

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055504	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER Overland Terrace Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 3515 Overland Avenue Los Angeles, CA 90034	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement their policy regarding reporting resident to resident's allegation of physical abuse and to submit a conclusion report of investigation within five days or in accordance with state or federal law for two of six sampled residents (Resident 1 and Resident 2). This resulted in a delay of an onsite inspection by the Department of Public Health to ensure the residents' allegation of abuse was investigated which can also lead to a delay in prevention of further physical abuse for Resident 1. Findings: A. During a review of Resident 1's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia and hemiparesis (loss of the ability to move in one side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting left dominant side, dysphagia (difficulty swallowing) following cerebral infarction and heart failure (a condition in which the heart does not pump blood as well as it should). During a review of Resident 1's Minimum Data Set (MDS - resident assessment tool) dated 3/24/2026, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired for daily decision-making and required maximal assistance to dependent from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 4/10/2026, the SBAR indicated, Other resident (Resident 2) accidentally bumped into his right face hitting his right upper cheek, the other resident (Resident 2) apologetic for what had happened. During a concurrent observation and interview with Resident 1 on 4/16/2026 at 12:55 p.m., Resident 1 stated, Resident 2 was yelling and arguing with him and hit (Resident 2) hit him on his face. Resident 1 did a hand gesture of how Resident 2's both fist hit him on his face. Resident 1 stated, Resident 2 ended up on top of his bed after he had tried to push the bedside table to push Resident 2 away from him. Resident 1 stated, there was no staff around when it happened and he explained what happened to the staff. During an interview with Licensed Vocational Nurse 1 (LVN 1) on 4/16/2026 at 1:23 p.m., LVN 1 stated, on 4/10/2026, Resident 2 came back from out on pass and was yelling and walking wobbly. LVN 1 stated, I could smell alcohol from Resident 2. LVN 1 stated, he assumed it was alcohol as Resident 2 came back holding a brown paper bag with a can inside. LVN 1 stated, he had asked Resident 2 to go back inside his room, where Resident 1 was in the same room as his (Resident 2). LVN 1 stated, he then heard a loud crashing sound inside Resident 2's room and when he went inside, he found Resident 2 on top of Resident 1. LVN 1 stated, he then saw Resident 1 with a black eye after that incident. LVN 1 stated, he asked Resident 1 what happened, where Resident 1 stated, he (Resident 2) fell on top me and Resident 1 asked him not to let him go back to his room. LVN 1 stated, he did not witness what happened and Resident 2 was unable to explain exactly what happened because he was intoxicated. LVN 1 stated, he reported the incident to Registered Nurse 1 (RN 1). B. (continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a chemical imbalance in the blood affecting the brain), respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) and type II Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognition was moderately impaired for daily decision-making and required setup assistance to dependent from staff for ADLs. During a review of Resident 2's Progress Notes (PN), dated 4/10/2026, the PN indicated, Resident (2) from out on pass, resident walked in started screaming, yelling in the dining room by himself. he (Resident 2) started cursing at the staff nurses. Resident (2) was walking towards his bed that resident accidentally able to grabbed the bedside table for support but then resident (2) elbow touched other neighbor resident's (1) right cheek. staff able to support resident to prevent fall. During a concurrent interview and record review with RN 1 on 4/16/2026 at 1:57 p.m., RN 1 stated, on 4/10/2026, LVN 1 reported to her that Resident 2 was intoxicated and found Resident 2 on top of Resident 1. RN 1 stated, Resident 1's face was red when she assessed her. RN 1 stated, she documented that when Resident 2 went inside the room, Resident 2 was able to grab the bedside table for support but resident (2)'s elbow accidentally touched other neighbor (Resident 1)'s right cheek. RN 1 stated, she did not witness that Resident 2's elbow accidentally touched Resident 1's right cheek. RN 1 stated, she should not have documented it that way and she should have investigated that incident further. During an interview with Administrator (ADM) on 4/16/2026 at 2:51 p.m., ADM stated, he was not in the facility when the incident happened. ADM stated, he had just seen Resident 1 and he had a black eye on his right eye. ADM stated, he have to further investigate the incident and will interview staff and residents. A review of the facility's policy and procedures (P&P) titled, Abuse Prevention and Management, reviewed on 1/2026, the P&P indicated, When the Administrator or designated representative receives a report of an allegation of resident abuse, mistreatment, neglect. the Administrator or designated representative, will initiate an investigation immediately. The administrator or designated representative conducting the investigation will interview individuals who may have information relevant to the allegation or suspected crime. the Administrator or designated representative will notify law enforcement by telephone immediately, or as soon as practicably possible, but no longer than (2) hours of an initial report and send a written SOC341 report to the Ombudsman, Law Enforcement, and CDPH Licensing and Certification within two hours.</p>		