

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Pasadena Palace Tcu		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete/and follow through with the Preadmission Screening and Resident Review (PASARR; a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) for two (2) of three (3) sampled residents (Residents 3 and 4) under the PASARR care area by not: Completing a PASARR level 1 screening for Resident 3 upon admission on [DATE]. 2. Conducting a follow up to obtain a PASARR level II (a resident-centered evaluation that is completed for anyone identified by the Level 1 Screening as having, or suspected of having, a PASRR condition, such as serious mental illness [SMI], intellectual disability [ID], developmental disability (DD), or related condition [RC]) evaluation for Resident 4 in accordance with the facility policy. This failure had the potential to result in inappropriate placement and unidentified specialized services for Residents 3 and 4. During a review of Resident 3's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of dementia (a progressive state of decline in mental abilities) and paranoid schizophrenia (a subtype of schizophrenia [a mental illness that is characterized by disturbances in thought] characterized by prominent delusions). During a review of Resident 3's Minimum Data Set (MDS &ndash; a resident assessment tool), dated 9/1/2025, the MDS indicated the resident had severe impairment (difficulty with or unable to make decisions, learn, remember things) with cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 3 was dependent (helper does all of the effort. Resident does none of the effort to complete activity or the assistance of two [2] or more helpers is required for the resident to complete the activity) with chair/bed-to-chair transfers, going from lying to sitting on the side of the bed, upper and lower body dressing (the ability to dress and undress above and below the waist), putting on/taking off footwear, and personal hygiene. Resident 3 needed substantial/maximal assistance (helper does more than half the effort) with eating. During a concurrent interview and record review on 10/1/2025 at 10:14 AM with Social Services Director (SSD), Resident 3's Electronic Medical Record (EMR; a digital version of a patient's paper chart containing the resident's medical history, diagnoses, treatment sand other health information) dated October 2025 was reviewed. SSD stated Resident 3 last had a PASARR level 1 screening done on 9/16/2019 and verified that Resident 3's admission profile indicated she was last admitted to the facility on [DATE]. SSD stated there was no PASSAR level 1 screening done for Resident 3's admission on [DATE] and further stated that the purpose of the PASARR is to screen if a resident has any mental/developmental disabilities and indicated if the resident may have any specific psychiatric (anything related to mental illness or its medical treatment) issues and needs so that the facility may address them. SSD further stated if the PASARR screening is not done, the facility cannot comply with needs that a resident may have. 2. During a review of Resident 4's admission Record, the admission Record indicated the resident was (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 4's PASARR completed on 7/2/2024, it indicated Resident 4's need for Level II PASARR evaluation. During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognitive skills for daily decision making was independent (decisions consistent/reasonable). The MDS indicated Resident 4 required set up or clean up assistance (Helper sets up or cleans up; resident completes activity) with eating. The MDS indicated Resident 4 required substantial/maximal assistance with oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 4 was dependent with toileting hygiene, shower, lower body dressing, and putting on/taking off footwear. The MDS also indicated Resident 4 was receiving antipsychotic (medication primarily used to manage psychosis). During a concurrent record and interview on 11/19/2025 at 9:13 AM, with MDS nurse (MDSN), Resident 4's PASARR dated 7/2/2024 were reviewed. The MDSN stated she was responsible for overseeing PASARR. The MDSN stated she is newly hired in the facility and has not checked all PASARR's yet. The MDSN verified Resident 4's PASARR level I evaluation dated 7/2/2024 indicated level II evaluation is required. The MDSN stated that there was no follow up made with a PASARR representative regarding the need for Resident 4's Level II evaluation. The MDSN stated that Level II evaluation was to determine appropriate placement and/or the need for specialized services. During a review of the facility's Policy and Procedure titled, admission Criteria, revised March 2019, indicated all new admissions and readmissions are screened for MD, ID or related disorders (RD) per the Medicaid PASARR process. It also indicated if the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. (1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID or RD. (2) The social worker is responsible for making referrals to the appropriate state-designated authority.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure proper food handling pas practiced and was provided in accordance with the facility's policy and procedure (P&P) by failing to ensure an open bag with eight (8) chicken patties and a cheesecake in the kitchen's walk-in freezer was labeled with open date and best by (expiration) date. The deficient practice of failing to ensure unlabeled foods are disposed accordingly had the potential to result in growth of bacteria and transmission of foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea (the frequent passing of loose, watery stools), and fever and can lead to other serious medical complications and hospitalization. Findings: During a concurrent observation in the facility kitchen and interview on 9/29/2025 at 7:47 AM with the Dietary Supervisor 1 (DS 1), walk-in freezer was observed. There were eight (8) chicken patties in an open bag, with no label of open date, expiration date, and no best by date. In addition, there was a cheesecake with no label of received date (dates of delivery), expiration date, and no best by date. DS 1 stated she did not know why some of the items were not labeled with open date, received date, expiration date and best by date. DS 1 stated, all items that are being opened in the facility's kitchen should have a label of the date when it was opened or first use and use by date or expiration date. During an interview on 11/18/2025 at 2:04 PM with DS 3, DS 3 stated the food items in the facility's kitchen without a label of open date, received date, and best by date are not safe to use/ to serve to the residents because of uncertainty whether it is still good to use or not. DS 3 stated the 8 chicken patties and the cheesecake observed in the walk-in freezer should be discarded because no one knows how long it has been there, and those foods might cause residents to get sick, or experience stomach issues like diarrhea. During a review of facility's P&P titled Food Receiving and Storage, revised in November 2022, indicated all foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). During a review of facility's P&P titled Refrigerators and Freezers, revised in November 2022, indicated all food is appropriately dated to ensure proper rotation by expiration dates. The P&P indicated Received dates (dates of delivery) are marked on cases and on individual items removed from cases for storage, Use by dates are completed with expiration dates on all prepared food in refrigerators and expiration dates on unopened food are observed and use by dates are indicated once food is opened. It also indicated supervisors are responsible for ensuring food items in pantry, refrigerator and freezers are not past use by or expiration dates.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement facility's policy and procedures (P&P) for food brought by family/visitors for five of seven sampled residents (Residents 4, 9, 25, 37 and 32) by failing to ensure:1. A container of rice and noodles for Resident 4 was labeled with use by date.2. Food was removed and discarded from the resident's refrigerator for Resident 9 who was discharged from the facility on 9/26/2025.3. A container of pozole (a kind of soup) and bag of cabbage for Resident 25 was labeled with use by date.4. A box of pizza for Resident 37, dated 9/6/2025 was disposed. 5. Multiple containers of food containing rice fish, bitter melon and beef for Resident 32 was labeled with use by date.6. Food brought by Resident 32's visitor was not left in resident's room for more than 2 hours. These deficient practices had the potential to result in food-borne illnesses (food poisoning) for Residents 4, 9, 25, 37 and 32, with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea and fever and can lead to other serious medical complications and hospitalization.Findings: 1. During a review of Resident 4's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 4's medical records, it indicated a diet order of renal diet (diet plan for people with kidney disease) / Consistent or Controlled Carbohydrate diet (CCHO diet, a dietary approach for managing blood sugar levels) mechanical soft texture (a diet of foods that are modified to be easy to chew and swallow), regular liquid consistency, ordered on 8/22/2025, and discontinued on 11/3/2025. During a concurrent observation and interview on 9/29/2025 at 8:09 AM with Dietary Supervisor 1 (DS 1), the resident's refrigerator was observed. DS 1 stated there is a container of rice, and a container of noodles with Resident's 4 name with no date when it was received and it was not labeled with use by date. 2. During a review of Resident 9's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses of anemia (a condition where the body does not have enough healthy red blood cells), hypertension (HTN-high blood pressure) and dementia (a progressive state of decline in mental abilities). During a review of Resident 9's medical records, it indicated a diet order of CCHO diet, mechanical soft chopped texture, regular liquid consistency, ordered on 7/31/2025, and discontinued on 9/26/2025. During a concurrent observation and interview on 9/29/2025 at 8:10 AM with DS 1, the resident's refrigerator was observed. DS 1 stated there is a container of sour cream, yogurt, pickles and a bottle of prune juice with Resident's 9 name. DS 1 stated all these foods should have been discarded after the resident was discharged from the facility on 9/26/2025. 