requirement is not a target and facilities must assess the needs of their resident population and make comprehensive staffing decisions based on those needs. Often, that will require higher staffing than the minimum requirements."^{lxviii}

"We expect that many facilities will need to staff above the minimum standards to meet the acuity needs of their residents depending on case-mix and as mandated by the facility assessment required at § 483.71."^{lxix}

"We emphasized in the proposed rule and reiterate here that facilities are also required to staff above the minimum standard, as appropriate, to address the specific needs of their resident population (88 FR 61369). We expect that most facilities will do so in line with strengthened facility assessment requirements at § 483.71 (88 FR 61368)."^{lxx}

"All LTC facilities must provide adequate staffing to meet their specific population's needs based on their facility assessments. In many cases, facilities will need higher levels of staffing as a result."^{lxxi}

The May 10, 2024, standard clearly repudiates CMS's current claim that it does not account for resident acuity and requires all facilities to staff at a single level.

CMS's reasons for rescinding the staffing standard are not based on evidence and ignore the language of the staffing standard.

CMS's Rescission of the Staffing Standard Returns Staffing to the Status Quo with no Plan to Address the Staffing Crisis in Nursing Homes

If CMS rescinds the standard, it must still fulfill its statutory duty to ensure that facilities have sufficient staff to meet the needs of all residents.^{lxxii} It is unclear how CMS intends to achieve this mandate. The minimum staffing standard set a floor below which 13,000 lives would be lost annually and provided a framework for assessing and staffing needs for all residents. The requirement that facilities assess the needs of all residents and ensure they have sufficient staff to meet those needs remains in place. CMS must act to enforce these requirements.

Going forward, CMS must have a staffing enforcement model that:

- Is grounded upon resident acuity, recognizing that staffing needs vary widely based on clinical complexity, functional limitations, cognitive status, and behavioral health needs.
- Ensures that every resident's staffing needs are fully met by aggregating residents' needs across a facility and accurately calculating and meeting staffing requirements.
- Accounts for the skills and competencies required to deliver high-quality care, including the appropriate skill mix of RNs, LPNs/LVNs, CNAs, and specialized staff.
- Is fully enforced by state and federal surveyors during annual and complaint surveys, incorporating data review, implementation of the facility assessment, and impact on residents.

CMS is rescinding the most significant increase in protections for nursing home residents in decades. It is doing so despite Congress's intent to implement the standard in 2034 and even though its decisions are based on reasons refuted by empirical evidence and the standard itself.

We strongly urge CMS to fulfill its statutory obligations to protect our nation's 1.2 million nursing home residents, rescind this proposed interim final rule, enforce staffing requirements and protect the lives of our nation's most vulnerable citizens.

Sincerely,

Samuel Brooks

Samuel Brooks
Director of Public Policy

ⁱ <https://ldi.upenn.edu/our-work/research-updates/nursing-homes-owe-more-to-their-residents/>

