STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 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 and interview, the facility failed to:1. Ensure kitchen staff labeled all foods stored in the freezer with the correct food name, date of food delivery, date the food container was opened, and best by date. 2. Ensure staff did not pick up a meal ticket off the floor then placed the contaminated (something has been made impure, unclean, or dangerous by contact with or the addition of a harmful, foreign, or undesirable substance) meal ticket on one of six residents' (Resident 12) food trays then walked towards the dining room to serve the food tray to Resident 12 with the contaminated meal ticket still on the food tray. These deficient practices had the potential for Resident 12 and the residents who consume food from the kitchen to suffer from foodborne illnesses (refer to illnesses such as nausea, vomiting, and diarrhea, caused by the ingestion of contaminated food or beverages) and food to contamination (the introduction of pathogens or infectious material into or on normally clean or sterile objects, spaces, or surface) resulting in hospitalization. Findings: a. During an initial kitchen tour 6/01/2026 at 8:18 AM, several food items in the freezer were not properly labeled: Diced ham - food label did not indicate what the dates 4/15/26 and 4/13/2027 were for.Chicken patties - food label did not indicate what food the label was for; the food label indicated the date 5/11/26 was for shell life and 5/15/26 was the used by date.Beef steak - food label indicated date opened was on 5/25/2026 but did not indicate when the food was delivered and when was the expiration date.Barbeque (BBQ) pork - food label indicated date opened was on 5/26/2026 but did not indicate when the food was delivered and when was the expiration date. During a concurrent observation and interview on 6/01/2026 at 8:27 AM with the Dietary Services Supervisor (DSS - manages daily food service operations, ensuring safe, nutritious, and appealing meals while supervising staff, controlling budgets, and upholding health regulations), DSS stated the frozen chicken patties are good for five days after opening. DSS added the BBQ pork & beef steak are good for 1 month from the date it was opened. During an interview on 6/03/2026 at 2:06 PM with dietary aide (DA - assists in preparing, serving, and delivering meals in healthcare settings) 2, DA 2 stated as soon as the food is delivered to the facility, the delivered food is labelled and the label must include food name, date of delivery, date the food was opened, and when the food will expire. DA 2 also stated that when a food label has incomplete information, the food must be thrown away. b. During an interview on 6/03/2026 at 2:17 PM with DA 1, DA 1 stated all foods received must be labeled when it's delivered to the facility. DA 1 also stated all foods must be labeled so we know when the food will expire or when we opened the bag and we don't want to use expired food to serve the residents and food may be bad and it may make them (residents) sick they might go to the hospital for that. During an interview on 6/03/2026 at 2:26 PM with the dietary cook (DC), DC stated, the reason why food labeling is important is to tell us when food is good to use for residents to eat; we need to know when the food was received, when it's good for and when it will expire. During a follow interview on 6/03/2026 at 2:39 PM with DSS, when asked why several food items in the freezer were not labeled, DSS stated, I in-serviced the staff about it but some of them may be forgot and food labeling is important because, you don't know how long the meat has been there. Some items are good for example two years but once the package is opened, the date of expiration is now changed. For frozen (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	foods once opened, it's only good for 5 days. If the food was in the refrigerator, you will still have it good for up to 5 days. According to DSS stated that, the food might cause them (residents) illness like nausea, vomiting, diarrhea and stomach pains. A review of the facility's in-service education (a professional development for workers aimed to enhance their skills, knowledge, and competence to improve job performance) dated 2/21/2026 indicated dietary staff were educated on which products need labeling, how to label products, and which items need dating which includes date items were received, used by date, and date all items when opened. A review of the facility's policy and procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Food Storage and Handling with a revision date of 1/2026 indicated, raw meat.should be labeled, dated, and stored in refrigerators/freezers. and frozen meat.should be labeled, dated. A review of the facility's P&P titled Receiving Food and Supplies with a revision date of 1/2026 indicated, items received should be dated. CROSS REFERENCE F880c. During a dining observation on 6/01/2026 at 12:33 PM, Activities Director (AD - designs and leads recreational, social, and therapeutic programs to improve residents' quality of life) was observed picking up a meal ticket that fell on the floor with her bare right hand. AD proceeded to place the contaminated meal ticket on Resident 12's food tray then proceeded to walk towards the dining room. AD was stopped by the surveyor prior to entering the dining room. AD stated, I was going to give [Resident 12] the food tray. AD also stated [Resident 12] might get sick if [Resident 12] ate the food because I contaminated the food tray. AD stated that had Resident 12 consumed the food that was on the contaminated food tray, Resident 12 will have stomach pains.might vomit.will have a lot of pain because of the stomach pains, and the resident will go to the bathroom a lot. I am so sorry. During an interview on 6/01/2026 at 12:42 PM with Activities Assistant (AA - assistant to the Activities Director), AA stated that a meal ticket that fell on the floor is a dirty meal ticket because all floors are dirty. AA also stated that the dirty meal ticket should not be put on the food tray because food is clean. AA stated Resident 12 will get sick from eating the food.will have diarrhea, vomiting.might go to the hospital if [Resident 12] is too sick. During an interview on 6/03/2026 at 2:17 PM with DA 1, DA 1 stated that when staff break infection control (measures taken to prevent or stops the spread of infections in the healthcare settings), residents might get diarrhea, infection, vomit. They [residents] might end up in the emergency room. During an interview on 6/03/2026 at 2:39 PN with DSS, DSS stated the residents are vulnerable and we don't know what the [residents'] immune system can or cannot tolerate. We always have to make sure we follow proper rules and instructions. DSS added that residents get so sick like bad diarrhea and vomiting or bad food poisoning that they end up in the hospital. A review of the facility's in-service education (a professional development for workers aimed to enhance their skills, knowledge, and competence to improve job performance) indicated education on infection control was not provided to the staff prior to the 6/03/2026 break in infection control incident. A review of the facility's P&P titled Dietary Department Infection Control for Dietary Employees with a revision date of 3/25/2026 indicated, during food preparation, as often as necessary to remove soil and contamination, and to prevent cross-contamination when changing tasks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 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 ensure that staff treated residents with respect and dignity and did not calling the residents feeders for seven of seven sampled residents (Residents 2, 3, 20, 56, 57, 58 and 84) who needed assistance with feeding. This deficient practice had the potential for Residents 2, 3, 20, 56, 57, 58 and 84 not attain and maintain the highest practicable physical, mental and psychosocial well-being and also suffer lowered self esteem.Findings: A review of Resident 2's admission record, indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included, muscle weakness (a lack of physical or muscle strength, throughout the body), diabetes Type 2 (high blood sugar). A review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 5/6/2026, indicated Resident 2's cognition (the mental ability to make decisions of daily living) was severely impaired. Resident 2 required substantial/maximal assistance with all activities of daily living (ADL- bed mobility, transfer, eating, toilet use and personal hygiene). During a concurrent lunch observation and interview on 6/01/2026 at 12:58 PM, in the presence of Resident 2, Certified Nursing Assistant (CNA) 3 stated she was currently helping Resident 2 with lunch because the resident, is a Feeder. A review of Resident 3's admission record, indicated Resident 3 was admitted to the facility on [DATE], with diagnoses that included, pressure ulcer (also known as bedsore or pressure sore, is damage to the skin and underlying tissue caused by prolonged pressure, due to lying or sitting in one position for too long), of sacral region (the area between the lower back and the tailbone), and muscle weakness (a lack of physical or muscle strength, throughout the body). A review of Resident 3's MDS, dated [DATE], indicated Resident 3's cognition was severely impaired. The MDS indicated Resident 3 required substantial/maximal assistance with all ADL (bed mobility, transfer, eating, toilet use and personal hygiene). A review of Resident 20's admission record, indicated Resident 20 was admitted to the facility on [DATE], with diagnoses that included, heart failure (a condition where the heart muscle is too weak or stiff to pump enough oxygen-rich blood to meet the body's needs), and muscle weakness (a lack of muscle strength). A review of Resident 20's MDS dated [DATE], indicated Resident 20's cognition was intact. The MDS indicated Resident 20 required substantial/maximal assistance with all ADL (bed mobility, transfer, eating, toilet use and personal hygiene). A review of Resident 56's admission record, indicated Resident 56 was admitted to the facility on [DATE], with diagnoses that included, hypertension (HTN-high or raised blood pressure), and muscle weakness. A review of Resident 56's MDS, dated [DATE], indicated Resident 56's cognition was severely impaired. The MDS indicated Resident 56 required substantial/maximal assistance with all ADL (bed mobility, transfer, eating, toilet use and personal hygiene). A review of Resident 57's admission record, indicated Resident 57 was admitted to the facility (skilled nursing facility [SNF]) on 10/17/2025, with diagnoses that included, HTN, and muscle weakness. A review of Resident 57's MDS dated [DATE], indicated Resident 57's cognition was moderately impaired. The MDS indicated Resident 57 required substantial/maximal assistance with all ADL (bed mobility, transfer, eating, toilet use and personal hygiene). A review of Resident 58's admission record, indicated Resident 58 was admitted to the facility on [DATE], with diagnoses that included, depression (a serious mood and brain disorder characterized by a persistent feeling of sadness, emptiness, and a significant