STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055341	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pasadena Palace Tcu	716 South Fair Oaks Ave Pasadena, CA 91105

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to change the enteral (nutrition taken through the mouth or through a tube that goes directly to the stomach or small intestine) feeding bag every shift/every 24 hours for one of four sampled residents (Resident 2) in accordance with the physician ‘s order and facility policy.This deficient practice had the potential for Resident 2 not to get adequate nutrients via enteral feeding which could lead to malnutrition (serious condition that occurs when a resident's diet does not contain the right amount of nutrients) and results in hospitalization and death. Findings: During a review of Resident 2's admission Record, the admission Record indicated that Resident 2 was admitted to the facility on [DATE] with dysphagia (difficulty swallowing), encounter for attention to gastrostomy (a surgically created opening from the abdomen to the stomach for feeding or medication.) and adult failure to thrive (not a specific disease, for inadequate physical growth or a decline in physical and mental function). During a review of Resident 2's Minimum Data Set (MDS - a comprehensive standardized assessment and screening tool), dated 10/26/2025, the MDS indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were impaired. The MDS indicated Resident 2 required total dependence (full staff performance) on staff for oral hygiene, toilet hygiene, and personal hygiene. The MDS indicated Resident 2 was on feeding tube.During a review of Resident 2's Order Summary, dated 10/22/2025, the Order Summary indicated to change enteral administration set with every bottle of formula, every shift. During a review of Resident 2's Care Plan, initiated on 9/17/2025, the Care Plan indicated Resident 2 was at risks for significant weight loss and risks for dehydration (condition that occurs when the loss of body fluids, mostly water, exceeds the amount that is taken in). The staff interventions included were for the the staff to assist with tube feeding and water flushes and to see orders for current feeding orders. During a Resident 2's family member (R2FM) phone screenshot review and interview on 12/17/2025 at 2:10 PM, R2FM's phone screenshot, dated 11/14/2025 at 12:21 PM, indicated the screenshot of the Resident 2's enteral feeding bottle, dated 11/11 2025 9 PM. R2FM stated Resident 2's enteral administration feeding set had not been changed for three (3) days from 11/11/2025 to 11/14/2025. R2FM stated, My father did not get his nutrition and hydration needed for his body. During an interview on 12/17/2025 at 3:03 PM with the Director of Nursing (DON), the DON stated R2FM validated the screenshot with the DON. The DON stated the licensed nurse did not change the enteral feeding bottle and hydration water bag every shift as indicated in the order. As a result, Resident 2 was at risk of not getting or maintaining adequate nutrition and hydration needed for his body. The DON stated it was facility's procedure to change administration set and formula bottle every 24 hours or followed physician's order.During a review of facility's undated policy and procedure (P&P) titled, Enteral Tube Feeding via Continue Pump, the P&P indicated formulas that had been reconstituted in advance and discard within 24 hours. Discard reconstituted formulas kept at room temperature with four hours. The P&P also indicated to refer to facility procedure for hang times and administration set changes.