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	05/01/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47384 Based on observations of the physical environment, review of policies procedures and facility staff interview performed on 04/29/2025 from 8:00 AM through 3:30 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 15 out of 15 residents. Findings include: During the observational tour of the facility on 04/29/2025 the following was noticed: 1. Mold stains due to humidity were noticed on ceiling tiles located on the Occupational Therapy room. 2. Dust clogs were observed on room [ROOM NUMBER]B 3. Medical tape observed on curtain rail on room [ROOM NUMBER]B 4. Water damage was observed on the window wall on room [ROOM NUMBER]. 5. Water damage and lifted paint was observed on the window wall and on ceiling on room [ROOM NUMBER]. 6. Loose grab bar next to toilet was observed on bath on room [ROOM NUMBER]. 7. A perforation is observed in the air conditioning pipe in room [ROOM NUMBER]. 8. Nightstand on room [ROOM NUMBER]B was found unstable due to uneven wheels. 9. Cement plastering on the ceiling was observed loose. 10. Peeling paint behind beds B and C on room [ROOM NUMBER]. 11. Loose grab bars in bathroom on room [ROOM NUMBER] 12. Water damage behind sprinkler piping and in front of air conditioning on room [ROOM NUMBER]. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	13. Shower drain with broken tiles around it was observed in room [ROOM NUMBER]. 14. Water damage on the window wall was observed on room [ROOM NUMBER]. 15. Room # 17 closed because the toilet does not work.

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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** 51637 Based on ten records reviewed (R.R) and resident interview performed from 04/29/2025 thru 05/01/2025, from 8:00 AM thru 3:30 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 12 records reviewed. (RR #203) Findings include: R.R #203 is a [AGE] year-old female resident admitted [DATE] with a diagnosis of fracture of unspecified part of neck of left femur. This resident had a diagnosis of Cerebral Palsy. Resident was admitted for rehabilitation services. During the record review performed on 04/29/205 at 10:30 AM, it was identified that the Baseline Care Plan did not state the Cerebral Palsy diagnosis although in consultation with the psychiatrist this diagnosis had been identified.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 15884 Based on staff interviews and documents reviewed, it was determined that the facility failed to designate a registered nurse to serve as the director of nursing on a full-time basis. 51629 Findings include: 1. During an interview with the facility administrator (employee # 1) on 04/29/2025 at 10:00 AM, it was informed that the previous director of nursing (DON) resigns on March 1, 2025 and that he was acting both as an acting director of nursing (DON) and as the Minimum Data Set (MDS) coordinator. Also, employee # 1 explained that the facility hired a new Minimum Data Set (MDS) coordinator on 04/28/2025, expecting to be appointed as well as the new director of nursing (DON) after completing the training in the first role (MDS coordinator). 2. Upon review of the acting director of nursing (DON) resignation letter and during interview with the associate administrator (employee # 2) on 04/30/2025 at 10:30 AM, it was informed that the previous director of nursing (DON) submitted its resignation letter on March 1, 2025 with an effective date on March 14, 2025 but the person leaves the facility on the day the resignation letter was submitted. 3. During the review of the new Minimum Data Set (MDS) coordinator appointment document on 04/30/2025 at 11:00 AM, it showed that the person was hired only as the MDS coordinator. 4. Upon interview with the nurse supervisor (employee # 3) on 04/29/2025 at 8:30 AM, it was informed that her role was as nurse supervisor, not having any acting designation as a director of nursing (DON). 5. The facility failed to designate a full-time director of nursing for the last two months (March - April 2025), not having an expected date to fill the position.