loss of interest in activities), and muscle weakness. A review of Resident 58's MDS dated [DATE], indicated Resident 58's cognition (the mental ability to make decisions of daily living) was severely impaired. The MDS indicated Resident 58 required substantial/maximal assistance with all ADL (bed mobility, transfer, eating, toilet use and personal hygiene). A review of Resident 84's admission record, indicated Resident 95 was admitted to the facility on [DATE], with diagnoses that included, HTN, and muscle weakness. A review of Resident 84's MDS dated [DATE], indicated Resident 95's cognition was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	severely impaired. The MDS indicated Resident 84 required substantial/maximal assistance with all ADL (bed mobility, transfer, eating, toilet use and personal hygiene). During an interview on 6/3/2026 at 3:05 PM Director of Staff Development (DSD)/Licensed Vocational Nurse (LVN) 2 stated that she has a list of feeders (Residents who need assistance with feeding) and that she makes the assignment for the two Restorative Nursing Assistants (RNAs) to care for the feeders. During a concurrent interview and record review with Registered Nurse Supervisor (RNS) 1 on 6/4/2026 at 2:23 PM, the facility's document titled Feeders was reviewed. RNS 1 stated, we have a list of all the feeders in the facility and not only the RNAs feed them the CNAs also feed them so that they do not loose weight. RNS 1 stated that the residents on the current feeders list are Residents 2, 3, 20, 56, 57, 58, and 84. RNS 1 stated the list that is titled feeders contain all the feeders in the facility. During an interview on 6/4/2026 at 2:58 PM, the Director of Nursing (DON) stated, we have only a few feeders, the ones on the list entitled FEEDERS is correct they are (Residents 2, 3, 20, 56, 57, 58, and 84) are all currently feeders. When asked if the word feeder is appropriate for a resident who needs assistance with feeding, the DON stated, Yes, although I do not use the word feeders out loud. It is just between the staff, so they know who the feeders are. The DON state, It is not appropriate to use the word feeders around the residents; it is a matter of respect and providing the residents with dignity while they are being cared for in the facility. During an interview on 6/05/2026 at 9:01 AM, CNA 3 stated all the residents on the list entitled FEEDERS is correct. CNA 3 stated Residents 2, 3, 20, 56, 57, 58, and 84 are all feeders and has the feeders listed on her assignment. CNA 3 stated the charge nurse writes in the word FEEDERS so that the CNAs assigned to assist the residents with feeding assistance, will know how many feeders the CNA has. During an interview on 06/05/2026 9:18 AM LVN 6 stated, I write in the assignment the residents that are feeders so the CNAs will know how many feeders they have. I have the RNA help with at least one of the feeders. During record review on 6/3/2026 at 3:27 PM, the facility's of a document entitled FEEDERS, was reviewed. The document revealed a list of residents that needed assistance with feeding and the residents corresponding room and bed numbers. During record review on 6/5/2026 at 1:18 PM of the facility's policies and procedures (P&P) titled Residents Rights - Quality of Life, the P&P indicated the following:PurposeTo ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.PolicyEach resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being.ProcedureVII. Facility staff speaks respectfully to residents at all times, including addressing the resident by his or her name of choice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that three of five residents (Resident 1, Resident 43, and Resident 61) who had severe cognitive (the mental ability to make decisions of daily living), did not sign the consent forms for Influenza (flu - illness caused by a virus that infect nose, throat and lungs), Pneumonia Immunization (immunization that protects against bacteria that causes pneumonia [infection of lungs)] and Corona Virus disease 2019 (COVID 19- is a highly contagious illness that affect lungs and then entire body) according to the facility's policies and procedures titled Resident Rights - Quality of Life reviewed on 1/2026, and P-NP67 Informed Consent effective date 1/30/2026. This deficient practice violated the rights of Resident 1, Resident 43 and Resident 61 and the residents' representatives to make informed decisions whether or not to receive and refuse the Flu, Pneumonia, and COVID 19 vaccines. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 4/13/2026 with diagnoses that included but not limited to quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), muscle weakness and dysphagia (difficulty swallowing). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/28/2026, the MDS indicated Resident 1 had severe cognitive (the mental ability to make decisions of daily living) impairment. The MDS indicated Resident 1 needed staff assistance with activities of daily living (ADL- dependent on staff for using shower/bathe/toileting, dressing and tub/shower transfer, oral hygiene, personal hygiene, sitting/laying/standing and, supervision with eating). During a review of Resident 1's History and Physical (H&P - medical document which include resident's background, physical exam and assessment) by resident's physician and signed by the same physician, dated 4/15/2026, H&P indicated, The patient (Resident 1) has waxing and waning (increases or decreases)capacity for medical decision making due to dementia (a progressive state of decline in mental abilities). During a review of Resident 43's AR, the AR indicated the facility admitted the resident on 4/6/2026 with diagnoses that included but not limited to Dysphagia and unspecified Protein-Calorie malnutrition (potentially life-threatening condition due to inadequate intake of protein, calories or both). During a review of Resident 43's MDS dated [DATE], the MDS indicated Resident 43 had severe cognitive impairment. The MDS indicated Resident 43 was dependent on staff and required maximum staff assist for ADL- (fully dependent on staff for eating, toilet hygiene, shower/bathe, personal hygiene, laying/sitting and chair/bed transfer, and need maximum staff assist for oral hygiene, lower body dressing, roll left/right and upper body dressing). During a review of Resident 43's H&P dated 5/21/2026, H&P indicated, The patient (Resident 43) does not have the capacity for medical decision making due to: CVA, encephalopathy (brain disease characterized by mental confusion, memory loss, loss of coordination or muscle twitching). During a review of Resident 61's AR, the AR indicated the facility admitted Resident 61 on 2/14/2026 with diagnoses that included but not limited to dysphagia (difficulty swallowing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (neurologic symptom characterized by weakness or partial paralysis on one side of the body). During a review of Resident 61s MDS dated [DATE], the MDS indicated Resident 61 had moderate cognitive impairment. The MDS indicated Resident 61 needed staff assistance with ADL- dependent on staff for using wheelchair and tub/shower transfer, maximum assistance with toileting hygiene, shower/bathe, lower body dressing, and sitting/laying, and moderate staff assistance with personal hygiene, upper body dressing, chair/bed transfer and laying/sitting, supervision with rolling and setup/cleaning assistance with eating and oral hygiene. During a concurrent interview and record review of immunization record on 6/4/2026 at 9:21 am, with Infection Prevention Nurse/licensed vocational nurse (LVN) 3, LVN 3 stated that Influenza vaccine is offered to all residents annually starting in August every year, pneumococcal vaccine and COVID 19 offered once upon admission. LVN 3 stated that LVN 3 obtains the consent for influenza, COVID 19, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and pneumococcal vaccines from residents or the residents' representatives. LVN 3 confirmed and stated the following:a)Resident 1 signed to refuse to receive influenza vaccine (dated 8/5/2025), pneumococcal vaccine (dated 12/29/2023), and COVID - 19 (dated 8/5/2025). b)Resident 43 signed the consent forms to receive influenza vaccine (dated 8/5/2025), and COVID-19 vaccine (dated 4/8/2028).c)Resident 61 signed the consent forms to receive influenza vaccine (dated 8/5/2025), pneumococcal vaccine on(dated 3/29/2024), and COVID-19 vaccine (dated 2/4/2026). During an interview on 6/4/2026 at 11:40 am, with LVN 3, LVN 3 stated that informed consent is that the resident understands (has the knowledge) the vaccine, the side effects of the vaccine, and the resident making decisions about the vaccines. LVN 3 sated that the resident should be fully coherent (capable of thinking clear and logical) so that the resident understands the vaccine/s, and the effectiveness and side effects of the vaccine/s. LVN 3 stated that if a resident cannot make decisions, their representative should decide and sign the consent form on their behalf, as the representative understands the resident's wishes about receiving vaccines. During an interview on 06/04/2026 at 1:09 pm, with Director of Nursing (DON), DON stated that Resident 1, Resident 43 and Resident 61 did not have the capacity to make decision and sign the consent forms for receive or refuse any vaccine. DON stated that when a resident is not able to make decisions, facility needs to call the residents representative to give consent to receive or refuse vaccines. DON stated that if there is no family present for a resident, then the facility ethic committee (group of individuals that helps patient, families and medical staff navigate moral and legal dilemmas in care and treatment) makes the decision for the resident. DON stated that the facility is not respecting resident's wishes if resident with severe cognitive impairment signs any consent form/s. During a review of the facility's policy and procedures (P&P) titled, Resident Rights - Quality of Life reviewed on 1/2026, the P&P indicated that, Residents have freedom of choice., as much as possible, about how they wish to live their everyday lives and receive care, subject to facilities rule and regulations and applicable state and federal laws governing the protection of resident health and safety. During a review of the facility's P&P titled, P-NP67 Informed Consent, effective date 1/30/2026, P&P indicated that, If the resident lacks capacity to provide informed consent, the surrogate decision maker will provide informed consent. If the resident lacks capacity to provide informed consent and does not have a surrogate decision maker, the facility will convene a surrogate interdisciplinary team, IDT.