STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555893	A. Building B. Wing	10/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pasadena Nursing Center	1570 North Fair Oaks Ave Pasadena, CA 91103

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to ensure that the facility followed proper food handling practices in accordance with the professional standards for food service safety (the rules, regulations, and guidelines that ensure food is handled, prepared, and stored to prevent foodborne illnesses [also known as food poisoning, it is a condition that occurs when consuming contaminated food or beverages]) such as prevention of cross-contamination, maintaining equipment and surfaces in clean, sanitary condition, by failing to:1. Ensure the facility did not prepare the residents' meals in the facility's kitchen with a large gaping hole that measured three (3) feet (ft.- unit of measurement) by four (4) ft. from the kitchen ceiling exposing, dry wall, pipes, wood framings, and a bent steel panel for light fixture hanging over the food tray transport rack with food trays ready to be served to the 50 of 51 residents who are receiving food prepared in the facility's kitchen, resulting from a water leak and with persistent water leak in other sections of the kitchen ceiling on 10/18/2025 in the morning.2. Create and implement a kitchen emergency plan that includes the facility's plan if kitchen is under construction and/or is deemed not safe to be used to prepare the residents' meals. This deficient practice had the potential for the 50 residents to experience foodborne illness from ingesting food contaminants from debris, dust, or water from the ceiling that can fall into food, cooking equipment, or on preparation surfaces in the kitchen which can lead to serious sickness and/ or death. Findings:During an interview on 10/17/2025, at 6 PM, the Assistant Director of Nursing (ADON) confirmed that the facility's kitchen's ceiling had a leak and believed it started two (2) days ago around 10/15/2025. The ADON stated the facility's kitchen was still being utilized for food preparation for the residents. During an interview on 10/17/2025, at 6:31 PM, the Maintenance Supervisor (MS) stated the leak on the kitchen ceiling started on Friday 10/10/2025. MS stated a part of the kitchen's ceiling and drywall was removed by the plumbers but did not know when exactly it was removed. During an observation of the facility's kitchen on 10/18/2025 at 7AM, during a tour of the facility's kitchen, a large gaping hole in the kitchen ceiling with exposed pipes, hanging drywall, wood framings, and a bent steel panel for light fixture hanging over the hand washing sink, food tray transport rack and approximately five feet away from the stove and food preparation area was observed. On the opposite side of the kitchen, there were two metal pans, and multiple wet towels on the floor that were visibly wet and catching the leak from the ceiling. During an observation on 10/18/2025, at 7:08 AM, the Kitchen staff had already prepared the residents' breakfast, and the residents' food was on the food trays and placed in the food tray transport rack and was being taken up to resident's rooms. The Kitchen staff were observed pushing the food tray transport rack and walking under the large gaping hole in the kitchen ceiling with exposed pipes, hanging drywall, wood framings, and a bent steel panel for light fixture to leave the kitchen. Observed there was a red plastic food tray connected to a portion of the large gaping hole in the kitchen ceiling and hanging above the handwashing catching a small leak and dripping into a gray trash bin. On the opposite side of the kitchen, there was a second leak that was dripping in a yellow trash bin. During an interview on 10/18/2025, at 7:15 AM, the ADMN stated the water leak found in the facility kitchen ceiling was first noticed on 10/10/2025. ADMN stated, Plumber Company staff 1 (PC1) came to the facility on [DATE] to repair leaks in kitchen, and it was PC 1 who opened the kitchen ceiling to determine the cause of the leak. ADMN stated PC1 does not repair drywall, so he had to get another company (PC2) to fix the ceiling. During an interview on 10/18/2025, at 7:45am, ADMN confirmed the facility continued to use their kitchen for resident food preparation including the residents' breakfast on 10/18/2025. ADMN stated the facility has 50 residents who are receiving their food prepared in the facility kitchen out of their 51 residents. ADMN stated he asked the plumber (did not specify if PC1 or PC2) if it was still safe to use the kitchen and the plumber told the ADMN yes. ADMN stated, ADMN did not consult any outside company or the facility's Dietary Supervisor (DS) to confirm if it was safe to use the facility's kitchen to prepare the residents' food and felt that expertise of plumbers was enough. During an interview on 10/18/2025, at 7:5 AM, PC1 stated they came out on 10/11/2025, discovered a leak in the facility's kitchen ceiling, and they opened the ceiling to expose the leaking pipe which created the large gaping hole over the hand washing sink. PC 1 stated PC 1 repaired the leak and placed a plastic tarpaulin (plastic tarp) over the large gaping hole. PC1 stated that it was safe to prepare the residents' food with the plastic tarp covering the large gaping hole on the kitchen's ceiling but does not know if it is safe to prepare the residents' food if the large gaping hole is not covered. During an interview on 10/18/2025, at 8:04 AM