STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	405030	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millennium Institute for Advance Nursing Care Inc	Calle Cosme Reparto San Lucas Rio Piedras, PR 00926

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47384 Based on observations of the physical environment, review of policies procedures and facility staff interview performed on 04/15/2024 through 04/16/2024 to from 8:00 AM through 5:00 PM, it was determined that the facility failed to promote the resident right to receive services in a safe, clean, comfortable, and homelike environment. This deficient practice had the potential to affect 22 out of 22 residents. Findings include: During observational tour of facility on 04/15/2024 the following was noticed: 1. Mold stains due to humidity were noticed on ceiling tiles located on the Ocupational Therapy room. 2. Mold stains due to humidity were noticed on ceiling tiles located on Medical record room. 3. [NAME] shelves on the Ocupational Therapy room were observed with water damage due to a leak on the wall it is mounted. 4. Plinth in the physical therapy area were observed loose from the wall and with exposed glue.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 405030	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024
NAME OF PROVIDER OR SUPPLIER Millennium Institute for Advance Nursing Care Inc		STREET ADDRESS, CITY, STATE, ZIP CODE Calle Cosme Reparto San Lucas Rio Piedras, PR 00926	

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15884 Based on a recertification survey, review of sixteen records reviewed (R.R), resident interview and interview with the Nursing Supervisor (employee #2) performed from 04/15/2024 thru 04/16/2024, from 8:20 AM thru 4:30 PM, it was determined that the facility failed to develop and implement a complete baseline care plan within 48 hours of a resident's admission in order to promote the continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of all care and services required. This deficient practice was identified in 1 out of 16 records reviewed. (RR #68) Findings include: 1.R.R #68 is a [AGE] year-old female resident admitted [DATE] with a diagnosis of Status Post Left Knee Replacement. This resident had Neobladder reconstruction who is a surgical procedure to construct a new bladder [AGE] years ago. Resident was admitted for rehabilitation services. During the record review performed on 04/16/2024 at 10:30 AM, it was identified that the Baseline Care Plan did not have established initial goals for treatment based on the admission orders for the management and care of the Neobladder. Director Nursing Supervisor (employee #2) stated in an interview on 04/16/2024 at 1:35 PM that no provisions were included in resident #68 baseline care plan within 48 hours of a resident's admission because it was not identified that the resident had a Neobladder when admitted resident to the facility. He also explained that the delay in the identification of the Neobladder on the resident was due to the resident herself who manages the intermittent catheterization required to empty urine from the bladder. The surveyor requested information to the Director Nursing Supervisor (employee #2) on 04/16/2024 at 2:05 PM in relation to assessment performed by personnel when resident was admitted to the facility to identify if the resident could perform the intermittent catheterization without problems. This is because the resident is recovering from a Left Knee Replacement and could experience difficulties with mobility. No information was provided in relation to the evaluation or consideration of this resident's ability to perform intermittent catheterization while participating in a rehabilitation program due to her Left Knee Replacement.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15884 Based on review of sixteen records reviewed (R.R), resident interview and interview with the Nursing Supervisor (employee #2) performed from 04/15/2024 thru 04/16/2024, from 8:20 AM thru 4:30 PM, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment related to did not individualized and review each plan of care. This deficient practice was identified in 1 out of 16 records reviewed. (RR #69). Findings include: 1. R.R #69 is a [AGE] year-old male resident admitted [DATE] with a diagnosis of Left Knee Replacement. Resident was admitted for rehabilitation services. Resident #69 was interviewed on 04/16/2024 at 11:55 AM and stated that he was admitted to the facility to receive rehabilitation after a surgery on left knee, resident also stated that he has history of Asthma and require respiratory therapy for his condition. Resident stated that since his admission to the facility, he is receiving respiratory therapy for his condition. When asked how it provided the respiratory therapy treatment, he stated that nursing personnel assist him in the procedure preparing the medications and he administers the treatment. During the RR performed on 04/16/2024 at 1:42 PM, it was identified that resident had an order to receive Receiving respiratory therapy every 12 hours with Budesodine inhalation suspension 0.5 mg/2 ml and Levalbuterol HCL inhalation nebulization solution 0.63 mgs/ml 1 application. On interview on 04/16/2024 at 12:00 PM nurse in charge of medication pass (employee #3) stated that this resident help with the administration of his respiratory therapy treatment. She also stated that respiratory assessment was performed before and after the administration of the respiratory therapy in order to identify respiratory system improvement or decline. 