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 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 provide television (TV) remote control for two of two sampled residents (Resident 7 and 62). This deficient practice resulted in Resident 7 feeling frustrated and complained of inability to watch TV and and feeling bored., and Resident 62 complaining of not having a TV remote for a long time and did not keep getting up to change the TV channel. Findings: During a review of Resident 7's admission Record (AR), the AR indicated the facility admitted Resident 7 on 4/26/2026 with diagnosis that included but not limited to muscle weakness, Type 2 Diabetes Mellitus without complications (DM type 2- (high blood sugar) and dependance on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During the review of Resident 7's Minimum Data Set (MDS - a resident assessment tool) dated 4/23/2026, the MDS indicated Resident 7 had a moderate cognitive (the mental ability to make decisions of daily living) impairment. The MDS indicated Resident 7 was dependent on staff for activities of daily living (ADL- set up/clean-up assistance for eating, supervision for oral hygiene, maximum assistance for shower/bathe and lower body dressing, moderate assistance for upper body dressing, laying/sitting/standing, chair/bed transfer, personal hygiene and walking 10 feet). During the review of Resident 62's AR, the AR indicated the facility admitted the resident on 6/23/2025 with diagnoses that included but not limited to DM type 2 without complications, hypertension (HTN-high blood pressure) and insomnia (difficulty sleeping at night). During the review of Resident 62's MDS) dated [DATE], the MDS indicated Resident 62 had a severe cognitive (the mental ability to make decision of daily living) impairment. The MDS indicated Resident 62 was dependent on staff for ADL -(set up/clean-up assistance for eating) and wheel with wheelchair 50 feet with two turns, moderate assistance for oral hygiene, upper body dressing, laying/sit/stand, chair/bed transfer, toilet transfer and partial assist for toilet hygiene, lower body dressing and wheel 150 feet). During a concurrent observation and interview on 6/3/2026 at 9:48 am with Resident 7 in resident's room, Resident 7 stated that Resident 7 did not have a TV remote control. There was no TV remote control was found in the resident's room. Resident 7 stated that she has to get up from the bed or ask someone to turn the TV on or change the channel/volume manually from wall mount TV set. Resident 7 stated that she does not feel comfortable getting up frequently or repeatedly to ask the staff to help with TV. Resident 7 stated that, it has been several days that she did not have TV remote control. During an interview on 6/3/2026 at 10:17 am with Resident 7 in resident's room, Resident 7 stated, I can't watch TV. It's frustrating, I miss home. I am bored, I don't know what to do when I am bored coz I can't watch TV. During a concurrent observation and interview on 6/03/2026 10:15 am with Resident 62, in Resident 62's room, Resident 62 stated that Resident 62 did not have a television (TV) remote control. There was no TV remote control was found in the resident's room. Resident 62 stated, I don't have TV remote for a long time. I can't remember for how long I didn't have TV remote. I like to watch TV but its only at one channel. I would like to change the channel but there is no TV remote control to change it. I can't keep getting up to change the channel. During an interview on 6/3/2026 at 10:25 am, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated not having access to TV remote control can affect the resident's mood. LVN 1 stated that the residents will not feel like home in the facility if they don't have TV remote. LVN 1 stated that the resident will not t be able to be entertained when they are bored. During an interview on 6/04/2026 1:02 pm with Director of Nursing (DON), DON stated, If the residents does not have a TV remote control, they will feel lonely, they will feel isolated. There is no stimulation for residents, they won't know what's going on in outside world. It could make them sad. During a review of the facility's policy and procedures (P&P) titled Residents Room and Environment revised on 3/2026, the P&P indicated, The Facility provides residents with a safe, clean, comfortable, and homelike environment. Facility staff will provide residents with a pleasant environment and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to protect the residents' rights to privacy and confidentiality of records when Licensed Vocational Nurses (LVN) 1 and LVN 5 left two of two residents' (Resident 8 and Resident 11) personal and medical information displayed on the computer screen unattended. This deficient practice of violating the residents' rights to privacy and confidentiality of records had the potential to cause psychological and financial harm to Resident 8 and Resident 11. Findings: 1.A review of Resident 8's admission record (face sheet - a document containing demographic and diagnostic information) indicated the facility admitted Resident 8 on 12/31/2025 with the following diagnoses: type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), acute kidney failure (when kidneys suddenly cannot remove waste from the blood), myocardial infarction type 2 (caused by a severe imbalance between the heart's oxygen supply and demand, rather than a blocked artery), tachycardia (heart rate that exceeds 100 beats per minute), calculus of gallbladder (gallstone - hardened deposits of digestive fluid that form in the gallbladder), depression (a common but serious mood disorder that causes a persistent feeling of sadness and loss of interest), essential (primary) hypertension (high blood pressure without a single identifiable cause), dysphagia (difficulty swallowing), cognitive communication deficit (trouble participating in conversations), generalized muscle weakness (lack of physical or muscle strength), long term (current) use of insulin (an effective treatment for advanced Type 2 diabetes when oral medications are no longer sufficient), and osteoarthritis (a progressive disorder of the joints caused by a gradual loss of cartilage). During a review of Resident 8's history and physical (H&P - a physician's complete patient examination) dated 1/05/2026 indicated, Resident 8 was at significant risk of worsening medical status and re-admission to the hospital. H&P also indicated Resident 8 had the capacity for medical decision making. During a review of Resident 8's Minimum Data Set (MDS - a mandated resident assessment tool) dated 4/08/2026 indicated, Resident 8 has moderately impaired cognition (make poor decisions, cues and supervisions required). MDS also indicated Resident 8 used a walker and wheelchair for mobility (ability to move freely, purposefully, and independently). The MDS indicated that Resident 8 required supervision or touching assistance with activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). 2. A review of Resident 11's admission record indicated the facility admitted Resident 11 on 5/10/2026 with the following diagnoses: atherosclerotic heart disease (damage or disease in the heart's major blood vessels), presence of coronary angioplasty implant and graft (long-term medical recording of a patient who has received heart stents or bypass grafts to restore and maintain blood flow), hypertensive chronic kidney disease (elevated blood pressure caused by kidney disease), generalized muscle weakness), dysphagia (difficulty swallowing), cognitive communication deficit (trouble participating in conversations), anxiety disorder (a condition of excessive worry about daily issues and situations), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and essential hypertension (primary high blood pressure without a single identifiable cause). During a review of Resident 11's H&P dated 5/11/2026 indicated, Resident 11 was at significant risk of worsening medical status and re-admission to the hospital. H&P also indicated that Resident 11 had the capacity for medical decision making. During a review of Resident 11's MDS report dated 5/17/2026, MDS indicated Resident 11 has intact cognition (a person's thinking and reasoning abilities are functioning properly and are not significantly impaired). During a facility tour on 6/01/2026 at 11:58 AM, a laptop computer sitting on top of Medication Cart A (Med Cart - a mobile workstation used by nurses to securely store, organize, and administer daily medications to residents) was observed unattended. Med Cart A was parked in the hallway against a wall. The writer touched the computer mouse and Resident 8's personal and medical information was displayed on the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	laptop computer screen. During the same facility tour and concurrent interview at 12 noon, LVN 1 arrived at Med Cart A. LVN 1 confirmed and stated that LVN 1's name written on the top right corner of Med Cart A laptop computer screen. LVN 1 stated Resident 8's personal and medical information including the resident's name, date of birth , physician's name, code status, allergies, vital signs (blood pressure reading, respiratory rate, temperature, blood glucose [measure the amount of glucose in your bloodstream], heart rate, oxygen level, weight, and pain) and medical record number were displayed on the computer screen. LVN 1 stated Honestly, I thought I closed the computer screen. LVN 1 stated that LVN 1 violated Health Insurance Portability and Accountability Act (HIPAA - a privacy rule which establishes national standards to protect individuals' medical records and other individually identifiable health information) law when LVN 1 left Resident 8's personal and medical information displayed on the laptop computer screen unattended. LVN 1 stated Resident 8's information may be used for identity theft, impersonation, and stolen financial information. LVN 1 added that Resident 8 may experience that the trust is gone, may feel hurt and anger. During a facility tour on 6/01/2026 at 12:58 PM, a laptop computer sitting on top of Med Cart B was observed unattended. Med Cart B was parked in the hallway parked against the wall between rooms [ROOM NUMBERS]. When surveyor touched the mouse pad on the computer screen, Resident 11's personal and medical information were displayed on the screen within one second. During the same facility tour and concurrent interview at 12:59 PM, LVN 5 arrived at Med Cart B was parked. LVN 5 confirmed and stated that LVN 5's name was on the top right corner of the Med Cart B laptop computer screen. LVN 5 stated Resident 11's personal and medical information such as name, date of birth , vital signs (heart rate, weight, oxygen level, pain level and blood pressure reading), doctor's name and the medication acetaminophen (a common over-the-counter [OTC] medication used to relieve mild to moderate pain [e.g., headaches, toothaches, muscle aches] and reduce fever) were displayed on the computer screen. When asked why Resident 11's personal and medical information were displayed on the computer screen unattended, LVN 5 stated I was called by another resident. I thought I closed the screen. LVN 5 stated LVN 5 violated HIPAA law when LVN 5 left Resident 11's personal and medical information on Med Cart B laptop computer screen for anyone to see. LVN 5 stated that Resident 11's information may be used for financial and insurance fraud and identity theft. LVN 5 stated Resident 11 may feel very upset, distraught, anger, and disappointed when Resident 11's privacy and confidentiality was violated. During an interview on 6/04/2026 at 2:15 PM with LVN 4, LVN 4 stated, HIPAA law is important to follow because it's the law and you don't want residents' information out there for all to see, it should remain private. LVN 4 stated that when Residents 8 and 11 personal and medical information were displayed on the computer screen unattended, both residents may become depressed, may have psychological impact, and have their identities fraudulently used. During an interview on 6/04/2026 at 3:49 PM with the Director of Nursing (DON), DON stated HIPAA is a federal law that protects patient's privacy and confidentiality. DON also stated that when Residents' 8 and 11 personal and medical information were displayed on the computer screen unattended, both residents may feel violated causing Residents 8 and 11 mental anguish, feel depressed, and experience loss of esteem. DON added Residents 8 and 11 may have their health and well-being negatively affected. A review of the facility's policy and procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Electronic Protected Health Information Security with a revision date of 1/2026 indicated, when not in use, laptops or other mobile electronic devices should be stored in a physically secure location and after a certain period of inactivity, the user will be logged off of the electronic record keeping system.