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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** 51637 Based on initial tour observation, resident interview, and policies reviewed (Recording food temperatures on the service line), it was determined that the facility failed to ensure that food and drink is palatable, attractive, and at a safe and appetizing temperature. This deficient practice was identified in 4 out of 15 residents receiving services (sample resident #55, # 203, #205 and #212). Findings include: 1.Resident #203 is a female admitted to the facility on [DATE]. During an interview on 04/29/2025 at 8:10 AM she says the food is not pleasant to the taste and there are things that she does not consume that have been brought to her and the temperature of the food has not been adequate. 2.Resident #205 is a female admitted to the facility on [DATE]. During an interview on 04/29/2025 at 8:25 AM she states that the food has come cold most of the time and she must ask the facility staff to be reheated on the microwave. 3.Resident #212 is a female admitted to the facility on [DATE]. During an interview on 04/29/2025 at 8:05 AM she states that the temperature of the food has not been adequate most of the time. 4. A test tray was requested. During the test trays performed on 04/29/2025 at 11:35 AM the following was found: a. Meatballs: 118.3 grade( ) Fahrenheit (F) b. Spaghetti: 132.6 F c. [NAME] Salad: 57.9 F d. Fruit cocktail: 45.5 F e. Fruit Juice: 51.2 F f. Milk: 49.5 F 5. During the facility policy review performed on 05/01/2025 at 9:53AM named Registro de temperaturas de alimentos en la linea de servicio, Temperature Register on the Service Line, reviewed on April 2025, states that the temperature of food on the serving line must be maintained outside the temperature at the danger zone (41 F - 135 F). 15884 6. On 04/30/25 08:57 AM it was informed by resident #55 that she receive for breakfast hot cereal , soda crackers, apricot juice ,coffee and two boil eggs. She stated that she ate one of the boiled eggs so not to go hungry ; because the boiled eggs were cold, and she does not want personnel to reheat it due to the possibility of changes in texture and flavor.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51637 Based on dining observations, review of the institutional menu and residents interview performed on 04/29/2025 through 05/01/2025 from 8:00 AM through 3:30 PM, it was determined that the facility failed to ensure that each resident receives food that accommodates resident allergies, intolerances, and preferences. This deficiency was identified in 2 out of 8 residents of the sample selection (Residents #203 and #212). Findings include: 1. Resident #203 is a female admitted to the facility on [DATE]. During an interview on 04/29/2025 at 8:10 AM she refers that on several occasions they have brought her food that she does not eat and, since she does not eat it, they do not offer her alternative foods. a. During the record review performed on 04/30/2025 at 9:25 AM it was noted that the initial nutrition assessment established the foods that the resident does not consume. 2. Resident #212 is a female admitted to the facility on [DATE]. During an interview on 04/29/2025 at 8:05 AM she states that she does not drink milk and has been brought to her on several occasions and has not been offered a substitute. a. During the record review performed on 04/30/2025 at 9:35 AM it was noted that the initial nutrition assessment established the foods that the residents do not consume. During the review of both residents' meal cards performed on 04/30/2025 at 11:45 AM it was noted that both cards included the patients' taste and preference specifications. During the review of the facility's menu cycle conducted on 05/01/2025 at 9:15 AM it was noted that the facility does not have an alternate menu created for cases where the resident refers to not liking the food served.

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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 04/29/2025 from 8:00 AM through 3:30 PM, it was determined that the facility failed to comply with the required sink compartment sanitations. This deficient practice could affect 15 out of 15 residents admitted receiving care at the facility. Findings include: 1. During the observation of the preparation of the three-compartment sink, it was identified that the water inside the washing sink does not reach the required temperature of 110 degrees Fahrenheit indicated on the manufacturer's signs placed in front for reading. 2. During observation of the dry storage area, loose rice and beans were observed underneath the storage racks. 3. Insect (grasshopper) was found on the dry storage area.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 51637 Based on observations and medication drug pass performed during the survey process from 04/29/2025 through 05/01/2025 from 8:30 AM through 3:30 PM, it was determined that the facility failed to comply with accepted infection control precautions and standards of practice for hand washing during medication pass. Findings include: 1. During the medication drug pass performed on 04/30/2025 at 8:12 AM the register nurse (RN) (Employee #8) was observed accessing the gloves box without performing hand hygiene. 2. During the medication drug pass performed on 04/30/2025 at 8:33 AM the RN (Employee #7) was observed accessing the gloves box without performing hand hygiene. 3. During the medication drug pass performed on 04/30/2025 at 8:40 AM the RN (Employee #7) was observed placing the gloves on the resident's bedside table without disinfecting them to proceed to wash her hands and then put on the gloves. 4. The soiled linen room was observed on 04/30/2025 at 11:29 AM and the following were found: a. The room door was not labeled. b. The extractor fan was not working. c. There was no thermometer inside the room to measure temperature and humidity. d. There was no hand sanitizer dispenser accessible inside or outside of the room. e. A policy or procedure for the soiled linen room was requested from the facility but was not provided.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47384 Based on observations of the physical environment and facility staff interview performed on 04/29/2025 from 8:00 AM through 3:30 PM, it was determined that the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. This deficient practice had the potential to affect 15 out of 15 residents. Findings include: During the observation tour the following was observed: 1. It was observed that the vinyl floor had ripples, possibly due to moisture damage or an uneven platform, which could be a potential cause of falls. 2. An undetermined number of pigeons were observed nesting in and around the facility. [NAME] droppings were observed on the exterior walls and windows of rooms. 3.Exterior lights were observed covered in green mold in the entrance and parking area.