

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/30/2026
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)		
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the policy for pressure ulcer/injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) care assessment and treatment was followed, for one of three sampled residents (Resident 1) by failing to:Identify and document the pressure ulcer upon re-admission to the facility.Document a change of condition once the pressure ulcer was identified.Contact the resident's responsible party upon identification of a new pressure ulcer.Implement a low air-loss mattress (pressure ulcer intervention) in a timely manner after pressure ulcer was identified.These deficient practices resulted in Resident 1 having a delay in assessment, treatment and interventions for the sacrococcyx (area including the sacrum, large, triangular bone at the base of the spine and the coccyx the tailbone) pressure ulcer identified six days after re-admission from hospitalization on 5/8/26.1. During a review of Resident 1's admission Record, dated 6/30/28 indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), anemia (a condition where the body does not have enough healthy red blood cells), hypertension, (HTN - high blood pressure), muscle weakness, hyperlipidemia (HLD - a condition characterized by elevated levels of lipids (fats) in the bloodstream), vascular dementia (decline in thinking, reasoning, and memory caused by decreased blood flow to the brain), chronic kidney disease (CKD - progressive damage to kidneys reducing their ability to function), metabolic encephalopathy (dysfunction caused by chemical imbalances in the brain), dysphagia (difficulty swallowing), and muscle weakness. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 5/15/26 indicated, Resident 1 had severe cognitive (function of the mind, related to thinking memory, problem-solving, decision making, judgement) impairment and was totally dependent on staff for bed mobility, transfers and activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), and the resident was at risk for pressure ulcers. During a review of Resident 1's hospital physician transfer notes and orders dated 5/8/26 indicated the resident had wounds on the right 4th toe with order of betadine daily and one on the left leg which had an ordered treatment of collagenase (an enzyme that specifically breaks down collagen, a structural protein found in connective tissues like skin, bone, and tendons) (Santyl) ointment topical daily to left leg, first dose 5/2/26. During a review of Resident 1's Clinical Admission note dated 5/8/26, no documentation of a sacrococcyx pressure ulcer noted.During a review of Resident 1's Skin Check note dated 5/10/26, no documentation of a sacrococcyx pressure ulcer noted.During a review of Resident 1's Long Term Care Evaluation note dated 5/10/26, no documentation of a sacrococcyx pressure ulcer noted.During a review of Resident 1's Skin Issues note dated 5/14/26, no documentation of a sacrococcyx pressure ulcer noted.During a review of Resident 1's IDT (interdisciplinary team) Progress notes - Skin dated 5/15/26 indicated IDT done for left shin diabetic ulcer resolved and 4th toe with stable gangrene - again no documentation of a sacrococcyx pressure ulcer.During a review of Resident 1's Long Term Care Evaluation note dated 5/17/26, no documentation of a sacrococcyx pressure ulcer noted.During a review of Resident 1's Skin Issues (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	note dated 5/20/26 indicated the first time the sacrococcyx pressure ulcer was documented, as unstageable (wound covered by dead tissue that which one cannot see the depth and underlying tissues). During a concurrent telephone interview on 6/30/26 at 3:45 pm with Treatment Nurse (TXN) 2 Resident 1's nursing progress notes above were reviewed. TXN verified she had not documented the pressure ulcer on admission because she does not stage the wounds and stated when the wound care specialist saw the resident on 5/13/26 he said it was an unstageable pressure ulcer. TXN 2 further stated the Registered Nurse does the admission assessment, and does not know why the pressure ulcer was not captured on her assessment. During a concurrent interview and record review with Registered Nurse (RN), 1 on 6/30/26 at 2:26 pm, Resident 1's admission summary note dated 5/8/26 was reviewed, the summary indicated resident re-admitted from hospital Has right foot fourth toe dry with skin gangrene, left lower leg shin diabetic skin ulcers with dressing dry and intact noted. RN 1 verified this and stated she noted the resident came from the hospital without a documented or endorsed (verbal report) of any pressure ulcer, in contradiction to the TXN 2's account the resident arrived with the pressure ulcer. During a telephone interview with the Director of Nursing (DON), on 7/7/26 at 3:49 pm, the above documentation omissions were discussed and the DON acknowledged there was no documentation of a sacrococcyx pressure ulcer done upon admission, so it is not possible to know when it was identified. DON agreed the treatment nurse should have documented something in the resident's chart upon the admission before the day the wound care specialist Physician's Assistant documented their consult note on 5/13/26, and it was within her scope to document and describe the pressure ulcer. 2. During a review of Resident 1's Wound Assessment documented by Physician's Assistant (PA) 1 indicated Consult on hospital acquired unstageable PU to sacrococcyx. During a review of Resident 1's Skin Issues note dated 5/20/26 indicated the first time the sacrococcyx pressure ulcer was documented by a nurse. During a concurrent interview and record review with Registered Nurse (RN) 1 on 6/30/26 at 2:26 pm, the above notes were reviewed. RN 1 verified and stated a change of condition should be done for any new changes on the resident. 3. During a review of Resident 1's care plan titled: The resident has potential for pressure ulcer development r/t decreased mobility, use of anticoagulants (medication that prevents or slows down blood clotting)/antiplatelet (blood thinner, prevents clotting factors in the blood from clumping together and clot) to medication revised 6/8/26 indicated 5/27/26 Resident has an unstageable wound to sacrococcyx. Educate the resident/family/caregivers as to causes of skin breakdown. 