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 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. Based on observation, interview, and record review, the facility failed to ensure the toilet bowl was clean and sanitary for one of three sampled residents (Resident 79). This deficient practice placed Resident 79 at risk for infections, lowered self esteem, and embarrassment. Findings: During a review of Resident 79's admission Record, the admission record indicated the facility admitted the resident on 1/16/2026 with diagnoses that included but not limited to Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and muscle spasm (sudden, involuntary tightening of muscle which is difficult to relax). During a review of Resident 79's Minimum Data Set (MDS - a resident assessment tool) dated 4/25/2026, the MDS indicated Resident 79 had no cognitive (the mental ability to make decisions of daily living) impairment. The MDS indicated Resident 79 needed set up or clean up assistance with activities of daily living (ADL- including upper/lower body dressing, personal hygiene, eating, oral hygiene, shower and toileting hygiene and independent for rolling left/right, sit/laying, chair/bed transfer. Tub/shower transfer, car transfer toilet transfer and walking 150 feet). During an observation on 06/02/2026 at 10:31 am, the toilet commode in resident's bathroom had brown dried uneven stains around the inside rim (top portion of inside portion of the toilet bowl) of the commode. During a concurrent observation and interview on 06/02/2026 at 11:32 am with Maintenance, Housekeeping & Central Supply Supervisor (MHSS) in Resident 79's room, the toilet commode in resident's bathroom had brown dried uneven stains around the inside rim (top portion of inside portion of the toilet bowl) of the commode. MHSS stated, It's not clean. Resident wouldn't be comfortable using this restroom. They wouldn't feel like it's their home. During an interview on 6/4/2026 at 12:55 pm with Director of Nursing (DON), DON stated, Resident will feel dirty. Resident wouldn't want to use the restroom. They wouldn't feel like its home when they would have to use dirty toilet. During a review of the facility's policy and procedures (P&P) titled Residents Room and Environment revised on 3/2026, the P&P indicated, Facility Staff aim to create a personalized, home like atmosphere, paying close attention to cleanliness and order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document the assessment, observation and communication entries on the nursing progress notes for two of the five residents (Residents 1 and 9). Resident 1 had a behavior of throwing feces on the floor. This deficient practice had the potential to negatively affect the plan of care and delivery/provision of necessary care and services for Resident 1 and Resident 9. 1.During a record review of Resident 1's admission Record (face sheet - a document containing demographic and diagnostic information) indicated the facility admitted Resident 1 on 5/20/2020 and was re-admitted on [DATE] with the following medical diagnoses: muscle weakness (when muscles are weak causing difficulty performing normal activities that require strength), cognitive communication deficit (trouble participating in conversations), epilepsy (a long term brain disease that causes repeated seizures due to abnormal electrical signals produced by damaged brain cells), atherosclerotic heart disease of native coronary artery (damage or disease in the heart's major blood vessels), unspecified dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems), contracture (curl or pull in towards the palm), quadriplegia (paralysis [complete or partial loss of muscle strength] that affects all four limbs and body from the neck down), anoxic brain damage (occurs when the brain is completely deprived of oxygen, leading to brain cell death within minutes), transient ischemic attack (TIA - a temporary blockage of blood flow to the brain, schizophrenia (a mental illness that is characterized by disturbances in thought), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 1's care plan (CP - a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient) with a date initiated on 11/24/2024, revision date of 5/05/2026 and a target date of 8/05/2026, the CP indicated that Resident 1 had new behavioral problem of throwing feces on the floor. The CP goal indicated that Resident 1 will decrease frequency of throwing feces on the floor by the next review date (review date was not indicated). The CP interventions included encourage Resident 1 not to touch feces; monitor behavior and episodes and attempt to determine underlying cause; monitor more frequently and provide bedside care; and provide good hand hygiene and skin care to Resident 1. During a record review of Resident 1's History and Physical (H&P - a thorough assessment of a patient's health, combining a detailed conversation about their medical history and a physical examination) dated 4/15/2026, indicated the patient is at significant risk of worsening medical status and readmission to the hospital and the patient has waxing and waning (a patient's symptoms, condition, or disease intensity alternate between getting better [waning] and getting worse [waxing] over time) capacity for medical decision making due to dementia. During a record review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/20/2026 indicated, Resident 1 is cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 1 used a manual wheelchair for mobility (the ability to move or be oved freely, easily, and without restriction). As indicated by the MDS, Resident 1 has functional limitations in range of motion in both upper and lower extremities (upper extremities are the arms from the shoulder to the hands and the lower extremities are the legs from the hip to the toes). The MDS also indicated Resident 1 was completely dependent on staff with activities of daily living (ADLs - tasks of everyday life) and was incontinent (lack of voluntary control over urination or bowel movement) of urinary and bowel. During a review of Resident 1's care plan with a date initiated on 11/24/2024, revision date of 5/05/2026 and a target date of 8/05/2026, the CP indicated that Resident 1 had a behavioral problem related to constant tearing apart [Resident 1]s] diaper and making mess on the floor while sitting on a chair at dining hall and while in bed. The CP goal indicated that Resident 1 will have no evidence of behavior problems by review date (review date was not (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated). The CP interventions included intervene as necessary to protect the rights and safety of others; minimize potential for Resident 1's disruptive behaviors by offering tasks which divert attention; monitor behavior episodes and attempt to determine underlying cause. During an interview on 6/01/2026 at 2:26 PM with Resident 1, Resident 1 could not answer simple questions such as name, date of birth , time of day (day or night time) or location. During a concurrent interview and record review on 6/04/2026 at 3:30 PM with Licensed Vocational Nurse (LVN) 4, LVN 4 stated nursing observation, progress notes or documentation regarding Resident 1's behaviors of throwing feces on the floor and tearing Resident 1's own incontinent brief (material used to contain urine/feces) during the months of May and June 2026 were not found in the electronic health record called Point Click Care (PCC - technology platform that specializes in providing software solutions for the senior care industry, particularly skilled nursing facilities and assisted living facilities) I cannot find anything. LVN 4 stated that nursing observation, progress notes or documentation are all important so we know what we are doing for the resident and if that is helping the resident or not. LVN 4 added something may be missed when nursing documentation was not done. During a concurrent interview and record review on 6/04/2026 at 4:11 PM with the Director of Nursing (DON), the DON stated there is nothing here (referring to PCC) when asked to locate in the PCC any nursing observation, progress notes or documentation regarding Resident 1's behaviors of throwing feces on the floor and tearing Resident 1's own diaper during the months of May and June 2026. DON stated that documenting nursing care and interventions meant the care will be continuous if it's done; once it's written, it's done; if not written, it was not done. DON also stated that when nurses do not document the care and interventions they provided to Resident 1, care will be inconsistent because we don't have any idea what interventions were provided to [Resident 1]. 