- ⁱⁱ Li, Y., H. Temkin-Greener, G. Shan, and X. Cai. 2020. COVID-19 infections and deaths among Connecticut nursing home residents: Facility correlates. *Journal of the American Geriatrics Society* 68(9):1899–1906; Gorges, R. J., and R. T. Konetzka. 2020. Staffing levels and COVID-19 cases and outbreaks in U.S. nursing homes. *Journal of the American Geriatrics Society* 68(11):2462–2466; Konetzka, R. T., E. M. White, A. Pralea, D. C. Grabowski, and V. Mor. 2021. A systematic review of long-term care facility characteristics associated with COVID-19 outcomes. *Journal of the American Geriatrics Society* 69(10):2766–2777.
- ⁱⁱⁱ Li, Y., H. Temkin-Greener, G. Shan, and X. Cai. 2020. COVID-19 infections and deaths among Connecticut nursing home residents: Facility correlates. *Journal of the American Geriatrics Society* 68(9):1899–1906; Gorges, R. J., and R. T. Konetzka. 2020. Staffing levels and COVID-19 cases and outbreaks in U.S. nursing homes. *Journal of the American Geriatrics Society* 68(11):2462–2466; Konetzka, R. T., E. M. White, A. Pralea, D. C. Grabowski, and V. Mor. 2021. A systematic review of long-term care facility characteristics associated with COVID-19 outcomes. *Journal of the American Geriatrics Society* 69(10):2766–2777.
- ^{iv} Horn, S.D., Sharkey, S.S., Hudak, S., Smout, R.J., Quinn, C.C., Yody, B. and Fleshner, I (2010). Beyond CMS Quality Measure Adjustments: Identifying Key Resident and Nursing Home Facility Factors Associated with Quality Measures. *J. American Medical Directors Association*. 11 (7):500-5.
- ^v Alexander, G.L. 2008. An Analysis of Nursing Home Quality Measures and Staffing. *Quality Management in Health Care*. 17 (3):242-51.
- ^{vi} Horn, S.D., Buerhaus, P., Bergstrom, N., Smout, R.J. (2005). RN staffing time and outcomes of long-stay nursing home residents: pressure ulcers and other adverse outcomes are less likely as RNs spend more time on direct patient care. *Am J Nurs*. 105(11):58-70.
- ^{vii} Dorr, D.A., Horn, S.D., & Smout, R.J. (2005). Cost analysis of nursing home registered nurse staffing times. *J. of Amer Geriatrics Society*, 53: 840-845.
- ^{viii} Castle, N.G. & Anderson, R.A..
- ^{ix} Horn, S.D., Buerhaus, P. et al.
- ^x Dorr et al.
- ^{xi} Wan, T.T.H., Zhang, N.J. & Unruh, L. (2006). Predictors of resident outcome improvement in nursing homes. *Western J. Of Nursing Research*. 28 (8):974-993.
- ^{xii} Castle, N.G. & Anderson, R.A..
- ^{xiii} Horn, S.D., Buerhouse, P. et al.
- ^{xiv} Simmons, S.F., Schnelle, J.F. (2004). Individualized feeding assistance care for nursing home residents: staffing requirements to implement two interventions. *J Gerontol A Biol Sci Med Sci*. 59(9):M966-73.
- ^{xv} Simmons, S.F., Keeler, E., Zhuo, X., Hickey, K.A., Sato, H.W., Schnelle, J.F. (2008). Prevention of unintentional weight loss in nursing home residents: a controlled trial of feeding assistance. *J Am Geriatr Soc*. Aug;56(8):1466-73.
- ^{xvi} Horn, S.D., Bender S.A. et al.
- ^{xvii} Horn, S.D., Bender S.A. et al.
- ^{xviii} Phillips, L.J., Birtley, N.M., Petroski, G.F., Siem, C., Rantz, M. (2018). An observational study of antipsychotic medication use among long-stay residents without qualifying diagnoses. *J. Psychiatry Mental Health Nursing*. 25(8):463-474.
- ^{xix} Castle, N.G. & Anderson, R.A
- ^{xx} Wan, T.T.H., et al,
- ^{xxi} Park, J. and Stearns S.C. (2009). Effects of state minimum staffing standards on nursing home staffing and quality of care. *Health Serv Res*. 44(1):56-78.
- ^{xxii} Uchida-Nakakoji, M., Stone, P. W., Schmitt, S. K., & Phibbs, C. S. (2015). Nurse workforce characteristics and infection risk in VA Community Living Centers: A longitudinal analysis. *Medical Care*, **53**, 261–267.
- ^{xxiii} Trivedi, T.K., DeSalvo, T., Lee, L., Palumbo, A., Moll, M., Curns, A., Hall, A.J., Patel, M., Parashar, U.D., Lopman, B.A. (2012). Hospitalizations and mortality associated with norovirus outbreaks in nursing homes, 2009-2010. *JAMA*. Oct 24;308(16):1668-75.
- ^{xxiv} Leland NE, Gozalo P, Teno J, Mor V. (2012). Falls in newly admitted nursing home residents: a national study. *J Am Geriatr Soc*. 60(5):939-45.
- ^{xxv} Spector, W., Shaffer, T., Potter, D.E., Correa-de-Araujo, R., Rhona Limcangco, M. (2007). Risk factors associated with the occurrence of fractures in U.S. nursing homes: resident and facility characteristics and prescription medications. *J Am Geriatr Soc*. 55(3):327-33.