2. During the record review performed on 04/16/2024 at 1:42 PM, it was identified that no comprehensive care plan was prepared by the Interdisciplinary group that includes measurable objectives and timeframe's to meet the resident's medical and nursing needs while receiving respiratory therapy treatment.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15884 Based on review of sixteen records reviewed (RR), resident interview and interview with the Nursing Supervisor (employee #2) performed from 04/15/2024 thru 04/16/2024, from 8:20 AM thru 4:30 PM, it was determined that the facility failed to ensure that a comprehensive assessment of resident, is performed when resident choose to self-administer treatment and medications. This deficient practice was identified in 2 out of 16 records reviewed (RR #62 and RR #69). Findings include: 1.R.R. #69 is a [AGE] year-old male resident admitted [DATE] with a diagnosis of Left Knee Replacement. Resident was admitted for rehabilitation services. Resident #69 was interviewed on 04/16/2024 at 11:55 AM and stated that he was admitted to the facility to receive rehabilitation after a surgery on left knee, resident also stated that he has history of Asthma and require respiratory therapy for his condition. Resident stated that since his admission to the facility he is receiving respiratory therapy for his condition. When asked how it provided the respiratory therapy treatment, he stated that nursing personnel assist him in the procedure preparing the medications and he administers the treatment. Resident stated that he wants to self-administer the respiratory therapy as he does it at home and he informed facility personnel about this. No assessment was found documented when reviewing the medical record on 04/16/2024 at 2:00 PM with the Director of Nursing (employee #2) in relation to the ability to self-administer medications for this resident. During the record review performed on 04/16/2024 at 1:42 PM, it was identified that no care plan was prepared by the Interdisciplinary group and pharmacist who include the assessment of the resident to determine if self-administration of medication is clinically appropriate, safe and feasible, to honor the residents' request and to maintain the resident's independence consistent with and individualized plan. 2. R.R. #62 is a [AGE] year-old female resident admitted [DATE] with a diagnosis of Right Knee Replacement. Resident was admitted for rehabilitation services. Resident #62 was interviewed on 04/15/2024 at 8:55 AM and stated that he was admitted to the facility to receive rehabilitation after surgery on right knee. The resident also stated that he has a history of Cataract. Resident stated that for her Cataract condition she use drops on both eyes four times a day. Resident stated that she wanted to self-administer the drops as she does it at home and she informed facility personnel about this when was admitted to the facility. A vial of Prednisolone Ophthalmic solution at 1% was observed on the resident night table. Resident stated that she administers the drops and that she had the medication at her bedside. No assessment was found documented when reviewing the medical record on 04/15/2024 at 3:00 PM with the Director of Nursing (employee #2) in relation to the ability to self-administer this medication by this resident. (continued on next page)

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	405030	A. Building B. Wing	04/16/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the record review performed on 04/15/2024 at 10:52 AM, it was identified that no comprehensive care plan were prepared by the Interdisciplinary group and pharmacist who include the assessment of the resident to determine if self-administration of medication is clinically appropriate, safe and feasible, to honor the residents' request and to maintain the resident's independence consistent with and individualized plan. 3. During an interview on 04/16/2024 at 9:44 AM Nursing Supervisor (employee #2) explains the process/procedure for determination that is appropriate that a resident had the ability to self -administrate medications. Nursing Supervisor (employee #2) provide a copy of the document where the interdisciplinary group make this determination. This procedure title is Determinacion de Residentes para Autoadministracion de Medicamentos and was last updated in July 2022.