3. During a review of Resident 25's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was re admitted on [DATE], with diagnosis of (continued on next page)		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	end stage renal disease (ESRD, irreversible kidney failure), and paraplegia (loss of movement and/or sensation, to some degree, of the legs). During a review of Resident 25's medical records, it indicated a diet order of double protein renal/CCHO diet, regular texture, regular liquid consistency, ordered on 9/19/2025, and discontinued on 11/3/2025. During a concurrent observation and interview on 9/29/2025 at 8:11 AM with DS 1, the resident's refrigerator was observed. DS 1 stated there is a container of pozole, and a bag of cabbage with Resident's 25 name and not labeled with the date when it was received and not labeled with the use by date. 4. During a review of Resident 37's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was re admitted on [DATE], with diagnosis of hypertension, anemia and muscle weakness. During a review of Resident 37's medical records, it indicated a diet order of regular diet, regular texture, regular liquid consistency, ordered on 9/2/2025, discontinued on 10/8/2025. During a concurrent observation and interview on 9/29/2025 at 8:12 AM with DS 1, the resident's refrigerator was observed. DS 1 stated there is a box of pizza labeled with Resident 37's name, with 2 slices of pizza left inside the box, dated 9/6/2025. DS 1 stated the pizza should have been discarded and not left in the refrigerator for a long time. 5. During a review of Resident 32's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of paroxysmal atrial fibrillation (an irregular heartbeat that starts and stops on its own) and type 2 diabetes mellitus (high blood sugar). During a review of Resident 32'S Minimum Data Set (MDS &ndash; a resident assessment tool), dated 10/15/2025, the MDS indicated the resident was cognitively intact (ability to think, remember, and reason) with cognitive skills for daily decision making. It indicated Resident 32 needed supervision or touching assistance (helper sets up or cleans up; resident completes activity) with walking 150 feet, chair/bed-to-chair transfers, personal hygiene and upper body dressing (the ability to dress and undress above the waist). The MDS indicated Resident 32 needed partial/moderate assistance (helper does less than half the effort) with lower body dressing (the ability to dress and undress below the waist) and putting on/taking off footwear and needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating. During a concurrent observation and interview on 9/29/2025 at 8:44 AM with Resident 32 inside his room, a bowl of fish soup on top of a plate with a half-eaten piece of chicken was observed uncovered and unlabeled with the use by date that was placed on top of Resident 32's rolling bedside table. Resident 32 stated Resident 32's visitor brought it for him last night. During a concurrent observation and interview on 9/29/2025 at 8:51 AM with Licensed Vocational Nurse 3 (LVN 3) and Resident 32 inside Resident 32's room, a bowl of fish soup on top of a plate with a half-eaten piece of chicken was observed uncovered and unlabeled with the use by date that was placed on top of Resident 32's rolling bedside table. LVN 3 verified, the uncovered bowl of fish soup on top of a plate of half-eaten chicken had no label of use by date. Resident 32 stated he would like to eat it later & LVN 3 told the resident that she would have someone put it in the refrigerator. During a concurrent observation and interview on 9/30/2025 at 12:28 PM with Resident 32 inside his room, two Tupperware containers (continued on next page)		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were observed on Resident 32's rolling bedside with one containing rice and the other containing soup and were not labeled with use by date or time. Resident 32 stated his friend had brought it in for him earlier that same day. During an interview on 9/30/2025 at 12:30 PM with Registered Nurse 1 (RN 1), RN 1 stated Resident 32's friend had come by around 12:00 PM on 9/30/2025. During a concurrent observation and interview on 9/30/2025 at 3:12 PM with the Director of Nursing (DON) inside Resident 32's room, two Tupperware containers were observed on top of Resident 32's rolling bedside table with one containing rice and the other containing soup with a labeled date of 9/30/2025 and time at 12:00 PM. The DON verified Resident 32's food brought in from the outside at 12:00 PM was still at the resident's bedside at 3:12 PM. During an interview on 11/18/2025 at 2:11 PM with DS 3, DS 3 stated food brought by residents, residents' visitors/family are being stored in facility's resident's refrigerator. DS 3 stated CNAs stored the food in resident's refrigerator, and CNAs should label it with the date when it was received, and the use by date. DS 3 stated that partially eaten food should not be kept in the resident's refrigerator. DS 3 stated it is important to label resident's food with use by date to ensure the resident does not consume the food after the use by date that was labeled on their foods. DS 3 stated residents might get sick for consuming food that is being stored there for a while. During a concurrent interview and record review on 10/1/2025 at 10:38 AM with the DON, the facility's policy and procedure (P&P) titled, Food Brought by Family/Visitors, revised March 2025 was reviewed. The P&P indicated: a. Food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that is clearly distinguishable from facility-prepared food. Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the use by date. b. The nursing staff will discard perishable foods on or before the use by date. c. Potentially hazardous foods that are left out for the resident without a source of heat or refrigeration longer than 2 hours will be discarded. The DON stated, since Resident 32's food that was brought in on 9/30/2025 at 12:00 PM was still at the bedside on 9/30/2025 at 3:12 PM, it should have been discarded since their policy indicated foods that are left out for the resident/s without a source of heat or refrigeration longer than 2 hours will be discarded. The DON stated, food brought from outside the facility for the resident should be labeled with use by date and if not properly stored could potentially cause the resident to get sick due to a foodborne illness (a sickness caused by eating food or drinking liquids contaminated with bacteria, viruses, parasites or toxins) or food poisoning (sickness that occurs from eating food or drinking beverages contaminated with germs, toxins or chemicals).		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their infection control policies & procedures for five (5) of six (6) sampled residents (Residents 10, 18, 40, 61, and 77) by not ensuring:1-4. The availability of environmental Protection Agency (EPA; a United States federal agency that protects human health and safeguards the environment by creating and enforcing environment laws and regulations) registered sanitizing wipes or bleach wipes effective against Clostridium Difficile (C. diff; a highly contagious bacterial infection that causes an infection of the colon [the longest part of the long intestine]) for Residents 10, 18, 61 and 77 on contact isolation (a transmission based precautions to stop germs from spreading through direct touch with a patient or indirect touch with contaminated objects in their environment) for C. diff infection. 5. Used disposable tray, disposable food containers and disposable utensils (single use eating tools, such as forks, knives, and spoons, that are discarded after one use) of Resident 40 who was on contact isolation, were properly disposed. These failures have the potential to result in the spread of infection to other residents in the facility.1. During a review of Resident 10's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of enterocolitis (an inflammation of both the small intestine and the large intestine) due to clostridium difficile and pneumonia (an infection of the lungs). During a review of Resident 10'S Minimum Data Set (MDS &ndash; a resident assessment tool), dated 9/5/2025, the MDS indicated the resident was severely impaired (difficulty with or unable to make decisions, learn, remember things) with cognitive skills (ability to think, remember, and reason) for daily decision making. Resident 10 was dependent (helper does all of the effort; resident does none of the effort to complete the activity or the assistance of two (2) or more helpers is required for the resident to complete the activity) with upper and lower body dressing (the ability to dress and undress above and below the waist), putting on/taking off footwear and personal hygiene. Resident 10 needed substantial/maximal assistance (helper does more than half the effort) with going from lying to sitting on the side of the bed and rolling left and right in bed. During a review of Resident 10's Order Summary Report dated 10/2/2025, Resident 10's Order Summary Report indicated an order from 9/21/2025 for contact isolation every shift for stool C. diff. 2. During a review of Resident 18's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of enterocolitis due to clostridium difficile and multiple sclerosis (a chronic autoimmune [a condition where the immune system turns against itself] disease that affects the central nervous system [brain and spinal cord]). During a review of Resident 18'S MDS, dated [DATE], the MDS indicated the resident was moderately impaired cognitive skills for daily decision making. Resident 18 was dependent with chair/bed-to-chair transfers, going from lying to sitting on the side of the bed, putting on/taking off footwear and lower body dressing. Resident 18 needed substantial/maximal assistance with upper body dressing and personal hygiene and needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating. During a review of Resident 18's Order Summary Report, dated 10/2/2025, Resident 18's Order Summary Report indicated an order from 9/23/2025 for contact isolation (stool c. diff).During a review of Resident 18's Care Plan, dated 9/24/2025, Resident 18's Care Plan indicated Resident 18 had C. Difficile. The care plan indicated staff interventions were to put Resident 18 on contact isolation and to disinfect all equipment used before it leaves the room. 3. During a review of Resident 61's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	polyarthritis (a condition where multiple joints experience inflammation) and dysphagia (difficulty swallowing), oropharyngeal phase (a stage of swallowing that involves moving food or liquid from the mouth to the top of the esophagus [a muscular tube that connects the throat to the stomach]). During a review of Resident 61's MDS, dated [DATE], the MDS indicated the resident was severely impaired with cognitive skills for daily decision making. Resident 61 was dependent with rolling left and right in bed, upper/lower body dressing, putting on/[NAME] off footwear, personal hygiene and eating. During a review of Resident 61's Order Summary Report dated 10/2/2025, Resident 61's Order Summary Report indicated an order from 9/29/2025 for contact isolation precautions for stool C. diff. During a review of Resident 61's Care Plan