2. During a record review of Resident 9's admission Record, the record indicated the facility admitted Resident 9 on 1/23/2023 and re-admitted on [DATE] with the following diagnoses: multiple sclerosis (a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), acute cystitis without hematuria (a sudden infection of the bladder without blood in the urine), paraplegia (paralysis of the legs and lower body), polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body), chronic pain syndrome (a condition where persistent pain lasts beyond the expected healing time [typically 3 to 6 months] and is accompanied by emotional, physical, and behavioral symptoms like depression, anxiety, and severe sleep disruption that severely interfere with daily life), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a condition of excessive worry about daily issues and situations), muscular dystrophy (cause progressive muscle weakness and loss of muscle mass over time), generalized muscle weakness (lack of physical or muscle strength), cognitive communication deficit (trouble participating in conversations), contracture of the right and left hips and knees (conditions where the soft tissues [muscles, tendons, and ligaments] around the joints tighten and shorten, permanently restricting movement), essential (primary) hypertension (high blood pressure without a single identifiable cause), presence of urogenital implants (the existence of artificial devices or materials within the urogenital system, which includes the urinary and reproductive organs), neuromuscular dysfunction of the bladder (a condition where the nerves and muscles controlling bladder function don't work properly due to damage to the brain, spinal cord, or nerves), and muscle spasm (sudden, involuntary contractions of a muscle that cannot relax). During a review of Resident 9's Care Plan (CP - a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient) on dependency on staff with an initiated date of 12/10/2024, revision dates of 2/23/2025 and 5/03/2026, and a target date of 8/16/2026, indicated Resident 9 dependent on staff for meeting emotional, intellectual, physical, and social needs related to physical limitations. The CP's goal indicated Resident 9 will attend/participate in activities of choice by next review date (date was not indicated). The CP interventions included modifying daily schedule and treatment plan as necessary to accommodate activity participation requested by the [Resident 9]. During a record (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of Resident 9's Nursing Progress Notes for February 2026, Notes from a licensed staff as to why Resident 9 required to be transferred to a general acute care hospital (GACH - a health facility having a professional responsibility and an organized medical staff that provides 24-hour inpatient care) on 2/21/2026 were not found. No notes found that indicated the reason why Resident 9 required to be transferred to GACH, date and time the transfer happened, vital signs (clinical measurements, specifically heart rate, temperature, respiration rate, blood pressure and pain, that indicate the state of a patient's essential body functions) prior to hospital transfer, and the date and time the physician and family/responsible party were notified. During a record review of Resident 9's MDS dated [DATE] indicated, Resident 9 has intact cognition (a person's thinking and reasoning abilities are functioning properly and are not significantly impaired). The MDS indicated that Resident 9 used a wheelchair for mobility. As indicated by the MDS, Resident 9 has functional limitations in range of motion in lower extremities (the legs from the hip to the toes) and substantially required assistance from the staff with his ADLs and toileting (incontinent of urinary and bowel). During a record review of Resident 9's H&P dated 5/30/2026 indicated, Resident 9 is at significant risk of worsening medical status and re-admission to the hospital. H&P also indicated that Resident 9 has the capacity for medical decision making. During an interview on 6/03/2026 at 3:16 PM with Resident 9, Resident 9 stated that on the morning of 6/03/2026, Resident 9 reminded Social Service Director (SSD) that on 6/02/2026 and again on 5/28/2026 or 5/29/2026 (Resident 9 unsure which date in May), Resident 9 expressed to SSD about not wanting Licensed Vocational Nurse (LVN) 7 assigned to Resident 9's care anymore. Resident 9 explained to SSD that LVN 7 was being unprofessional, not a nice nurse and disrespectful to [Resident 9]. According to Resident 9, SSD stated sorry about that; okay so for tonight [6/03] for the 11 PM to 7 AM shift, [LVN 7] will not go your room, if anything, another nurse will give you your medications. Resident 9 stated that on 6/03/2026 SSD was reminded I don't want [LVN 7] to care for me. I reminded [SSD] that we talked about it already like 4-5 days (5/28/2026 or 5/29/2026) ago. During a record review of the facility's Medication Administration Audit Report (a report that shows what and when a medication is scheduled to be given, what is the actual date & time the licensed nurse administered the medication, date and time the licensed nurse documentation the medication administration, and the name of the license nurse who gave the medication to the patient), LVN 7 gave the following medications to Resident 9: Sunday, 5/31/2026, 11 PM to 7AM shift:5/31/2026 at 11:14 PM: oxycodone 10 milligram (mg - a unit of measure of mass [amount of material it contains] in the metric system) by mouth every 8 hours as needed for severe pain 9-10 pain levelXanax 1.5 mg by mouth every 8 hours for anxiety as manifested by the inability to relax leading to panic 6/01/2026 at 6:11 AM: oxycodone 10 mg by mouth Monday, 6/01/2026, 11 PM to 7 AM shift: 6/01/2026 at 11:30 PM: Xanax 1.5 mg by mouth Tuesday, 6/02/2026, 11 PM to 7 AM shift: 6/03/2026 00:19 AM: Xanax 1.5 mg by mouth. During a record review of Resident 9's Nursing Progress Notes (captures the details of a patient's health status, treatment progress, and any changes in their condition over time), LVN 7 continued to care for Resident 9 for a total of 14 times after Resident 9 requested a change in nursing assignments to SSD on 5/29/2026. The Notes indicated LVN 7 provided nursing assessments, administered medications, and nursing care to Resident 9 on the following dates and times: 5/31/2026 at 6:39 AM 5/31/2026 at 11:14 PM6/01/2026 at 6:11 AM 6/01/2026 at 11:30 PM6/01/2026 at 11:58 PM 6/02/2026 at 5:39 AM6/03/2026 at 00:19 AM 6/03/2026 at 1:30 AM 6/03/2026 at 2:30 AM6/03/2026 at 2:45 AM 6/03/2026 at 3 AM 6/03/2026 at 4:56 AM 6/03/2026 at 6 AM6/03/2026 at 6:50 AM During a record review of Resident 9's Nursing Progress Notes for May and June 2026, Notes from SSD or any licensed staff about Resident 9's request to not have LVN 7 assigned to Resident 9's care anymore were not found. During a review of the facility's nursing assignment sheets (a structured document used to clearly assign specific residents to nurses and Certified Nursing Assistants [CNAs]), the assignment sheets for 11 PM to 7 AM shift indicated that on 6/01/2026, and 6/02/2026, LVN 9 was assigned to care for Resident 9. During a concurrent interview and record review on 6/03/2026 at 4:09 PM with RN Supervisor (RNS) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1, RNS 1 stated that staff are aware about Resident 9's desire not to have LVN 7 care for Resident 9, we are all aware, he tells everyone about it. RNS 1 stated RNS 1 have known about this probably a couple of months. RNS 1 asked why LVN 7 continued to be assigned to care for Resident 9 even after Resident 9 expressed his right to assign a different nurse during the 11 PM to 7 AM shift, RNS 1 stated we only had two LVNs that shift. When asked why not just switch the two LVNs assignments, RNS 1 stated because LVN 7 has always been assigned to that side, nursing station B (where Resident 9's room was located). RNS 1 was also asked why there were no documentation from any licensed nurses, including RNS 1, about Resident 9's request to change nursing assignments, RNS 1 stated I don't know, there should have been. When asked how Resident 9 felt about not having Resident 9's right to request for a different nurse not honored, RNS 1 stated upset, may become verbally abusive, aggressive. During a concurrent interview and record review on 6/04/2026 at 2:51 PM with LVN 4, LVN 4 stated I can't find anything in the PCC when asked to find any written progress notes, observations or documentations in the PCC related to Resident 9's hospital transfer on 2/21/2026 and Resident 9's request not to have LVN 7 to care for Resident 9 anymore. LVN 4 stated it was important that nurses document why Resident 9 required to be hospitalized on [DATE] because we have to know what is going on with [Resident 9].reason for the transfer. If it's not done then no one knows what happened to [Resident 9], what interventions were done or not done for [Resident 9]. LVN 4 stated residents always have the right to choose another nurse to care for them. During a concurrent interview and record review on 6/04/2026 at 4:41 PM with the Director of Nursing (DON), the DON stated yes, it's known to most of us when asked about Resident 9's request to change nursing assignments. DON stated that the DON was notified about Resident 9's request to change nursing assignments on 6/01/2026. When asked about why LVN 7 continued to be assigned to Resident 9's care even after 6/01/2026, DON responded RNS 1 did the scheduling.I don't know. DON was asked to show any nursing documentation that indicated Resident 9's hospital transfer on 2/21/2026 were documented and Resident 9's request to [NAME] nursing assignment was documented, DON stated there is nothing here (referring to the PCC). DON added that when documentation was not done nothing was done; it should have been documented, the result, the follow up. DON stated that the nursing documentation should have been done on the same hour it happened and they lax in their documentation. DON stated that Resident 9 has the right to choose a nurse always.it's their right. During a review of the facility's policy and procedure (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Completion & Correction with an effective date of 3/25/2026 indicated, the facility will work to complete and correct medical records in a standardized manner to provide the highest quality and accuracy in documentation and documentation will reflect medically relevant information concerning the resident and will be documented in a professional manner. The P&P also indicated the purpose of this policy is to ensure that medical records are complete and accurate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a baseline care plan for one of four sampled residents (Resident 1) in accordance with the facility policy and procedures (P&P) titled Person-Centered Care Planning with a revision date of 1/2026, by failing to initiate a baseline care plan within 48 hours after the resident was readmitted to the facility on [DATE]. This deficient practice had the potential to negatively affect the delivery of necessary care and services needed for Resident 1 immediately upon admission.Findings: During a record review of Resident 1's admission Record (face sheet - a document containing demographic and diagnostic information) indicated the facility admitted Resident 1 on 5/20/2020 and was re-admitted on [DATE] with the following medical diagnoses: muscle weakness (when muscles are weak causing difficulty performing normal activities that require strength), cognitive communication deficit (trouble participating in conversations), epilepsy (a long term brain disease that causes repeated seizures due to abnormal electrical signals produced by damaged brain cells), atherosclerotic heart disease of native coronary artery (damage or disease in the heart's major blood vessels), unspecified dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems), contracture (curl or pull in towards the palm), quadriplegia (paralysis [complete or partial loss of muscle strength] that affects all four limbs and body from the neck down), anoxic brain damage (occurs when the brain is completely deprived of oxygen, leading to brain cell death within minutes), transient ischemic attack (TIA - a temporary blockage of blood flow to the brain, schizophrenia (a mental illness that is characterized by disturbances in thought), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a record review of Resident 1's history and physical (H&P - a thorough assessment of a patient's health, combining a detailed conversation about their medical history and a physical examination) dated 4/15/2026, indicated the patient is at significant risk of worsening medical status and readmission to the hospital and the patient has waxing and waning (a