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 405030	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 47384 Based on observations and interview with the Administrative Dietitian (employee #6) performed from 04/15/2024 thru 04/16/2024, from 8:20 AM thru 4:30 PM, it was determined that the facility failed to provide sufficient support for personnel safely and effectively carry out the functions of the food and nutrition service. This deficient practice had the potential to affect 22 admitted residents. Findings include: During interview with the Administrative Dietitian (employee #6) performed on 04/15/2024 she stated that the facility did not have covered the dishwasher position. The administrative Dietitian stated that this makes difficult the function of the kitchen because she must use a TSA for the dishwashing functions.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15884 Based on observations, and interview with the Administrative Dietitian (employee #6) performed from 04/15/2024 thru 04/16/2024, from 8:20 AM thru 4:30 PM, it was determined that the facility failed to provide food to residents in a manner that is attractive and maintain an appetizing temperature. This deficient practice had the potential to affect 22 out of 22 admitted residents. Findings include: 1. During survey procedures from 04/15/2024 through 04/16/2024, from 8:20 AM thru 4:30 PM, it was observed that resident breakfast is delivered to residents in Styrofoam trays and Styrofoam containers instead of insulated thermal food domes and trays. 2. On interview on 04/15/2024 at 9:00 AM sample selection #[AGE] years old female resident stated that since her admission on 04/13/2024 to the facility, breakfast is served using Styrofoam trays and Styrofoam containers instead of insulated thermal food plates and trays. Case #68 also stated that breakfast could be more attractive in presentation if facility use the same insulated thermal food plates and trays that they use for lunch and dinner. 3. On interview on 04/16/2024 at 8:50 AM sample selection # 69 a [AGE] year-old male resident who stated that since his admission on 04/13/2024 to the facility, breakfast is served using Styrofoam trays and Styrofoam containers instead of insulated thermal food plates and trays. Case #69 also stated that the use of insulated thermal food plates ensures consistent food heat distribution and helps deliver a hot breakfast. 4. During interview on 04/16/2024 at 11:55 AM Administrative Dietitian (employee #6) stated that facility had a job vacancy at kitchen area for the employee in charge of dishwashing. She stated that this position is vacant from March 12, 2024. Administrative Dietitian (employee #6) stated on interview on 04/16/2024 at 1:00 PM that until a dishwasher is recruited it can be necessary to assign the dishwasher duty to other kitchen employees and this duty could be delay until 9:00 AM or later until those other kitchen employees finish other kitchen tasks. 5. The facility failed to maintain a good food appearance at the residents' breakfast presentation. 20423 6. Resident #71 is a [AGE] years old female admitted to the facility on [DATE] with a diagnosis of Left Total Knee replacement. During interview performed on the initial tool on 4/15/2024 at 8:30 am the resident state that the food arrive to the room in styrofoam trays and cold.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47384 Based on observations of the Kitchen, review of policies procedures and facility staff interview performed on 04/15/2024 to from 8:00 AM through 4:30 PM, it was determined that the facility failed to comply with the require sink compartment sanitations. Findings include: Review of facility's policy and procedure Limpieza y Desinfeccion en Fregadero de Tres Compartimientos , Cleaning and Disinfection of three compartment Sinks regarding the process of cleaning and sanitization of kitchen equipment was reviewed on 04/15/2024 at 11:30 AM and it says that compartment one (1) must have a temperature of 110 F, on compartment two (2) temperature must be at 110 F and on compartment three (3) temperature must be a 171 F with a sanitizing solution concentration of 200 ppm. 1. During the visual inspection and staff interview it was noticed that 3 compartment sink was not prepared as stated in the facility policies and procedures. It was observed that the staff working the sink did not have knowledge of the temperatures required in the different sinks' compartments. In turn, it was requested that the concentration of sanitizer be taken on the third compartment and the concentration measurement read 100 ppm and the requirement is a minimum of 200 ppm.