- xxvi Xing, J., Mukamel, D. B., & Temkin-Greener, H. (2013). Hospitalizations of nursing home residents in the last year of life: Nursing home characteristics and variation in potentially avoidable hospitalizations. *Journal of the American Geriatrics Society*, **61**, 1900–1908.
- xxvii Spector, W.D., Limchangco, R., Williams, C., Rhodes, W., Hurd, D. (2013). Potentially avoidable hospitalizations for elderly long-stay residents in nursing homes. *Med Care*. 2013 Aug; 51(8):673-81.
- xxviii Min, A. and Hong, H.C. (2019). Effect of nurse staffing on rehospitalizations and emergency department visits among short-stay nursing home residents: A cross-sectional study using the US nursing home compare database. *Geriatr Nurs.*, 40 (2):160-165
- xxix Konezka, R.T., Spector, W. & Limchangco, M.R. (2007). Reducing hospitalizations from long-term care settings. *Medical Care Research & Review*, 65:40-66.
- xxx Simmons, S.F., Durkin, D.W., Rahman, A.N., Choi, L., Beuscher, L., Schnelle, J.F. (2013). Resident characteristics related to the lack of morning care provision in long-term care. *Gerontologist*. 53(1):151-61.
- xxxi Schnelle, J.F., Schroyer, L.D., Saraf, A.A., and Simmons, S.F. (2016). Determining nurse aide staffing requirements to provide care based on resident workload: A discrete event simulation model. *J. American Medical Directors Association*. 17:970-977.
- xxxii Konezka, R.T., Stearns, S.C., Park, J. (2008). The staffing-outcomes relationship in nursing homes. *Health Serv Res*. 43(3):1025-42.
- xxxiii Trivedi, T.K., et al.
- xxxiv Tong PK. (2011). The effects of California minimum nurse staffing laws on nurse labor and patient mortality in skilled nursing facilities. *Health Econ*. 20(7):802-16.
- xxxv Harrington C., Zimmerman D., Karon S.L., Robinson J., Beutel P. (2000). Nursing Home Staffing and Its Relationship to Deficiencies. *Journal of Gerontology Series B: Psychological Science and Social Science*. 55(5): S278-87.
- xxxvi Castle, N.G., Wagner, L.M., Ferguson, J.C. & Handler, S.M.. (2011). Nursing home deficiency citations for safety. *J. Aging and Social Policy*, 23 (1):34-57.
- xxxvii Kim, H., Harrington, C. & Greene, W. (2009). Registered nurse staffing mix and quality of care in nursing homes: A longitudinal analysis. *Gerontologist*, 49 (1):81-90.
- xxxviii Nursing Home Staffing Study: Comprehensive Report, Abt Associates, June, 2023.
<https://www.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf>
- xxxix Consumer Voice, "The Impact of Understaffing on the Daily Lives of Nursing Home Residents: A Survey Report of Residents," 2024, Available at: https://theconsumervoicework.org/wp-content/uploads/2024/04/The_Impact_of_Understaffing_on_Residents.pdf
- xl Abt Associates, *Nursing Home Staffing Study Comprehensive Report* (2023)
- xli Abt Associates. 2001. *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*; Report to Congress: Phase II Final; Volume I, Contract #500-0062/TO#3, December 2001.
- xlii Abt Associates, *Nursing Home Staffing Study Comprehensive Report* (2023)
- xliii Schnelle JF, Schroyer LD, Saraf AA, Simmons SF. Determining Nurse Aide Staffing Requirements to Provide Care Based on Resident Workload: A Discrete Event Simulation Model. *J Am Med Dir Assoc*. 2016 Nov 1;17(11):970-977. doi: 10.1016/j.jamda.2016.08.006. PMID: 27780572.
- xliv 90 Fed. Reg., 55689. (December 3, 2025)
- xlv 90 Fed. Reg., 55688. (December 3, 2025)
- xlvi Abt Associates, *Nursing Home Staffing Study Comprehensive Report* (2023), p. 46.
- xlvii Id. pp. 45-46
- xlviii Id.
- xlix <https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/skilled-nursing-facility-all-owners>
- ^l The study authors looked at turnover of staffing hours annually, as compared with actual staff. Gandhi A, Yu H, Grabowski DC. High Nursing Staff Turnover In Nursing Homes Offers Important Quality Information. *Health Aff (Millwood)*. 2021 Mar;40(3):384-391. doi: 10.1377/hlthaff.2020.00957. PMID: 33646872; PMCID: PMC7992115.
- ^{li} Bryant, Olalya Ayanna, "Employee Turnover in the Long-Term Care Industry" (2017). Walden Dissertations and Doctoral Studies. 3389, <https://scholarworks.waldenu.edu/dissertations/3389>; Al-Hussami, M., et al, " Nurses' turnover intentions." *Int J Nurs Pract*, 2014 20: 79-88. <https://doi.org/10.1111/ijn.12124>; Negarandeh R. Enhancing transition to workplace. *Nurs Midwifery Stud*. 2014 Apr;3(1):e17554. doi: 10.17795/nmsjournal17554. Epub 2014 Apr 17. PMID: 25414894; PMCID: PMC4228524. National Academies of Sciences, Engineering, and Medicine. 2022. The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff. Washington, DC: The National Academies Press. <https://doi.org/10.17226/26526>.
- ^{lii} PHI, "Direct Care Workers in the United States," (2025). Available at <https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2025/>