5/27/26 low air loss mattress for skin management. inform the resident/family/caregivers of any new area of skin breakdown. During an interview with RN 1 on 6/30/26 at 2:26 pm the RN 1 stated there were various times she and the other staff spoke with the Responsible Party (RP) to inform them of the resident's care but they did not document it but should have to record it. During a review of the facility's policy and procedures (P&P) titled Pressure Injury Prevention, reviewed January 2026, the P&P indicated a skin evaluation upon admission/re-admission, weekly for four consecutive weeks after admission, quarterly and when there is a significant change in condition. A weekly skin check will be completed and documented in the medical record. During a review of the facility's P&P titled Skin Integrity Management, reviewed January 2026, the P&P indicated Assessments. A Licensed Nurse will complete a skin evaluation when there is a change in skin integrity. The physician and responsible party will be notified when there is a change of condition of the pressure injury or skin integrity condition. Review the resident's care plan and update as necessary. 4. During a review of Resident 1's Wound Assessment documented by Physician's Assistant (PA) 1 indicated Consult on hospital acquired unstageable PU to sacrococcyx. During a review of Resident 1's Order Summary Report dated from 4/1/26 - 6/30/26 indicated an order entered on 5/19/25 for Low air loss mattress for skin management. every shift for skin and wound management. During a review of Resident 1's care plan titled: The resident has potential for pressure ulcer development r/t decreased mobility, use of anticoagulants (medication that prevents or slows down blood clotting)/antiplatelet (blood thinner, prevents clotting factors in the blood from clumping together and clot) to medication revised 6/8/26 (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated 5/27/26 Resident has an unstageable wound to sacrococcyx. Educate the resident/family/caregivers as to causes of skin breakdown. 5/27/26 low air loss mattress for skin management. inform the resident/family/caregivers of any new area of skin breakdown. During a telephone interview on 6/30/26 at 3:45 pm with TXN 2. TXN verified the resident records above and stated there was not a delay in implementing the intervention of the low air loss mattress for skin management on the resident even though the resident was assessed with pressure ulcer on 5/13/26 and the mattress was not ordered until 5/19/26, contradicting herself she further stated however that interventions on the care plan should be followed. During a review of the facility's P&P titled Pressure Injury Prevention reviewed January 2026, the P&P indicated, implement interventions identified in the plan of care for the resident's risk factors. Implement interventions identified in the plan of care which may include, but are not limited to the following. Pressure redistributing devices for bed and chair.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure staff followed infection prevention policies and procedures for Enhanced Barrier Precautions (use of personal protective equipment, PPE [gloves, gown, mask and goggles or face shield] when providing wound care to a resident where EBP was indicated for one of three sampled residents (Resident 2). This deficient practice had the potential to result in exposure or transmission of infections to other residents and/or staff. During a review of Resident 2's admission Record, dated 6/30/26, the admission record indicated, the resident was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), anemia (a condition where the body does not have enough healthy red blood cells), hypertension, (HTN - high blood pressure), muscle weakness, hyperlipidemia (HLD - a condition characterized by elevated levels of lipids (fats) in the bloodstream), and peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs). During a review of Resident 2's History and Physical (H&P), dated 1/1/26 indicated, the resident had capacity for medical decision making. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 4/6/26 indicated, resident 2 was independent to requiring supervision from staff for most 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 2's Order Summary Report, dated 6/30/26 indicated an order for wound care of Santyl external ointment 250 unit/gram (Collagenase - an enzyme that specifically breaks down collagen, a structural protein found in connective tissues like skin, bone, and tendons), apply to right anterior ankle every day shift. Cleanse with normal saline (NS - a sterile mixture of salt and water containing exactly 0.9% sodium chloride) pat dry apply Santyl ointment cover with dressing ad wrap with ACE wrap daily and as needed (PRN). During an observation on 6/30/26, at 10:45 am outside Resident 2's room there was signage posted indicating Resident 2 to be on EBP and an isolation cart stocked with gloves, gowns and surgical masks. Further observation at Resident 2's bedside Treatment Nurse (TXN) 1 was observed providing wound care to Resident 2 without donning (putting on) a gown. During a concurrent observation and interview on 6/30/26 at 2:20 pm, outside Resident 2's room with TXN 1, the Enhanced Barrier Precautions sign (undated), was reviewed. The sign indicated, Everyone must: clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities. Wound care: any skin opening requiring a dressing., TXN 1 acknowledged the sign and stated she was nervous earlier and forgot to don the gown before doing the wound care, TXN 1 further stated a risk would be cross contamination. During a review of facility's policy and procedure (P&P), titled, Enhanced Barrier Precautions (EBP), reviewed January 2026, the P&P indicated, When Transmission-based precautions (advanced infection-control measures used in healthcare settings, i.e., isolation and PPE) are not appropriate and in addition to Standard Precautions (the minimum infection prevention practices used at all times for all patients in healthcare settings, i.e., hand washing, environmental cleaning), Enhanced Barrier Precautions will be used. Purpose. To reduce the risk of transmission of epidemiologically important microorganisms (infectious agents with a high potential to cause severe public health outbreaks, transmit rapidly through populations, or resist standard treatments) by direct or indirect contact. For residents for whom EBP are indicated, EBP is employed when performing the following. Wound care: any skin opening requiring a dressing.		