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F 0880 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17959 Based on observations performed on 04/15/2024 till 04/16/2024 8:00 AM till 2:30 PM and interview with the infection preventionist (employee #7), it was identified that the facility failed to ensure that infection prevention practice is perform to residents. This deficient practice affects 22 out of 22 residents. Findings include: 1. On 4/15/2024 at 8:10 AM during the initial tour the resident of (room [ROOM NUMBER]) was observed that the lights of the main entrance did not function. The borders of the faucet of the handwashing were observed with black dust. The ceiling was observed with bulky paint. 2. On 4/15/2024 at 8:05 AM during the initial tour the resident of (room [ROOM NUMBER]) was observed that the bathroom lacks crash can 3. On 4/15/2024 at 8:20 AM three metallic benches with peeling paint, mold and deteriorated material was observed in the yard. 4. On 4/15/2024 at 8:23 AM the floor of the corridor located at the left side of the physical therapy room was observed with black spots, dirty without shine, dust and water was observed around the bending machines. Mush dust was observed at the left side of the corridor of the grating bars. 5. On 4/15/2024 at 8:30 AM the floor of resident room [ROOM NUMBER] was observed with black spots. The resident suitcase was observed open and directly on the floor. Ceiling with peeling paint. The bathroom lacks trash disposal. 6. On 4/15/2024 at 8:35 AM the metal border of the closet located on the resident room was observed unfix to the ceiling. The biohazard crash can was observed with black spots and deteriorated lid. 7. On 4/15/2024 at 8:45 AM the floor of the main entrance of the recreative room was observed with black spots, borders around the room were observed dirty. The crash can lack the lid. The cover of the bulb localized on the ceiling was observed with black spots. 8. On 4/15/2024 at 8:50 AM black spots and dust were observed around the borders of the equipment storage for wheelchair, cane and other resident equipment were observed directly on the floor. 9. On 4/15/2024 at 8:55 AM in the interior of the refrigerator located on the pantry two hot /cold pack and one ice cream were observed in the interior of the freezer. This refrigerator is only used for residents' dinner. 10. On 4/15/2024 at 9:00 AM in the interior of the clean sheets was observed empty spaces due to the absence of slashes. 11. Th following was observed on the recreational therapy room: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Potential for minimal harm Residents Affected - Many	a. On 4/15/2024 at 9:15 AM abundant water outflow caused by rain was observed on the wall on the right side before the emergency exit, it falls on materials used for residents in recreational therapy. Materials were removed and discarded by recreational therapy personnel. b. Wooden shelves used to place craft materials were observed with evidence of abundant water and wood panels sponged by moisture. c. Edges and walls of the area where the lichen is located were observed with dark spots and absence of pieces of exposed electric cables and abundant dust. d. Plastic screen was observed with damp and dirty stains. e. Four of the six tables used for manual therapy were observed with dirt and mold on the edges of the tables. 12. On 4/15/2024 at 9:50 AM warehouse, two oxygen tanks were observed in its base wall in the back of the tanks, paint was observed after it was turned on by moisture. No temperature recorded broken thermometer. 13. On 4/15/2024 at 10:00 AM on the interior of the medication room a metal shelf with plenty of mold and dust was observed. Floor behind the shelf with dirty, accumulation of dust, water, and green spots. On the tablets of the shelve, tubes for blood samples were observed, tubes for crop samples needles, syringes, disposable hypodermic needle, syringe for single dose, compressor nebulizer, heparin locks, package of sterile gauze 2x2 open, syringes 50 ml and other materials. Drug cart dirty rubbers and mold. The shelf for storing supply of medicines is made of wood material with evidence of dust inside and outside.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	405030	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 47384 Based on observations with the Physical Plant Supervisor (employee #4) performed from 04/15/2024 thru 04/16/2024, from 8:20 AM thru 4:30 PM, it was determined that the facility failed to maintain equipment in a safe operating condition. This could affect 22 out of 22 residents and staff Findings include: During observational tour of facility on 04/15/2024 at 9:39 AM the following was noticed: 1. Parallel bars on the Physical Therapy room were observed with rust in many of its parts. 2. [NAME] steps apparatus was found to be rough in some parts of the handrails.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 47384 Based on observations with the Physical Plant Supervisor (employee #4) performed from 04/15/2024 thru 04/16/2024, from 8:20 AM thru 4:30 PM, it was determined that the facility failed to maintain an effective pest control program so that the facility is free of pests and rodents. Findings include: During observational tour of facility on 04/15/2024 at 9:15 AM the following was noticed: 1. Flying insects and centipedes were observed on light fixtures in the recreational room area. 2. Three cockroaches were found in the women's bathroom in the Physical Therapy room.