dated 9/30/2025, Resident 61's Care Plan indicated Resident 61 had C. Difficile. The care plan indicated staff interventions were to put Resident 61 on contact isolation and to disinfect all equipment used before it leaves the room. 4. During a review of Resident 77's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of systemic inflammation response syndrome (SIRS; a widespread inflammatory response throughout the body) and gastro-esophageal reflux disease (GERD; a condition where stomach acid flows back up into the esophagus, causing irritation and discomfort). During a review of Resident 77's History and Physical Examination (H&P), dated 9/26/2025, the H&P indicated Resident 77 had the capacity to understand and make decisions. During a review of Resident 77's Order Summary Report, dated 10/2/2025, Resident 77's Order Summary Report indicated an order from 9/25/2025 for contact isolation until confirmation resident is negative for stool C. diff. During a review of Resident 77's Care Plan, dated 10/1/2025, Resident 77's Care Plan indicated Resident 77 has C. Difficile. The care plan indicated staff interventions were to put the resident on contact isolation and to disinfect all equipment used before it leaves the room. During an observation on 9/30/2025 at 12:26 PM in the hallway outside of Resident 10 and 61's room, a contact isolation was observed indicating to clean and disinfect reusable equipment before use on another person. A supply cart was observed right outside the door with a purple container of Super Sani-Cloth Germicidal (an agent that kills microorganisms like bacteria and viruses) Disposable Wipes on top of the supply cart. During a review of the facility's Super Sani-Cloth Germicidal Wipes container, the Super Sani-Cloth Germicidal Wipes container did not indicate it was effective against C. Diff. During an observation on 10/1/2025 at 9:42 AM in the hallway outside of Resident 18 and 77's room, a contact isolation sign was observed indicating to clean and disinfect reusable equipment before use on another person. A supply cart was also observed right outside the door with a purple container of Super Sani-Cloth Germicidal Disposable Wipes on top of the supply cart. During an interview on 10/1/2025 at 9:42 AM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Residents 18 and 77's room is on contact isolation for C. diff in the stool. LVN 1 stated the Super Sani-Cloth Germicidal Wipes that are located outside the room are what he would use to clean and disinfect the objects inside the room such as the resident's bedside table and chairs. During a concurrent observation and interview on 10/1/2025 at 9:42 AM with LVN 1 in the hallway outside of Residents 18 and 77's room, a supply cart was observed right outside the door with a purple container of Super Sani-Cloth Germicidal Disposable Wipes on top of it. LVN 1 reviewed the Super Sani-Cloth Germicidal Disposable Wipes container and stated it did not name C. diff as an organism it was effective against. During a concurrent observation and interview on 10/1/2025 at 9:48 AM with Infection Preventionist 1 (IP 1) outside of Residents 10 and 61's room, a contact isolation sign was observed indicating to clean and disinfect reusable equipment before use on another person. A supply cart was also observed right outside the door with a purple container of Super Sani-Cloth Germicidal Disposable Wipes on top of the supply cart. IP 1 stated Residents 10 and 61 were on (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Pasadena Palace Tcu		STREET ADDRESS, CITY, STATE, ZIP CODE 716 South Fair Oaks Ave Pasadena, CA 91105	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contact isolation for C. diff and the purple container Super Sani-Cloth Germicidal Disposable Wipes outside their room would be used to wipe down the objects in their room. IP 1 reviewed the Super Sani-Cloth Germicidal Disposable Wipes container label and stated it did not indicate C. diff as an organism it was effective against and further stated the wipes that should be used for C. diff isolation were bleach wipes. During a concurrent observation and interview on 10/1/2025 at 9:50 AM with LVN 2 in the hallway outside of Resident's 10 and 61's room, a purple container of Super Sani-Cloth Germicidal Disposable Wipes was observed on the supply cart outside of the room. LVN 2 stated since the purple container of Super Sani-Cloth Germicidal Disposable Wipes was what was supplied outside of the room, they were the wipes she would use to disinfect her pulse oximeter (a device used to measure blood oxygen saturation [SpO2]) that she would use for the residents. LVN 2 stated they were the same wipes she had used yesterday to disinfect the objects in Residents 10 and 61's room. During an interview on 10/1/2025 at 9:53 AM with IP 1, IP 1 stated it's important to provide the correct wipes effective against C. diff because an outbreak of cross contamination with residents in other rooms could occur. IP 1 also stated C. diff spores are able to stay on a surface for three (3) months at a time and if anyone brushes against a surface contaminated with C. diff, they could easily transfer the bacteria to another resident if they are not using proper hand washing, personal protective equipment (PPE; equipment worn to protect against hazards like serious injuries, illnesses or infections) and disinfecting wipes. During a review of the facility's policy and procedure (P&P) titled, Clostridium Difficile, revised October 2018, the P&P indicated, Measures are taken to prevent the occurrence of Clostridium Difficile infections (CDI) among residents. Precautions are taken while caring for residents with C. Difficile to prevent transmission to other residents. The P&P further indicated: a. The primary reservoirs for C. difficile are infected people and surfaces. Spores can persist on resident-care items and surfaces for several months and are resistant to some common cleaning and disinfection methods. b. Steps towards prevention and early intervention include: a. Disinfection of items with potential fecal soiling (e.g. [for example] bedpans, commode chairs, bed rails, etc.) using a disinfecting agent recommended for C. difficile (e.g. household bleach and water solution or an EPA registered germicidal agent effective against C. difficile spores. 5. During a review of Resident 40's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses of enterocolitis due to clostridium difficile, dysphagia, and encounter for attention to gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 40'S MDS, dated [DATE], the MDS indicated the resident was severely impaired with cognitive skills for daily decision making. The MDS indicated Resident 40 was dependent with eating, oral hygiene, toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear, personal hygiene and rolling left and right in bed. During a review of Resident 40's Care Plan, initiated on 9/16/2025, the Care Plan indicated a focus on Resident 40 requiring contact isolation precautions related to Candida auris (C. auris, a type of yeast that can cause severe illness and spread easily among very sick patients in healthcare facilities) at gastrostomy tube site. The staff interventions indicated the following: Handle and transport lined and waste in a manner that avoids transfer of microorganisms (germ) to residents, staff, and environment. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement appropriate isolation techniques by staff, resident and visitors. Maintain adequate isolation supplies near the isolation room. Place necessary equipment and supplies in the room needed for isolation. During a concurrent dining observation and interview on 9/30/2025 at 1:05 PM, in the hallway with Certified Nurse Assistant 6 (CNA 6), CNA 6 was observed carrying a disposable tray with disposable bowl, disposable used spoon, used napkin and disposable food container. CNA 6 stated this was the lunch tray from Resident 40 on contact isolation. CNA 6 stated she will be throwing it outside the facility, in the dumpster. During a concurrent interview and record review on 10/1/2025 at 9:20 AM with IP 1, Resident 40's active orders and facility policy were reviewed. IP 1 stated Resident 40 has an active order of contact isolation precautions due to Candida auris (C. auris, a type of yeast that can cause severe illness and spread easily among very sick patients in healthcare facilities) at gastrostomy site since 9/16/2025. IP 1 stated CNA 6 did not and should have thrown all the disposable items inside Resident 40's room for infection control. IP 1 stated contact isolation order should be followed and implemented to protect other residents from infections. IP 1 stated the infection control policy on Disposable Dishes and Utensils did not but should have indicated that the disposable dishes and utensils for any residents on contact isolation should be thrown inside the resident's room or should be placed in an enclosed trash bag to be thrown in the dumpster. During an interview on 11/18/2025 at 1:49 PM with CNA 6, CNA 6 stated she should have not discarded Resident 40's disposable lunch tray outside the contact isolation room on 9/30/2025. CNA 6 stated Resident 40's disposable trays should have been thrown in the trash can inside the resident's room since the resident was on contact isolation to avoid spreading the germs to other residents. CNA 6 also added that anything that Resident 40 used while in contact isolation should be placed in a trash bag before transporting outside the contact isolation room. During an interview on 11/19/2025 at 10:53 AM with IP 2, IP 2 stated disposable trays, disposable food containers and utensils are being used for residents with contact isolation order. IP 2 stated it is important to implement and practice contact isolation precautions to prevent spreading the infection to other residents. IP 2 stated it was important to throw the contaminated disposable meal trays and disposable utensils inside the contact isolation room or placed in a trash bag if they need to be transported outside the room since it could come in contact with another resident and spread the infection. During a review of Facility's P&P titled, Disposable Dishes and Utensils, dated 2001, indicated single-service articles may be used to serve residents in isolation, per facility policy.