STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555908	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER South Pasadena Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 904 Mission St South Pasadena, CA 91030	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, the facility failed to ensure a safe environment free of accident hazards by not preventing smoke from entering the facility hallway leading to the front lobby as a result of a burnt Heating, Ventilation, and Air Conditioning unit's (HVAC unit, is a comprehensive system designed to regulate indoor temperature, humidity, and air quality) filter on 1/10/2026. This deficient practice had the potential to place residents, visitors, and staff at risk for smoke inhalation (damage caused to the respiratory system, airways, and lungs by breathing in harmful combustion products [smoke] from fires) which could result in respiratory irritation, including coughing, shortness of breath, and complications such as airway swelling, reduce amount of oxygen to the body, hospitalization, and death. Findings:During a telephone interview on 1/13/2026 at 5:33 PM with the Director of Nursing, the DON stated Registered Nurse 1 (RN 1) notified him on 1/10/2026 at 10:59 AM that they had noticed smoke inside the facility along the hallway leading to the facility lobby. The DON further stated paramedics (healthcare professionals trained to provide emergency medical care to individuals who are injured or ill) were in the facility to respond to a 911 (emergency telephone number to quickly connect callers to emergency services) call for a resident with change of condition when the paramedics noticed smoke in the building. The DON also stated the smoke detector did not alarm.During an interview on 1/14/2026 at 11:42 AM with Maintenance Director (MD), MD stated on 1/10/2026 at 11:15 AM, Maintenance Staff (MS) called and informed him that there was smoke inside the facility. Later, on 1/10/2026 at 11:26 AM, MS also reported that there was a smell of smoke in the hallway, which was coming from the ceiling vent connected to HVAC unit 15.During a concurrent observation and interview on 1/14/2026 at 11:47 AM with the facility's Administrator (ADM), the HVAC unit 15's filter was observed to be partially burnt. The ADM stated the filter caught fire while workers were torching (to deliberately set something on fire) the facility's roof. The ADM further explained that the torch used to patch the roof ignited in flame, causing the HVAC filter to catch fire, and the smoke immediately travelled down the vent.During an interview on 1/14/2026 at 1:24 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated that on 1/10/2026 (unable to recall the time), she smelled something burnt but did not see smoke. LVN 1 stated that an announcement was made to shut all residents' doors. LVN 1 stated shutting the residents' doors would help prevent smoke inhalation, which was harmful to residents as it can cause respiratory distress.During an interview on 1/14/2026 at 1:41 PM with LVN 2, LVN 2 stated that on 1/10/2026 (unable to recall the time), she smelled something burning inside the facility but did not see smoke. LVN 2 stated she did not hear the smoke detector alarm. LVN 2 stated that paramedics helped address the situation by turning on fans in the hallway and opening the facility's front door.During an interview on 1/14/2026 at 1:55 PM with LVN 3, LVN 3 stated that on 1/10/2026, he smelled a faint odor of some type of fumes in the hallway.During an interview on 1/14/2026 at 2:13 PM with MS, MS stated that on 1/10/2026 at 10:58 AM, he received a call from the facility's receptionist reporting that the facility (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	smelled of smoke. MS stated that he briefly went inside the facility, then went up to the roof and saw that the filter of HVAC unit 15 was partially burnt. MS added that the workers on the roof told him the filter had caught fire.During an interview on 1/14/2026 at 2:56 PM with the Activity Director (AD), AD stated that on 1/10/2026, before 11 AM, she saw haze in the hallway and heard staff saying there was smoke.During an interview on 1/14/2026 at 3:23 PM with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated that on 1/10/2026 (unable to recall the time), CNA1 observed smoke in the hallway coming from the ceiling and smelled something like burnt plastic.During an interview on 1/14/2026 at 4:41 PM with the facility's receptionist, she stated that on 1/10/2026 (unable to recall the time), while she was in the front lobby, she smelled something burning and then saw a hazy, foggy appearance in the hallway. The Receptionist stated that Registered Nurse 2 (RN 2) announced that all residents' doors should be closed.During an interview on 1/14/2026 at 5:15 PM with the DON, the DON stated that on 1/10/2026 at 10:59 AM, RN 1 called him to report that there was smoke inside the facility. The DON stated that having smoke inside the facility is not safe for residents and added that smoke inhalation is harmful to anyone because it can cause shortness of breath, which may lead to hospitalization for residents with underlying respiratory conditions.During a review of facility's Policy and Procedure (P&P) titled, Accidents/Incidents, dated May 2018, the P&P indicated facility shall provide a safe and secure environment for staff and residents.