patient's symptoms, condition, or disease intensity alternate between getting better [waning] and getting worse [waxing] over time) capacity for medical decision making due to dementia. During a record review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/20/2026, indicated Resident 1 is cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 1 used a manual wheelchair for mobility (the ability to move or be oved freely, easily, and without restriction). Resident 1 has functional limitations in range of motion in both upper and lower extremities (upper extremities are the arms from the shoulder to the hands and the lower extremities are the legs from the hip to the toes) as indicated by the MDS. The MDS also indicated Resident 1 was completely dependent on staff with activities of daily living (ADL - tasks of everyday life) and was incontinent (lack of voluntary control over urination or bowel movement) of urinary and bowel. During a concurrent interview and record review on 6/04/2026 at 3:30 PM with Licensed Vocational Nurse (LVN) 4, Resident 1 care plans were reviewed. LVN 4 stated the baseline care plan (an initial, temporary healthcare roadmap created immediately upon admission to a facility; it is designed to bridge the gap before a comprehensive plan is established, it must be developed and implemented within 48 hours of admission) will tell us what [Resident 1's] needs are and what interventions we need to do for [Resident 1]. Baseline care plan is created just for Resident 1. LVN 4 stated the baseline care plan for Resident 1's re-admission date of 4/13/2026 should be completed within 48 hours from the time Resident 1 was admitted to the facility. When LVN 4 was asked to show the baseline care plan, LVN 4 stated I cannot find anything here (referring to the electronic health record called Point Click Care (PCC - technology platform that specializes in providing software solutions for the senior care industry, particularly skilled nursing facilities and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assisted living facilities). LVN 4 stated when there is no baseline care plan for Resident 1, then we don't know what is the resident's needs, how we can help the resident, we might miss something important. During a concurrent interview and record review on 6/04/2026 at 4:11 PM with the Director of Nursing (DON), the DON stated baseline care plan for resident's readmission to the facility on 4/13/2026 I cannot find anything here (referring to the PCC). DON also stated the baseline care plan tells us what resident will need help with, what interventions we need to do to help the resident get better while in our facility. When asked what potential harm may happen to Resident 1 when the baseline care plan was not completed at all, DON stated immediate interventions for the resident will be missed; delay in care. DON stated the baseline care plan should be completed within 48 hours from Resident 1's re-admission. During a record review of the facility's policy and procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Person-Centered Care Planning with a revision date of 1/2026 indicated that the baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission. In addition, the P&P indicated, it should address resident-specific health and safety concerns to prevent decline or injury. The P&P also indicated that the baseline care plan will be developed within 48 hours of admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 observation, interview, and record review the facility failed to maintain proper weight settings for the low air loss mattress (LALM-mattress designed to treat and prevent pressure ulcers) for three of five sampled residents (Resident 3, Resident 19 and Resident 57).This deficient practice had the potential for Resident 3, Resident 19 and Resident 57's pressure injuries to worsen or to develop new pressure injuries.Findings: 1. A review of Resident 3's admission record indicated the facility originally admitted the resident on 9/20/2024 and readmitted the resident on 5/8/2026 with diagnosis that included unstageable pressure ulcer of sacral region (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar), type 2 diabetes mellitus (high blood sugar) with foot ulcer, and chronic kidney disease (kidneys are damaged and cannot filter blood as well as they should). A review of Resident 3's potential for pressure ulcer care plan, initiated 2/4/2025, indicated the resident was at risk for pressure ulcer development due to decreased mobility and the use of anticoagulants (medication that prevents blood clot formation). The care plan goal was for the resident to have intact skin, with no redness, blisters or discoloration. The care plan interventions included a low air loss mattress for skin management to be calibrated by resident's weight and to monitor for accurate settings every shift. A review of Resident 3's Physician Orders, dated 5/8/2026, indicated staff were to cleanse the unstageable pressure injury with normal saline (NS - a saltwater solution), pat dry, apply Santyl (a prescription ointment used to remove dead tissue from pressure injuries). A review of Resident 3's Braden Scale (pressure ulcer risk predictor tool) dated 5/8/2026, indicated Resident 3 had a Braden score of 10 which placed the resident in the high-risk category to develop a pressure ulcer. A review of Resident 3's History and Physical (H&P), dated 5/10/20206, indicated the resident weighed 152 pounds (lbs). The H&P also indicated Resident 3 did not have the capacity to make medical decisions. A review of Resident 3's Minimum Data Set (MDS – a resident assessment tool), dated 5/15/2026, indicated Resident 3's cognition (ability to think, reason and learn) was severely impaired. The MDS also indicated Resident 3 had one unhealed unstageable pressure ulcer and the resident was at risk for developing pressure injuries. A review of Resident 3's Order Summary Report, 6/5/2026 indicated on 5/19/26 the physician ordered the resident to have a LALM for skin management to be calibrated by resident's weight and to monitor for accurate settings every shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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	A review of Resident 3's Monthly Weight Report, dated 6/5/2026, indicated Resident 3 weighed 153 lbs in May 2026 and 152 lbs in April 2026. During an observation on 6/2/2026 at 9:37 AM Resident 3 was observed laying on a LALM, with the settings for the LALM observed on the weight setting of 200 to 250 lbs. During an observation on 6/3/2026 at 10:13 AM Resident 3 was observed laying on a LALM, with the settings for the LALM observed on the weight setting of 200 to 250 lbs. During a concurrent interview and observation on 6/4/2026 at 2:26 PM inside Resident 3's room, the resident's wound care was observed. Licensed Vocational Nurse (LVN) 8 cleansed Resident 3's removed the resident's sacral pressure ulcer dressing LVN 8 described the wound bed as having 70 % slough (dead tissue that is usually yellow, tan, gray, or green in color, usually moist and stringy in texture, that may be found in wounds) and 30% granulation tissue (tissue that grows from the wound bed to fill the gap while the wound heals). LVN 9 cleansed the site with normal saline pat dry applied Santyl covered with gauze then an adhesive bordered dressing. LVN 8 stated Resident 3's LALM setting was on 250 pounds earlier today, LVN 8 stated they changed the setting after calling the mattress company and being told to reduce the setting to the resident's weight of 152 lbs. LVN 8 also stated the LALM is to prevent the resident's wound from worsening. During an interview on 6/5/2026 at 11:22 AM, the Director of Nursing stated the LALM prevents the breakdown of the resident's skin and to aid in a wound's healing. The DON further stated the mattress' setting is set according to the residents weight and the wound may not improve if the mattress is on the wrong weight setting. During a review of the facility's policy and procedures (P&P) titled, Mattresses reviewed on 1/2026, the P&P indicated, Purpose To provide mattress appropriate for the resident's need. An air mattress is used under the direction of an attending physician's order or when the resident's clinical condition warrants pressure reducing devices. I. The Facility will provide mattresses capable of meeting the following needs of residents: To provide pressure reduction to residents at risk for skin breakdown. To distribute body weight relieving areas of pressure. To provide stimulation and pressure relief to residents at risk for skin breakdown. To distribute body weight relieving areas of pressure. To promote comfort to the bedridden resident and help prevent decubiti and other complications of immobility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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	To reduce pressure and evenly distribute body weight over a larger area of body surface. 2. During a review of Resident 19's admission Record (AR), the AR indicated the facility admitted Resident 19 on 10/7/2025 with diagnoses that included but not limited to cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain) and Right and left knee contracture (a stiffening/shortening at knee, that reduces the knee's range of motion). During a review of Resident 19's MDS dated [DATE], the MDS indicated Resident 19 had severe cognitive impairment. The MDS indicated Resident 19 needed staff assistance with activities of daily living (ADL- dependent on staff for using wheelchair, maximum assistance with shower/bathe/toileting, moderate assistance with upper body dressing and personal hygiene, and set up/cleaning assistance for eating and oral hygiene, supervising in sitting/laying). During the review of Resident 19's Order Summary, dated 3/24/2026 at 7:24 pm, Low air loss mattress for skin support/management every shift, verify functioning of low [NAME] loss mattress. Low air loss mattress for skin/wound management to be calibrated by resident's weight. Monitor for accurate settings QSHIFT using (+/-) (+ = Accurate) (- = Inaccurate) every shift. During the review of Resident 19's Weights and Vitals Summary, dated 5/6/2026, resident's weight was 156 pounds (lbs- unit to use for weight measurement). During an observation on 6/3/2026 at 10:40 am, Resident 19 was observed in bed. Resident was on LAM, which was set at 200 lbs. During a concurrent observation and interview on 6/3/2026 at 1:46 pm, with LVN 8 in Resident 19's room, Resident 19 lying in bed. LVN 8 confirmed and stated that Resident 19's LAM was set at 200 lbs. LVN 8 stated Resident 19's recent weight was 156 lb. LVN 8 stated that the LAM was supposed to set at 150 lbs to ensure that LAM was set closest to Resident 19's actual weight. 