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to promote dignity and respect in accordance with the facility's policy and procedure for one (1) of two (2) sampled residents (Resident 49) under the Dignity Care Area, when Certified Nursing Assistant 3 (CNA 3) was observed standing above Resident 49's eye level while assisting the resident during mealtime. This failure had the potential to affect Resident 49's self-esteem and self-worth. During a review of Resident 49's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of dementia (a progressive state of decline in mental abilities) and dysphagia oropharyngeal phase (a difficulty in the first stage of swallowing, where food is transferred from the mouth to the esophagus [muscular tube that connects the throat to the stomach]). During a review of Resident 49's Minimum Data Set (MDS - a resident assessment tool), dated 11/5/2025, the MDS indicated the resident had severe impairment (never/rarely made decisions) with cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 49 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with going from sitting to lying down, rolling left and right in bed, upper and lower body dressing (the ability to dress and undress above and below the waist), putting on/taking off footwear, personal hygiene and eating. During an observation on 9/29/2025 at 2:47 PM inside Resident 49's room, Resident 49 was observed sitting up in bed, with her bed in the lowest position and CNA 3 was observed standing next to the resident and attempting to feed her a spoonful of food. During an interview on 9/30/2025 at 1:04 PM with CNA 3, CNA 3 stated on 9/29/2025 she was standing when attempting to feed Resident 49 during mealtime. CNA 3 stated she should not be standing over the resident when assisting her with feeding. CNA 3 added that the correct way to assist a resident with feeding is to be sitting down next to her/him. CNA 3 further stated standing over a resident while assisting her/him with feeding could potentially scare the resident. During a concurrent interview and record review on 10/1/2025 at 10:34 AM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Assistance with Meals, revised March 2022 was reviewed. The P&P indicated, Resident who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: not standing over residents while assisting them with meals. The DON stated not standing over the residents means that the person assisting the resident with feeding should be at her/him eye level so that the resident feels comfortable, respected, and provided with a dignified dining experience. During a review of the facility's P&P titled, Dignity, revised February 2021, the P&P indicated that, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem, and also indicated: a. When assisting with care, residents are supported in exercising their rights. For example, residents are: a. Provided with a dignified dining experience. During a review of the facility's P&P titled, Resident Rights, revised February 2021, the P&P indicated, Employees shall treat all residents with kindness respect and dignity and further indicated: a. Federal and state laws guarantee basic rights to all residents of this facility. These rights include the resident's right to: a. Be treated with respect, kindness and dignity.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure three (3) of seven (7) sampled residents (Residents 6, 10 and 43) had their call light (a signaling device, typically a button, used by patients or residents in a healthcare setting to request assistance from staff) placed within reach under the Environment care area. This failure resulted in Residents 6, 10 and 43 not being able to call for help when they were attempting to reach for their call lights and placed them at risk for experiencing a delay in receiving assistance from facility staff which could have potentially led to a fall or accident. Findings: 1. During a review of Resident 6's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of Colles' Fracture (a break in the distal radius [the larger of the two bones in the forearm] near the write, most often caused by a fall onto an outstretched hand) of right radius and osteoarthritis (a degenerative joint disease that causes pain, stiffness, and swelling as the protective cartilage that cushions bones wears down over time). During a review of Resident 6'S Minimum Data Set (MDS - a resident assessment tool), dated 10/15/2025, the MDS indicated the resident was moderately impaired with cognitive (ability to think, remember, and reason) skills for daily decision making. It indicated Resident 6 needed substantial/maximal assistance (helper does more than half the effort) with chair/bed-to-chair transfers, personal hygiene, putting on/taking off footwear and lower body dressing (the ability to dress and undress below the waist). The MDS also indicated Resident 6 needed partial moderate assistance (helper does less than half the effort) with upper body dressing (the ability to dress and undress above the waist) and needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating. During a review of Resident 6's Care Plan dated 10/2/2025, Resident 6's Care Plan indicated Resident 6 had an activities of daily living (ADL; basic self-care tasks necessary for survival such as bathing, dressing, eating, using the toilet and moving around) self-care and/or mobility performance deficits and included an intervention to place call light within reach. During a concurrent observation and interview on 9/30/2025 at 1:01 PM in the hallway outside of Resident 6's room, Resident 6 was observed waving her hand calling for help. Upon entering Resident 6's room, Resident 6 was observed sitting in her wheelchair to the left of her bed with her call light curled up around itself on the right side of her bed out of Resident 6's reach. Resident 6 stated she needed help with being changed and could not reach her call light to call for help. During a concurrent observation and interview on 9/30/2025 at 1:02 PM with Minimum Data Set Nurse (MDSN) inside Resident 6's room, Resident 6 was observed sitting in her wheelchair on the left side of her bed with her call light curled up around itself on the right side of the resident's bed and out of Resident 6's reach. MDSN stated Resident 6's call light was wrapped around itself on top of the right side of Resident 6's bed and out of Resident 6's reach. MDSN stated the purpose of the call light is for residents to call for assistance with any need they may have. 2. During a review of Resident 10's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of enterocolitis (an inflammation of both the small intestine and the large intestine) due to clostridium difficile (a type of bacteria that can cause a severe intestinal infection leading to diarrhea, fever, and abdominal pain) and pneumonia (an infection of the lungs). During a review of Resident 10'S MDS, dated [DATE], the MDS indicated the resident was severely impaired (difficulty with or unable to make decisions, learn, remember things) with cognitive skills for daily decision making. It indicated Resident 10 was dependent (helper does all of the effort; resident does none of the effort to complete the activity or the assistance of two (2) or more helpers is required for the resident to complete the activity) with upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS also indicated Resident 10 needed substantial/maximal assistance with going from lying to sitting on the side of the bed and rolling left and right in bed. During a review of Resident 10's Care Plan dated 8/9/2025, Resident 10's Care Plan (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated Resident 10 had an ADL self-care and/or mobility performance deficit and indicated an intervention to place call light within reach. During a concurrent observation and interview on 9/30/2025 at 3:16 PM with Licensed Vocational Nurse 2 (LVN 2) inside Resident 10's room, Resident 10 was observed calling out for help with his call light was observed hanging off the right side of the bed with Resident 10 lying down diagonally on the bed with his back towards the right side of the bed's right half side rail and Resident 10's body turned towards the left bottom corner of the. LVN 2 stated Resident 10's call light was out of Resident 10's reach. During an interview on 9/30/2025 at 3:21 PM with LVN 2, LVN 2 stated earlier on 9/30/2025 at 3:16 PM inside Resident 10's room, Resident 10 was calling out for help and his call light was out of his reach & hanging off the right side of the resident's bed. LVN 2 stated the purpose of the call light is for residents to notify staff that the resident need help and if the call light is not within the resident's reach, it poses a risk for the resident to fall if the resident is not able to call the staff to get the help they need. 3. During a review of Resident 43's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of reduced mobility (limited ability to move around independently due to physical, sensory, or cognitive impairments) and lack of coordination (the inability to perform movements smoothly and controlled leading to clumsiness, unsteadiness and poor balance). During a review of Resident 43'S MDS, dated [DATE], the MDS indicated the resident was cognitively intact with cognitive skills for daily decision making. It indicated Resident 43 was dependent with chair/bed-to-chair transfers and needed substantial/maximal assistance with going from sitting to standing, putting on/taking off footwear and lower body dressing. The MDS also indicated Resident 43 needed partial/moderate assistance with upper body dressing and needed setup or clean-up assistance with personal hygiene and eating. During a review of Resident 43's Care Plan dated 8/10/2025, Resident 43's Care Plan indicated Resident 43 had an ADL self-car and/or mobility performance deficit and indicated an intervention to place call light within reach. During a concurrent observation and interview on 9/29/2025 at 10:06 AM with Resident 43 inside her room, Resident 43 was observed lying down in bed with her call light hanging on the left side of the resident's bed and out of reach of Resident 43. Resident 43 stated she could not reach her call light, and she would like someone to help her. During a concurrent observation and interview on 9/29/2025 at 10:08 AM with Registered Nurse Supervisor 1 (RNS 1) and Resident 43 inside Resident 43's room, Resident 43 was observed lying in bed with the resident's call light hanging off the left side of the resident's bed and out of reach of Resident 43. RNS 1 stated Resident 43 was unable to reach the resident's call light and it was out of Resident 43's reach. Resident 43 stated she could not reach her call light and asked for help to get it. During an interview on 10/1/2025 at 10:37 AM with the Director of Nursing (DON), the DON stated the purpose of the resident's call light is for the residents to use it to call for help from the staff. The DON stated if the call light is out of reach, the resident will not be able to call for any assistance with either being changed, needing water or wanting to be transferred back to bed and is a potential risk for the resident/s to attempt to get up on their own and have an accident. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, revised September 2022, the P&P indicated, The purpose of this procedure is to ensure timely responses to the resident's requests and needs, and also indicated to, Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and form the floor.		