liii Id.

liv Gandhi, Ashvin and Olenski, Andrew, "Tunneling and Hidden Profits in Health Care," NBER Working Paper, No. w32258, March, 18, 2024, <https://ssrn.com/abstract=4762965>.

lv These Administrative Actions Would Improve Nursing Home Ownership and Financial Transparency In The Post COVID-19 Period", Health Affairs Blog, February 11, 2021. DOI: 10.1377/hblog20210208.597573.

lvi Gandhi, Ashvin and Olenski, Andrew, "Tunneling and Hidden Profits in Health Care," NBER Working Paper, No. w32258, March, 18, 2024, <https://ssrn.com/abstract=4762965>

lvii Id.

lviii <https://www.nj.gov/comptroller/news/2025/approved/20260119.shtml>

lix Gandhi, Ashvin and Olenski, Andrew, "Tunneling and Hidden Profits in Health Care," NBER Working Paper, No. w32258, March, 18, 2024, <https://ssrn.com/abstract=4762965>

lx Miller, Matthew, "How much money do nursing homes really make? New report claims operators hide profits," MLive, June 46, 2025: Available at: <https://www.mlive.com/public-interest/2025/06/how-much-money-do-nursing-homes-really-make-new-report-claims-operators-hide-profits.html>

lxi <https://www.superyachtfan.com/yacht/silver-lining/owner/#TRPLINKPROCESSED>

lxii 90 Fed. Reg., 55688. (December 2, 2025)

lxiii 42 U.S.C. §§1395i-3(f)(1)

lxiv 42 U.S.C. § 1395i-3(b)(4)(a)(i)

lxv 42 U.S.C. § 1395i-3(b)(4)(C)(i)

lxvi 90 Fed. Reg., 55689. (December 3, 2025).

lxvii 89 Fed. Reg., 40989. (May 10, 2024).

lxviii 89 Fed. Reg. 40876, 48883 (May 10, 2024)

lxix 89 Fed. Reg. 40876, 40891 (May 10, 2024)

lxx 89 Fed. Reg. 40876, 40892 (May 10, 2024)

lxxi 89 Fed. Reg. 40876, 40948 (May 10, 2024)

lxxii 42 U.S.C. § 1395i-3(b)(4)(i)