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F 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Limit the charges against residents' personal funds for items or services for which payment is made under Medicare or Medicaid. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a charge against one (1) of 24 sampled residents (Resident 79) personal funds was not imposed during the resident's stay at the facility from 4/3/2025 to 6/14/2025. This deficient practice had a potential to result in emotional distress brought about by a financial loss due to Resident 79 not receiving the required reimbursement from the facility. Findings: During a review of Resident 79's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy (a brain disorder caused by a chemical imbalance in the body) and sepsis (a life threatening medical emergency where the body has an overwhelming and extreme inflammatory [body's response to infection] response to an infection which can cause damage to its own tissues and organs). During a review of Resident 79's Minimum Data Set (MDS - a resident assessment tool), dated 4/9/2025, the MDS indicated the resident was severely impaired (difficulty with or unable to make decisions, learn, remember things) with cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 79 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of two [2] or more helpers is required for the resident to complete the activity) with chair/bed-to-chair transfers, personal hygiene, putting on/taking off footwear, and upper and lower body dressing (the ability to dress and undress above and below the waist, and needed substantial/maximal assistance (helper does more than half the effort) with eating. During a review of Resident 79's Resident Account Detail, dated 4/3/2025 to 6/13/2025, Resident 79's Resident Account Detail indicated an ending balance of \$8,170.50. During a concurrent interview and record review on 11/19/2025 at 8:44 AM with Business Office Manager 1 (BOM 1), Resident 79's billing records, dated 4/3/2025 to 6/14/2025 were reviewed. BOM stated Resident 79 was previously at the facility from 4/3/2025 to 6/14/2025 and was admitted under Medicare (the United States [U.S.] federal health insurance program for people age [AGE] and older). During a concurrent interview and record review on 11/19/2025 at 8:51 AM with Business Office Consultant (BOC), Resident 79's billing records dated, 4/3/2025 to 6/14/2025 were reviewed. BOC stated Resident 79 was under Medicare insurance and supplemental insurance (a type of insurance that fills gaps in a primary policy and provides an extra layer of coverage). BOC stated Resident 79 had no share of cost (a monthly dollar amount that some individuals with income over a certain limit must pay towards their medical expenses before their government-sponsored health coverage begins to pay) and her co-payment was covered by her supplemental insurance. During an interview on 11/19/2025 at 8:55 AM with BOM 1 and BOC, BOM stated they were aware that resident 79 was requesting a refund of \$8,170.50 and had reached out to the previous owner via (by) electronic mail (email) of the facility since the facility went under new ownership on 8/1/2025. BOC stated the old owner had told them that they would try to get in touch with Resident 79 and her family and take care of Resident 79's refund. BOC stated she does not know what happened after that. During a concurrent interview and record review on 11/19/2025 at 3:17 PM with BOC, an email thread between BOC, Business Office Manager 2 (BOM 2) and the facility's previous biller was reviewed. The email thread indicated BOC first reached out to the facility's previous biller on 8/13/2025 informing them that Resident 79 was requesting a refund and another email was sent out indicating the same thing to the previous biller on 10/10/2025 from BOM 2. No other email or communication was sent out after 10/10/2025. BOC stated they were first notified that Resident 79 needed a refund in the first or second week of August 2025 and provided the information to the previous biller on 8/13/2025. BOC stated the previous biller had told her that she would reach out to Resident 79's family. BOC stated BOM 2 took over afterwards and sent an email to the previous biller on behalf of Resident 79's family on 10/10/2025 and has since not heard of anything else regarding the matter until 11/19/2025 when (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was informed that Resident 79 had not yet received any refund. During the same interview on 11/19/2025 at 3:17 PM with BOC, BOC stated the normal process when a resident is newly admitted to the facility is to check and verify the resident's insurance and then speak with either the resident or family representative to explain the benefits, what insurance covers and whether there are any co-payments (a payment made by the beneficiary in addition to that made by insurance) or share of cost. BOC also stated that since the last email sent out to the facility's previous biller on 10/10/2025, another follow-up should have been made to ensure Resident 79 received her reimbursement of \$8,170.50. BOC further stated the importance of following up is to make sure the process is being followed and that the residents are getting their requested refunds. During an interview on 11/19/2025 at 3:42 PM with BOM 1, BOM 1 stated on 10/9/2025 she had spoken with Resident 79's family member about the refund and BOM 2 then sent an email to the previous biller on 10/10/2025. BOM 1 stated there was no follow up with Resident 79's family after 10/10/2025 and had assumed the refund was taken care of. During a concurrent interview and record review on 11/19/2025 at 4:02 PM with BOM 1, Resident 79's billing records, dated 4/3/2025 to 6/14/2025 were reviewed. Resident 79's billing records indicated an over payment of \$8,170.50. BOM 1 stated the amount is a total of what Resident 79 was paying for coinsurance (the percentage of costs for a covered healthcare service that is paid after one has met their deductible [the amount of money that must be paid out-of-pocket (spending your own money) for covered services before insurance starts to pay]) out-of-pocket.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review the facility failed to provide a clean, comfortable, and home-like environment for one (1) of 24 sampled residents (Resident 25) by failing to ensure that Resident 25's room has no pool of water beside the resident's bed and the resident's electric fan by the resident's room was not dusty. These deficient practices caused an unsanitary environment and had potential for Resident 25 to be placed at risk for infection and injury. Findings: During a review of Resident 25's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was re admitted on [DATE], with diagnosis of end stage renal disease (ESRD, irreversible kidney failure), dependence on renal (kidney) dialysis (process of removing waste products and excess fluid from the body), and paraplegia (loss of movement and/or sensation, to some degree, of the legs). During a review of Resident 25's Minimum Data Set (MDS- a resident assessment tool), dated 9/1/2025, indicated Resident 25 with modified independence (some difficult in new situations only) in terms of cognitive (ability to think and reason) skills for daily decision making. The MDS indicated Resident 25 required setup or clean up assistance (helper sets up or cleans up, resident completes activity) with eating and oral hygiene. The MDS indicated Resident 25 required partial/moderate assistance (helper does less than half the effort) with upper body dressing. The MDS indicated Resident 25 required substantial/maximal assistance (helper does more than half the effort) with shower, lower body dressing and putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 25 was dependent (helper does all of the effort) with toileting hygiene. During a review of Resident 25's Care Plan (CP) focused on residents' allergic rhinitis, initiated on 8/24/2025, it indicated an intervention to keep room cool and free of irritants (smoke, dust and cleaning agents). During an observation on 9/29/2025 at 1:36 PM in Resident 25's room, a dusty electric fan was observed in front of Resident 25's bed. During a concurrent observation and interview on 9/30/2025 at 9:20 AM in Resident 25's room, a dusty electric fan was observed and pool of water next to Resident 25's bed. Resident 25 warned the surveyor about the pool of water next to Resident 25's bed. Resident 25 stated he had a shower 10 minutes ago and Certified Nurse Assistant 4 (CNA 4) left the room after CNA 4 placed Resident 25 in bed. Resident 25 stated CNA 4 did not clean and dry the floor before leaving the room. CNA 5 entered the room and verified that there is a pool of water on the floor next to Resident 25's bed. CNA 5 stated CNA 4 should not have left the room with pool of water on the floor. During a concurrent observation and interview on 10/1/2025 at 9:37 AM in Resident 25's room, with the Housekeeping Supervisor (HS), the electric fan in the resident's room was observed. The HS verified that the electric fan was dusty. The HS stated it is the housekeeping department who needs to check the cleanliness of the electric fan inside resident's room, and if cleaning is needed, it's the housekeepers who need to report to maintenance department. The HS stated dusty electric fan is not good to use in resident's room because the dust can cause the resident to get sick like coughing. During a concurrent observation and interview on 10/1/2025 at 9:45 AM in Resident 25's room, with Registered Nurse Supervisor 1 (RNS 1), the electric fan was observed. RNS 1 stated the electric fan is dirty, and full of dust. RNS 1 further stated the electric fan should have been cleaned and should not have dust on it because the dust will move to the air and to residents when the electric fan is turned on. RNS 1 stated having a dusty electric fan can make Resident 25 sick such as coughing and shortness of breath. During an interview on 10/1/2025 at 9:48 AM with RNS 1, RNS 1 stated resident's room should always be kept clean. RNS 1 stated the floor of resident's room should remain dry to avoid accidents such as slip or fall because of the pool of water by the resident's bedside. RNS 1 stated CNAs should make sure the resident's room is clean and clutter free before leaving the room. RNS 1 stated leaving pooled of water on the floor after giving Resident 25 a shower is not a homelike environment because it is not safe for the resident, and it (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	looks unsanitary. RNS 1 stated CNA 4 should have told housekeeper to dry the floor and not just leave the room with water on the floor next to Resident 25's room. During a follow up interview on 11/19/2025 at 1:30 PM with CNA 5, CNA 5 stated she remembered the day on 9/30/2025 when pool of water was observed on the floor near Resident 25's bed. CNA 5 stated CNA 4 should have dried the floor before leaving the room because it is not safe and it looks dirty having water on the floor. During a review of Facility's Policy and Procedures (P&P) titled Homelike Environment, revised in February 2021, indicated the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized homelike setting, that included the following: Clean, sanitary and orderly environment. Comfortable and safe temperatures.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure the Low Air Loss mattress (LAL mattress, designed to prevent and treat pressure ulcer [localized damage to the skin and underlying soft tissue caused by prolonged pressure]) for one (1) of four (4) sampled residents (Resident 38) under pressure ulcer care area was set at the correct settings in accordance with the resident's weight. This deficient practice had the potential for Resident to develop new pressure injury. Findings: During a review of Resident 38's admission Record, the admission Record indicated the facility admitted Resident 38 on 10/11/2024. Resident 38's diagnoses included pressure ulcer of unspecified site , lack of coordination, and type 2 diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel). During a review of Resident 38's Minimum Data Set (MDS, standardized care and screening tool), dated 10/17/2025, the MDS indicated Resident 38 was dependent (helper does all the effort) on toileting and needed substantial /maximal assistance (helper does more than half of the effort) for personal hygiene. The MDS also indicated Resident 38 was at risk for developing pressure ulcer/ injuries. The MDS also indicated skin and ulcer/ injury treatment included pressure reducing device for bed and application of ointments/medications. During a record review of Resident 38's Order Summary Report dated 11/18/2025, the Order Summary Report indicated a physician's order dated 11/3/2024 for low air loss mattress to maintain skin integrity. During a record review of Resident 38's Care Plan, dated 9/3/2025, the Care Plan indicated the resident has potential/ at risk for impairment to skin integrity related to impaired mobility and fragile skin. The care plan also indicated that the resident's risk for development of further pressure injury/ ulcers will be reduced through implementation of preventative measures through LAL mattress for skin management. During a record review of Resident 38's Weights and Vitals, dated 11/18/2025, the Weights and Vitals indicated on 11/4/2025 at 9 AM Resident 38's weight was 139 pounds (lbs., to measure weight or mass). During a record review of Resident 38's Braden Scale (an assessment tool used for predicting the risk for developing pressure sores), dated 10/22/2925, the Braden Scale indicated a score of 17, meaning resident was at risk for developing pressure injury. During a concurrent observation in Resident 38's room interview and record review on 11/18/2025 at 9:30 AM with the Registered Nurse Supervisor (RNS 1), Resident 38's weight dated 11/4/2025 entered at 9 AM was reviewed. RNS 1 stated the LAL mattress setting was set at 300 lbs. RNS 1 stated the LAL mattress setting should have been set between 140 to 150 lbs. since Resident 38 weighed 139 lbs on 11/4/2025. RNS 1 also stated that when the LAL mattress was not in the correct setting, it defeats its purpose, and it can cause more harm to resident than prevent pressure ulcer. RNS 1 also stated Resident 28 was at risk for developing pressure injury. During an interview on 11/19/2025 at 2:04 PM with the License Vocational Nurse (LVN 4) LVN 4 stated Resident 38's LAL mattress setting was at 300 lbs and the dial should be set between 140 to 150 lbs. to prevent re-opening of the pressure injury on the sacrococcyx (the fused sacrum and coccyx, or tailbone). LVN 4 also stated that Resident 38 was at high risk for developing pressure injury, which is why the LAL mattress was ordered for wound management, to prevent the development and re-opening of the pressure injury on the resident's sacrococcyx area. During a concurrent interview and record review on 11/19/2025 at 3:02 PM with LVN 5, the facilities Policy and Procedures (P&P), dated 2001, titled, Specialty Mattress- Pressure Relieving Device was reviewed. LVN 5 stated the P&P indicated the purpose of this procedure is to provide guidelines for the appropriate pressure -relieving devices or LAL mattress for resident at risk of skin breakdown. LVN 5 also stated under General Guidelines of the P &P indicated to set the mattress according to the residents' weight when a resident is not able to provide the comfort preference. During a concurrent interview and record review on 11/19/2025 at 3:05 PM with LVN 5, the LAL mattress manufacturer's guide, dated 3/15/2016, titled, Med Aire Plus 8 Alternating Pressure and LAL Mattress Replacement System Operational Manual was reviewed. LVN 5 stated the operational manual indicated the weight setting (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	button, plus (+) and minus (-), can be used to adjust the pressure of the inflated cells (the air pockets in the mattress that fill with air to support the resident's body) based on the patient's weight. LVN 5 also stated the facility did not follow its P&P titled, Specialty Mattress- Pressure Relieving Device and the Med Aire Plus 8 Alternating Pressure and LAL Mattress Replacement System Operational Manual LVN 5 also stated this could possibly cause the development of a pressure injury, or re-opening of Resident 38's pressure injury on Sacrococcyx.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to identify the environment for potential hazard for one of two sample residents (Resident 12) under accidents care area by failing to ensure the floor was dry. This deficient practice had the potential for Resident 12 to sustain injury in an event of a fall due to the wet floor. Findings: During a review of Resident 12's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was re admitted on [DATE], with diagnosis of end stage renal disease (ESRD, irreversible kidney failure), dementia (a progressive state of decline in mental abilities), and generalized anxiety disorder (GAD, is a chronic condition characterized by excessive, persistent worry about everyday things that is difficult to control). During a review of Resident 12's Minimum Data Set (MDS- a resident assessment tool), dated 8/15/2025, the MDS indicated Resident 12's cognitive (ability to think and reason) skills for daily decision making was independent (decisions consistent/reasonable). The MDS indicated Resident 12 required setup or clean up assistance (helper sets up or cleans up, resident completes activity) with eating, oral hygiene, toileting hygiene, shower, lower body dressing, upper body dressing, putting on/taking off footwear, personal hygiene, sit to stand and chair/bed to chair transfer. During a concurrent observation and interview on 9/30/2025 at 9:25 AM in Resident 12's room, Resident 12 was observed sitting on the wheelchair, Resident 12 was observed approaching his side of the bed where there was a pool of water on the floor. Resident 12 stated that he was going to his bed. During an interview on 10/1/2025 at 9:49 AM with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated it was important to keep Resident 12's floor clean, dry and clutter/ accident hazard free because Resident 12 can transfer independently from wheelchair to bed and vice versa. RNS 1 stated there Resident 12 could slip and fall if the floor was wet or with a pool of water RNS 1 also added that the presence of water on the floor was not safe for anyone walking on the area. During an interview on 10/1/2025 at 10:43 AM with the MDS nurse (MDSN), the MDSN stated Resident 12 can transfer from wheelchair to bed with set up assistance. The MDSN stated the staff should set up and provide Resident 12 with safe environment such as clean and dry floor to be able for Resident 12 to perform the transfer safely. MDSN stated a wet floor could place Resident 12 at risk for accidents such as fall incident. During a review of Facility's Policy and Procedure (P&P) titled, Falls and Fall Risk, Managing, revised March 2018, the P&P indicated that based on previous evaluations and current data, the staff will identify interventions related to the resident's risk and causes to try to prevent the resident from falling and to try to minimize complications from falling. It also indicated the following environmental factors that contribute to the risk of falls included wet floors. During a review of Facility's P&P titled Homelike Environment, revised February 2021, the P&P indicated the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized homelike setting, that included clean, sanitary and orderly environment.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide dialysis (process of removing waste products and excess fluid from the body) care and services by failing to assess the resident's left upper arm dialysis access site (surgical or medical creations that allow for blood to be cleaned by a dialysis machine and returned to the body) on 11/11/2025, 11/12/2025, and 11/18/2025 for one of two sampled residents (Resident 25) under dialysis care area, in accordance with the facility policy and physician's order. This deficient practice had the potential for complications such as bleeding or infection on Resident 25's left upper arm arteriovenous (AV) fistula (shunt, a surgically created connection between an artery and a vein, most commonly in the arm, that provides access for hemodialysis when kidneys fail) dialysis access. Findings: During a review of Resident 25's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was re admitted on [DATE], with diagnosis of end stage renal disease (ESRD, irreversible kidney failure), dependence on renal (kidney) dialysis, and paraplegia (loss of movement and/or sensation, to some degree, of the legs). During a review of Resident 25's Minimum Data Set (MDS- a resident assessment tool), dated 9/1/2025, the MDS indicated Resident 25 had modified independence (some difficult in new situations only) in terms of cognitive (ability to think and reason) skills for daily decision making. The MDS indicated Resident 25 required setup or clean up assistance (helper sets up or cleans up, resident completes activity) with eating and oral hygiene. The MDS indicated Resident 25 required partial/moderate assistance (helper does less than half the effort) with upper body dressing. The MDS indicated Resident 25 required substantial/maximal assistance (helper does more than half the effort) with shower, lower body dressing and putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 25 was dependent (helper does all of the effort) with toileting hygiene. The MDS indicated Resident 25 was on hemodialysis treatment while a resident at the facility. During a review of Resident 25's Order Summary Report, dated 10/1/2025, the Order Summary Report indicated an order monitor bruit (whooshing sound heard over an artery, usually with a stethoscope, indicating turbulent blood flow, often due to a narrowing or obstruction) and thrill (palpable vibration felt over an artery, also indicating turbulent blood flow) on left arm AV shunt every shift, ordered on 9/19/2025. During a concurrent record review and interview on 11/18/2025 at 9:27 AM, with Registered Nurse Supervisor 1 (RNS 1), Resident 25's Dialysis Communication Record, dated 11/11/2025, 11/12/2025, and 11/18/2025 were reviewed. RNS 1 stated the forms indicated a blank box for the presence of bruit and thrill, and an incomplete dialysis access site assessment might cause confusion when delivering care to Resident 25. During a concurrent record review and interview on 11/19/2025 at 9:50 AM, with MDS nurse (MDSN), Resident 25's Dialysis Communication Record, dated 11/11/2025, 11/12/2025, and 11/18/2025 were reviewed. The MDSN stated the records were not filled out completely when the resident returned from dialysis on 11/11/2025, 11/12/2025, and 11/18/2025. The post dialysis assessment, which included cognitive status, AV shunt, access site, skin assessment and breathing patterns/breath sounds, was not completed on 11/11/2025, 11/12/2025, and 11/18/2025. The MDSN stated the dialysis communication record for Resident 25 should be completed by the charge nurse upon resident's return from dialysis to know the status of the resident. The MDSN stated it was important to properly assess resident, document accurately, and complete the dialysis communication record to make sure that resident will receive the proper care. The MDSN added resident's who's in hemodialysis might have complications after dialysis that might lead to change of condition and hospitalization. The MDSN stated that without the documentation meant the post dialysis assessment was not done. During an interview on 11/19/2025 at 11:03 AM, Quality Assurance nurse (QAN), stated assessing the resident after dialysis was important to make sure Resident 25's dialysis AV shunt was not bleeding, and ensure Resident 25's vital signs were within normal range after dialysis. QAN added that (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents who had dialysis sometimes come back with low blood pressure because of fluids that were removed from their body and completing and documenting the post dialysis assessment will ensure an intervention can be done if resident has a change of condition. During a review of the facility's policy and procedure (P&P) titled, Access and Care of Hemodialysis Catheters, dated 2001, the P&P indicated care of AV fistula included the following: Check for signs of infection (warmth, redness, tenderness or edema) at the access site when performing routine care at regular intervals. Check the color and temperature of the fingers, and the radial pulse of the access arm when performing routine care and at regular intervals. Check patency of the site at regular intervals. Palpate the site to feel the thrill, or use a stethoscope to hear the whoosh or bruit of blood flow through the access. The P&P indicated if dressing becomes wet, dirty, or not intact, the dressing shall be changed by a licensed nurse trained in this procedure. The P&P also indicated documentation of the following: Condition of dressing. Any part of report from dialysis nurse post-dialysis being given. Observation post-dialysis.		

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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** Based on observation, interview and record review, the facility failed to ensure one (1) of three (3) sampled residents (Resident 17), under food care area, was provided with a meal tray that did not contain a food the resident was allergic to. This failure had the potential to result in Resident 17 experiencing an allergic reaction such as anaphylaxis (a severe, whole-body allergic reaction that happens quickly and is life-threatening). Findings: During a review of Resident 17's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of morbid (severe) obesity (a chronic condition characterized by an excessive accumulation of body fat that poses a risk to health) due to excess calories (the energy content of food and drink) and lack of coordination (the inability to control and organize the movement of different parts of the body, resulting in movements that are awkward, unsteady and clumsy). Resident 17's admission Record also indicated, Resident 17 had an allergy to eggs. During a review of Resident 17's Minimum Data Set (MDS - a resident assessment tool), dated 7/18/2025, the MDS indicated the resident was cognitively intact (ability to think, remember, and reason) with cognitive skills for daily decision making. It indicated Resident 17 was dependent (helper does all of the effort; resident does none of the effort to complete the activity) with chair/bed-to-chair transfers (the ability to transfer to and from a bed to chair [or wheelchair]), going from lying to sitting on side of the bed, rolling left and right in bed, lower body dressing (the ability to dress and undress below the waist), and putting on/taking off footwear. The MDS also indicated Resident 17 needed partial/moderate assistance (helper does less than half the effort) with upper body dressing (the ability to dress and undress above the waist) and needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating and personal hygiene. During a review of Resident 17's Care Plan dated 10/4/2025, Resident 17's Care Plan indicated a food allergy to eggs with interventions including: a. Consult with the dietician to make sure foods served to resident are free of allergens. b. Instruct the resident and family in avoiding allergens. c. Make sure the resident's allergies are well documented throughout the chart, medication records, menu cards, dietary records, and all other pertinent documents. d. Make sure that all necessary staff members are alerted to the resident's allergies. e. Observe for signs and symptoms of allergic reaction. f. Offer food alternatives to replace foods resident is allergic to. During a concurrent interview and record review on 9/29/2025 at 9:29 AM with Resident 17 in her room, a picture of Resident 17's meal tray containing a piece of egg on her plate taken on Resident 17's phone dated 8/22/2025 at 7:19 AM was reviewed. Resident 17 stated she notified staff to show them the egg and reminded them that she was allergic to eggs. Resident 17 stated nothing else happened and that she could have died if she consumed it since she is allergic to eggs. During a concurrent interview & record review on 9/29/2025 at 9:31 AM with Resident 17 in her room, a picture of Resident 17's meal tray containing a salad and a hard-boiled egg cut in half taken on Resident 17's phone dated 9/20/2025 at 5:08 PM was reviewed. Resident 17 stated her egg allergy is listed on her meal tray/ card and she notified her Certified Nursing Assistant (CNA) that night and asked her to bring her a fresh plate with no egg. During an interview on 11/18/2025 with Resident 17, Resident 17 stated the incidents that happened where she received her meal tray with egg on 8/22/2025 and 9/20/2025 made her feel like no one cared about her. During a concurrent interview and record review on 11/18/2025 at 12:42 PM with Dietary Supervisor (DS), Resident 17's phone picture dated 8/22/2025 and 9/20/2025 showing Resident 17's meal trays containing eggs were reviewed. DS verified in both pictures, egg was observed on Resident 17's plate. DS stated when residents have an allergy, it is printed on an allergy spreadsheet that is checked for accuracy and there is also a paper indicating the resident's allergy on their meal tray and all meal trays are doubled checked before serving to the resident. DS stated it was not acceptable for Resident 17 to have (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	received egg on both of her meal trays on 8/22/2025 and 9/20/2025 because she could have had an allergic reaction if she had eaten it or any food on the tray that had cross-contamination (the transfer of harmful substances like bacteria or allergens from one surface, food, or person to another).During an interview on 11/19/2025 at 4:55 PM with the Director of Nursing, the DON stated Resident 17 should not have received any tray containing any food the resident was allergic to on her plate because she could have potentially had an allergic reaction. During a review of the facility's policy and procedure (P&P) titled, Food Allergies and Intolerances, revised August 2017, the P&P indicated, Resident with food allergies and/or intolerances are identified upon admission and offered food substitutions of similar appeal and nutritional value. Steps are taken to prevent resident exposure to allergen(s). The P&P also indicated: a. Meals for residents with severe food allergies are specially prepared so that cross-contamination with allergens does not occur. b. Residents with food intolerances and allergies are offered appropriate substitution for foods that they cannot eat.		

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NAME OF PROVIDER OR SUPPLIER Pasadena Palace Tcu		STREET ADDRESS, CITY, STATE, ZIP CODE 716 South Fair Oaks Ave Pasadena, CA 91105	
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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose garbage and refuse (disposable material, which includes both recyclable and non-recyclable material) from the kitchen properly when the designated green kitchen dumpster (a movable waste container designed to be brought and taken away by a special collection vehicle) was observed overfilled with a lid covering it halfway. This failure had the potential to result in the attraction and spread of vermin (animals that are believed to be harmful, or that carry diseases, e.g., rodent's parasitic worms or insects) that could potentially infiltrate the facility, affect the resident care areas and pose a threat to residents of the facility. Findings: During a concurrent observation and interview on 9/30/2025 at 10:49 AM with dietary aide 1 (DA 1), a kitchen green dumpster was observed at the back of the facility. The kitchen green dumpster was observed to be overflowing, and the dumpster lid cover was halfway open. DA 1 stated the dumpster's lid was not and should be closed. DA 1 stated, The dumpster is full and overflowing, that is why the lid cannot be closed. During an interview on 11/18/2025 at 2:32 PM with the Dietary Supervisor 3 (DS 3), DS 3 stated that overflowing dumpster was not acceptable. DS 3 stated trash needs to be entirely inside the dumpster, and lid should be properly closed to prevent attraction of rats, insects like ants, or fly. DS 3 stated, Rats and insects that carry diseases might go inside the facility and cause harm to residents. During record review of the facility's Policy and Procedure titled, Sanitation and Infection Control, dated 2011, indicated to keep lids of outside trash dumpsters closed.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure the ice machine drainage has an air gap (a vertical, unobstructed space between the ice machine's drain and the building's drainage system that prevents contaminated drain water from flowing back into the machine's clean water supply. It is a safety feature, often a simple pipe fitting or a dedicated device, that acts as a barrier, with the most common requirement being a 1-2 inch gap to comply with health and plumbing codes) to ensure no contact with outside contaminated (unfit for use, or unsafe) source as indicated in facility's policy and procedures (P&P). This deficient practice had the potential to result in backflow of contaminated water back to the ice machine and had the potential to result in pathogen (germ) exposure to residents, which could place the residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever) and can lead to other serious medical complications and hospitalization. During an observation on 11/19/2025 at 8 AM, ice machine was observed inside the utility room across nursing station 2. During a concurrent observation and interview on 11/19/2025 at 8:31 AM with Dietary Supervisor 3 (DS 3), ice machine inside the utility room was observed. There was no air gap observed from the ice machine's drainage. DS 3 stated the ice machine's drainage has no air gap because it is connected to other pipes for drain. DS 3 stated usually ice machine drainage host has an air gap to the floor drain to prevent water from backing up from the machine. DS 3 also stated there is water dripping from the pipe. During a concurrent observation and interview on 11/19/2025 at 8:40 AM with the Maintenance Supervisor (MS), the ice machine was observed. MS stated ice machine was moved to the utility room a month ago. MS stated the drain is a closed system, where in the ice machine drainage hose is connected to a water storage bin that collects water, and as soon as it reaches the water level, there is a pump in the water storage bin that will turn on to pump the water up to the black pipe that is four feet (unit of measurement) above the pump. MS stated all the hose, water storage bin and pipes are all connected with no air gap. MS stated the water dripping from the black pipe is a result of condensation (when a gas turns to a liquid) from the water that is inside the pipe. During the exit conference on 11/19/2025 at 5 PM, the facility's Administrator stated, it is the regulation for the ice machine to have an air gap. During a review of facility's P&P titled Ice Handling, dated 2011, it indicated the ice will be dispensed through an ice machine which has no contact with outside contaminated source (human contact or unsanitary water source.) The P&P also indicated water filters on ice machines should be checked and maintained on a routine basis by the maintenance department and the exterior of the ice machine will be cleaned and sanitized weekly. During a review of facility's P&P titled Food Receiving and storage, revised in November 2022, it indicated food services, or other designated staff, maintain clean and temperature/humidity-appropriate food storage areas at all times. It also indicated food may not be stored under leaking water lines, or under lines on which water has condensed.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to ensure the facility's staffing information was posted and placed in a visible and prominent area on 9/27/2025, 9/28/2025, and 9/29/2025 in accordance with the facility's policies and procedures (P&P). This deficient practice had the potential for the residents and not to be informed of the actual number of nurses providing direct care to the residents. Findings: During an observation, on 9/29/2025 at 8:24 AM, staffing information, dated 9/26/2025, was posted in the hallway near the nursing station. During a concurrent observation and interview on 9/29/2025 at 9:35 AM with Registered Nurse Supervisor 1 (RNS 1), the posted staffing information dated 9/26/2025 was reviewed. RNS 1 verified that the staffing information that was currently posted was dated 9/26/2025. RNS 1 stated the staffing information over the weekend and for today, 9/29/2025 were not posted. RNS 1 stated the staffing information that includes number of scheduled staff should be posted every day. During an interview on 10/1/2025 at 9:30 AM with the Director of Staff Development (DSD), the DSD stated she did not know why the staffing information she printed for 9/27/2025, 9/28/2025 and 9/29/2025 was not posted in the hallway. The DSD stated the printed staffing information was left in the binder and was not posted. The DSD stated that it is important to post the staffing information that consists of the census (the total number of residents living in the facility), the total number of RN, Licensed Vocational Nurses (LVNs) and Certified Nursing Assistants (CNAs) working each shift. DSD added that this posting should be easily seen and read by residents, visitors, and staff. During a review of Facility's P&P titled Posting Direct Care Daily Staffing Numbers, revised on August 2022, the P&P indicated facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents (means that individuals are responsible for residents' total care or some aspect of the residents' care including, but not limited to, assisting with activities of daily living ([ADLs]), giving medications, supervising care given by CNAs, and performing nursing assessments to admit residents or notify physicians of changes of condition).		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 11 of 31 resident rooms (rooms 12, 14, 15, 16, 17, 21, 22, 23, 24, 25 & 26) met the square footage requirement of 80 square feet (sq. ft.) per resident in a multiple resident room. This failure had the potential to affect the residents' personal space, decrease freedom of mobility and could compromise the provision of care.During the initial observation on 9/29/2025 from 9:00 AM to 11:00 AM, rooms 12, 14, 15, 16, 17, 21, 22, 23, 24, 25 and 26 did not meet the minimum requirement of 80 sq. ft. per resident. The residents in these rooms were able to ambulate and/or move around in their wheelchairs freely. Nursing staff were observed to have enough space to provide safe quality care and there was enough space for beds, side tables, dressers and other medical equipment. During a review of the facility's Room Waiver, dated 9/29/2025, the facility's Room Waiver indicated the rooms with 3 beds are in accordance with the needs of the residents with adequate space and do not have any adverse effects on the residents' health and safety. The facility's room also indicated the following: Room Sq. Ft. Bedroom [ROOM NUMBER] - 228 sq. ft. - 3 bedroom [ROOM NUMBER] - 228 sq. ft. - 3 bedroom [ROOM NUMBER] - 228 sq. ft. - 3 bedroom [ROOM NUMBER] - 228 sq. ft. - 3 bedroom [ROOM NUMBER] - 228 sq. ft. - 3 bedroom [ROOM NUMBER] - 228 sq. ft. - 3 bedroom [ROOM NUMBER] - 228 sq. ft. - 3 bedroom [ROOM NUMBER] - 228 sq. ft. - 3 bedroom [ROOM NUMBER] - 228 sq. ft. - 3 bedroomThe minimum square footage for a 3-bedroom is 240 sq. ft. During an interview on 11/19/2025 at 2:38 PM with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated there is enough room for him to provide care to the residents safely in all the resident's rooms. During an interview on 11/19/2025 at 2:42 PM with CNA 2, CNA 2 stated that all the resident's rooms at the facility have enough room for her to provide proper and safe care to the residents. During interviews with residents both individually and collectively, they did not express any concerns regarding the size of their rooms.		