2. During a review of Resident 57's AR, the AR indicated the facility admitted Resident 57 on 10/17/2025 with diagnoses that included but not limited to CVA, muscle weakness, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (neurologic symptom characterized by weakness or partial paralysis on one side of the body). During a review of Resident 57's MDS dated [DATE], the MDS indicated Resident 57 had moderate cognitive impairment. The MDS indicated Resident 57 needed staff assistance with ADL- dependent on staff for using wheelchair, toileting hygiene, upper/lower body dressing, shower/bathe, personal hygiene, tub/shower transfer, maximum assistance with roll in bed left/right and moderate assistance with eating and oral hygiene. During the review of Resident 57's Order Summary, dated 11/07/2025 at 8:08 am, Low air loss mattress for skin management, to be calibrated by resident's weight. Monitor for accurate settings QSHIFT using (+/-) (+ = Accurate) (- = Inaccurate). Every shift verify the functioning of Low air loss mattress. During the review of Resident 57's Weights and Vitals Summary, dated 5/6/2026, resident's weight was 160 lbs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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	During an observation on 6/3/2026 at 10:01 am, Resident 57 was observed in bed. Resident was on LAM, which was set at 200 lbs. During a concurrent observation and interview on 6/3/2026 at 1:48 pm with LVN 8 in Resident 57's room, Resident 19 lying in bed. LVN 8 confirmed and stated that the Resident 57's LAM was set at 200 lbs. LVN 8 stated that Resident 57's recent weight was 160 lbs. LVN 8 stated that the LAM was supposed to set at 150 lbs to ensure that LAM was set closest to Resident 57's actual weight . During an interview on 06/04/2026 at 12:48 pm, with Director of nursing (DON), DON stated, Low air loss mattress should be set at the correct weight and at resident's closest weight for all residents who are on low air loss mattress. DON stated that if LAM is set at higher settings than resident's actual weight, it can affect their (residents) mobility in bed and the residents can have skin impairment with that extra pressure from the mattress, and the residents can develop pressure ulcers. There will be a negative outcome and will impair resident's quality of life. During an interview on 6/4/2026 at 2:50 pm, LVN 8 stated that the LAM settings were incorrect for Resident 19 and Resident 57 in relation to the resident weights. LVN 8 stated that if a resident's LAM is set at higher weight than resident's actual weight, it can create more pressure on the resident's skin and that more pressure can create redness on resident's effected skin and resident can potentially develop pressure injury. During a review of the facility's policy and procedures (P&P) titled, Mattresses reviewed on 1/2026, the P&P indicated, Purpose To provide mattress appropriate for the resident's need. An air mattress is used under the direction of an attending physician's order or when the resident's clinical condition warrants pressure reducing devices. I. The Facility will provide mattresses capable of meeting the following needs of residents: To provide pressure reduction to residents at risk for skin breakdown. To distribute body weight relieving areas of pressure. To provide stimulation and pressure relief to residents at risk for skin breakdown. To distribute body weight relieving areas of pressure. To promote comfort to the bedridden resident and help prevent decubiti and other complications of immobility. To reduce pressure and evenly distribute body weight over a larger area of body surface.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on interview and record review, the facility failed to ensure that enteral feed tubing (a flexible tube for delivering nutrient-rich liquid formula directly into the stomach or small intestine) was labeled with the date and time when hung up for one of one sampled resident (Resident 43). This deficient practice had potential for Resident 43 to suffer abdominal discomfort and infection.Findings: During a review of Resident 43's admission Record, the admission record indicated the facility admitted the resident on 4/6/2026 with diagnoses that included but not limited to Dysphagia (inability to swallow) and unspecified Protein-Calorie malnutrition (potentially life-threatening condition due to inadequate intake of protein, calories or both). During a review of Resident 43's Minimum Data Set (MDS - a resident assessment tool) dated 4/20/2026, the MDS indicated Resident 43 had severe cognitive (the mental ability to make decisions of daily living) impairment. The MDS indicated Resident 43 was dependent on staff and required maximum staff assist for activities of daily living (ADL- fully dependent on staff for eating, toilet hygiene, shower/bathe, personal hygiene, laying/sitting and chair/bed transfer, and need maximum staff assist for oral hygiene, lower body dressing, roll left/right and upper body dressing). During the review of Resident 43's Order Summary, dated 5/20/2026 at 7:26 pm, order stated, Enteral feeding: Jevity 1.2 @ rate of 75 ml/hr x 20 hours provides 1500 ml in 12 hours - 1800 calories in 20 hours via Kangaroo Pump. Flush G-tube with 50 l of water before and after administration of medications.During an observation on 6/2/2026 at 9:15 am, Resident 43 was observed in bed. Resident 43 was connected to Jevity 1.2 calories enteral feeding (a method of delivering nutrients, fluids and medications in liquid form into the stomach or small intestine through a soft flexible tube to someone who is not able to eat or drink safely) via a GT/JT. The Jevity 1.2 calories bottle was attached to a feeding pump (device that delivers nutrients/fluids/medications in liquid form at a set rate and frequency per physician's order). The Resident 43 was receiving Jevity 1.2 calories 75 milliliters (ml: unit of measurement in liquid) at 75 ml/hour. The enteral feeding tubing (soft flexible tube that is used to deliver nutrients, fluids and medications in liquid form into the stomach or small intestine) was not labeled with a date and/or time when hung up. During an observation on 6/2/2026 at 2:20 pm, Resident 43's same enteral feeding tube was not labeled with a date and/or time when hung up. During an interview on 06/03/2026 at 2:05 PM with Licensed Vocational Nurse (LVN) 5, LVN 5 stated that, not labeling the enteral feed tubing is not the right practice. It's impossible to tell whether the enteral feed tube was opened on the same day or if it has been in use for several days. If tubing from a previous day or even earlier, was used, bacteria could develop and cause an infection. During an interview on 06/04/2026 at 12:58 PM with Director of Nursing (DON), DON stated, It's important to label tubing for enteral feeding to make sure that tubing is changed so that the residents do not get an infection from the old feeding tube The DON stated, We wouldn't know by looking at an unlabeled tubing if it was changed the same day or previous days. During a review of the facility's policy and procedures (P&P) titled, Nursing Manual - Dietary & Dining - DD16 Enteral Feedings reviewed on 1/2026, the P&P indicated, Label bag and tubing with date and time hung, Hung time is for no more than 24 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 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. Based on interview and record review, the facility failed to ensure one of one sampled residents (Resident 77) who received dialysis (process of removing waste products and excess fluid from the body) treatment received care in accordance with standards of practice, by failing to:1. Complete Post Dialysis Assessment following Resident 77 returning from dialysis treatment.2. Implement the physician's order for fluid restriction of 1200 cubic centimeters (cc-unit of measurement) a day. These deficient practices had the potential to result in harm to the resident which could include edema or unchecked bleeding. Findings: A review of Resident 77's admission record indicated the facility originally admitted the resident on 1/2/20213 and readmitted the resident on 8/1/2025 with diagnoses that included end stage renal disease (ESRD - loss of kidney function in which the kidneys no long work to meet the body's needs) and dependence on renal dialysis (the process of removing waste products and excess fluid from the body using a machine when the kidneys are not able to do so) and heart failure (heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). A review of Resident 77's care plan (CP) on ESRD and Dialysis Dependence, initiated 3/5/2022, indicated Resident 77 receives dialysis treatment every Tuesday, Thursday and Saturday. The CP goal was for the resident to have no signs or symptoms of fluid overload (occurs when the body retains too much fluid, particularly in the bloodstream or tissues). The CP interventions included approaches included fluid restriction of 1200 cc per day. The CP interventions also included if bleeding occurs at arteriovenous (AV-a surgically created connection between an artery and a vein used for hemodialysis) shunt (a passage or medical device used to divert the flow of bodily fluids from one part of the body to another site) anytime after dialysis, to apply pressure with clean gauze (a loosely woven, breathable cotton material used in healthcare for wound management, fluid absorption, and surgery) for 5 minutes-10 minutes Repeat until bleeding stops. If this intervention does not control bleeding, notify the physician. A review of Resident 77's Quarterly Minimum Data Set (MDS - a resident assessment tool), dated 3/18/2026, indicated Resident 77's cognition (the mental ability to make decisions of daily living) was intact. The MDS indicated Resident 77 was independent with eating, required supervision with oral hygiene and required substantial assistance with showering and dressing. The MDS also indicated Resident 77 was receiving dialysis treatment. A review of the Physician's History and Physical dated, 5/23/2026, indicated Resident 77 has the capacity to understand and make decisions. The MDs also indicated that Resident 77 was diagnosed with ESRD and was on hemodialysis (HD- a life-sustaining medical procedure that acts as an artificial kidney. HD filters waste, removes excess fluid, and balances electrolytes in the blood for patients experiencing acute or chronic kidney failure). A review of Resident 77's Physician Orders, dated 5/22/2026, indicated Resident 77 was to receive:- Dialysis treatment every Tuesday, Thursday and Saturday at a dialysis center from 8:30 AM to 12 PM and- Resident 77 had a fluid restriction of 1200 cc every 24 hours. A review of Resident 77's Physician Orders, dated 5/23/2026, indicated staff are to observe Resident 77's left upper arm catheter for dialysis for redness, tenderness, bleeding and drainage every shift A review of Resident 77's Certified Nursing Assistant (CNA) Documentation log for the month of May 2026 indicated Resident 77 received 1200 cc of fluid on the evening shift (3pm-11pm) on 5/4/2026, 5/5/2026, 5/6/2026, 5/10/2026, 5/13/2026, 5/14/2026, 5/18/2026, 5/19/2026, 5/24/2026, 5/28/2026 and 5/31/2026. A review of Resident 77's Pre Dialysis Evaluation, dated 6/2/2026 indicated the evaluation was completed prior to Resident 77 receiving dialysis. The review of the facility's Pre-dialysis Evaluation Form indicated is a two section form. The first section is the pre dialysis assessment to be completed by the facility. The second section is for the dialysis unit/center to fill out. The form indicated the resident had a left AV˜shunt and the resident's condition had not changed since the last dialysis treatment. During a concurrent interview and record review on 6/3/2026 at 11:12 AM, Resident 77's Electronic Medical Chart (EMC) and the facility's Dialysis binder was reviewed. Licensed Vocational Nurse (LVN) 6 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident 77 receives dialysis on Tuesday, Thursday and Saturday and has a left arm AV shunt. LVN 6 stated nursing staff complete pre (before) and post (after dialysis form when the resident goes to dialysis. LVN 6 further stated a pre dialysis form was filled out for the resident yesterday on 6/2/2026). LVN 6 also stated a post dialysis form was not completed. LVN 6 stated the nurse must complete a post dialysis form to evaluate the resident's vital signs (body temperature, blood pressure, pulse [heart rate], and breathing rate to help assess the general physical health of a person), access site for bleeding. LVN 6 also stated, it's important to assess the resident post dialysis because the resident could have low blood sugar or unchecked bleeding. During an interview on 6/3/2026 at 11:52 AM, Certified Nursing Assistant (CNA) 1 stated Resident 77 goes to dialysis. CNA 1 stated Resident 77 is on a fluid restriction and that a water pitcher is not provided to the resident. CNA 1 stated several times she has had to remove the water pitcher from Resident 77's bedside when CNA 1 comes to work in the morning. CNA 1 further stated staff can document the amount the resident drinks on the CNA documentation. During a concurrent interview and record review on 6/3/2026 at 12:39 PM with Registered Nurse Supervisor (RNS) 1, Resident 77's CNA documentation for the months of May and June 2026 was reviewed. RNS 1 stated Resident 77 receives dialysis Tuesday Thursday Saturday and that the resident was on a fluid restriction. During a concurrent review of Resident 77's physician orders. RNS 1 stated Resident 77 had a fluid restriction of 1200 cc per day. Dietary could provide Resident 77 700cc per day and CNAs could provide 240cc on the day and evening shift and the night shift could give 100cc. Upon review of Resident 77's CNA documentation, RNS 1 stated Resident 77 received 1200 cc during the evening shift on 6/2/2026. RNS 1 further stated in May 2026, it was documented that Resident 77 received 1200 cc during the evening shift on 5/24/2026, 5/28/2026 and 5/31/2026. RNS 1 stated Resident 77 could become overloaded (swollen due to too much fluid trapped in the body's tissues). During an interview on 6/5/2026 at 11:23 AM, the Director of Nursing (DON) stated a post dialysis assessment is completed within 30 minutes of the resident returning from dialysis. The DON stated bleeding could happen from not assessing the resident when they have returned from dialysis. The DON further stated CNAs report the resident's fluid intake to the charge nurses and the charge nurses complete the documentation. A review of the facility's policy and procedures titled, Dialysis Management, reviewed 2/2026, indicated, .3. A pre and post dialysis evaluation will be completed by the licensed nurse. a. Diet and fluid restrictions will be followed as ordered6. Emergency Care and Precautions:a. AV fistulai. If a patient's access site is oozing, apply moderate pressure for 5min-10 min until bleeding subsides. Repeat until bleeding stopsii. If bleeding continues, this needs to be evaluated by physician for further intervention.7. Documentationa. All documentation concerning dialysis services and care of the dialysis resident will bemaintained in the resident's medical record.b. Dialysis Communication Recordi. The Nursing Staff will send a dialysis communication form to the dialysis center every time a resident is scheduled for off-site dialysis.ii. The dialysis provider's nurse will be responsible for documentation of dialysis treatment and providing the resident's post dialysis weight. A review of the facility's P&P, Fluid Restriction, dated 5/26/2026, indicated: I. Residents on fluid restriction must have a Provider order and a plan of care for the restriction which indicates the amount of fluid allowed within a 24-hour timeframe.II. The Licensed Nurse will :A. Educate the Resident and/or responsible party regarding the fluid restriction. B. Complete Intake and Output documentationC. Notify the Provider and Resident and/or Responsible Party regarding any changes in the Resident's condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 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 to observe infection control measures for three of four sampled residents (Resident 3, Resident 12, and Resident 79) by failing to ensure: 1. Resident 3's urinals (a container used to collect urine closed parentheses were labeled with the residents names and room numbers. 2. Ensure staff did not pick up a meal ticket off the floor then placed the contaminated (something has been made impure, unclean, or dangerous by contact with or the addition of a harmful, foreign, or undesirable substance) meal ticket on one of six residents' (Resident 12) food trays then walked towards the dining room to serve the food tray to Resident 12 with the contaminated meal ticket still on the food tray. 3. Ensure the toilet bowl in one of one resident (Resident 79) was clean and sanitary (clean and free from germs). These deficient practices had the potential for the residents to suffer from foodborne illnesses (refer to illnesses such as nausea, vomiting, and diarrhea, caused by the ingestion of contaminated food or beverages) and food to contamination (the introduction of pathogens or infectious material into or on normally clean or sterile objects, spaces, or surface) resulting in hospitalization. Findings: 1. A review of Resident 3's admission record indicated the facility originally admitted the resident on 9/20/2024 and readmitted the resident on 5/8/2026 with diagnoses that included unstageable pressure ulcer (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) of sacral region (tail bone), Type 2 diabetes mellitus (high blood sugar) with foot ulcer, and chronic kidney disease (kidneys are damaged and cannot filter blood as well as they should). A review of Resident 3's Minimum Data Set (MDS – a resident assessment tool), dated 5/15/2026, indicated Resident 3's cognition (ability to think, reason and learn) was severely impaired. The MDS indicated the resident had an indwelling urinary catheter. The MDS also indicated Resident 3 had one unhealed pressure ulcer injury and the resident was at risk for developing pressure injuries. During a concurrent interview and observation on 6/4/2026 at 2:40 PM with Certified Nursing Assistant (CNA) 2, a urinal was observed hanging from the grab bar near the toilet in the restroom located in Resident 3's room. A small amount of urine was also observed in the urinal. CNA 2 stated the urinal belonged to Resident 3. CNA 2 stated the urinal should be marked with the resident's name, room number and date for infection control and to prevent cross contamination. During an interview on 6/5/2026 at 11:27 AM, the Director of Nursing (DON) stated, urinal must have the resident's name, room number and a date so we know when to replace it. The DON also stated, this is an infection control issue as we would not know who used the urinal. A review of the facility's policy and procedures (P&P), Urinal and Bedpan - Offering and Removing, reviewed 1/2026, indicated staff are to: I. Empty the bedpan/urinal into the commode. Flush the commode. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	J. Sanitize the bedpan/urinal. Wipe dry with a clean paper towel. Discard paper towel into designated container. Store the bedpan or urinal; do not leave it in the bathroom or on the floor. A review of facility's P&P, Infection Control - Policies & Procedures, reviewed 1/2026, indicated, the facility's infection control policies and procedures are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. 2. During a dining observation on 6/01/2026 at 12:33 PM, Activities Director (AD – designs and leads recreational, social, and therapeutic programs to improve residents' quality of life) was observed picking up a meal ticket that fell on the floor with her bare right hand. AD proceeded to place the contaminated meal ticket on Resident 12's food tray then proceeded to walk towards the dining room. AD was stopped by the surveyor prior to entering the dining room. AD stated, I was going to give [Resident 12] the food tray. AD also stated [Resident 12] might get sick if [Resident 12] ate the food because I contaminated the food tray. AD stated that had Resident 12 consumed the food that was on the contaminated food tray, Resident 12 will have stomach pains.might vomit.will have a lot of pain because of the stomach pains, and the resident will go to the bathroom a lot. I am so sorry. During an interview on 6/01/2026 at 12:42 PM with Activities Assistant (AA – assistant to the Activities Director), AA stated that a meal ticket that fell on the floor is a dirty meal ticket because all floors are dirty. AA also stated that the dirty meal ticket should not be put on the food tray because food is clean. AA stated Resident 12 will get sick from eating the food.will have diarrhea, vomiting.might go to the hospital if [Resident 12] is too sick. During an interview on 6/03/2026 at 2:17 PM with DA 1, DA 1 stated that when staff break infection control (measures taken to prevent or stops the spread of infections in the healthcare settings), residents might get diarrhea, infection, vomit. They [residents] might end up in the emergency room. During an interview on 6/03/2026 at 2:39 PN with DSS, DSS stated the residents are vulnerable and we don't know what the [residents'] immune system can or cannot tolerate. We always have to make sure we follow proper rules and instructions. DSS added that residents get so sick like bad diarrhea and vomiting or bad food poisoning that they end up in the hospital. A review of the facility's in-service education (a professional development for workers aimed to enhance their skills, knowledge, and competence to improve job performance) indicated education on infection control was not provided to the staff prior to the 6/03/2026 break in infection control incident. A review of the facility's P&P titled Dietary Department Infection Control for Dietary Employees with a revision date of 3/25/2026 indicated, during food preparation, as often as necessary to remove soil and contamination, and to prevent cross-contamination when changing tasks. 3. During a review of Resident 79's admission Record, the admission record indicated the facility admitted Resident 7 9 on 1/16/2026 with diagnoses that included but not limited to Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and muscle spasm (sudden, involuntary tightening of muscle which is difficult to relax). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 79's MDS dated [DATE], the MDS indicated Resident 79 had no cognitive (the mental ability to make decisions of daily living) impairment. The MDS indicated Resident 79 needed set up or clean up assistance with ADL (including upper/lower body dressing, personal hygiene, eating, oral hygiene, shower and toileting hygiene and independent for rolling left/right, sit/laying, chair/bed transfer. Tub/shower transfer, car transfer toilet transfer and walking 150 feet). During an observation in Resident 79's bathroom on 06/02/2026 at 10:31 am, the toilet commode had solid brown dried uneven stains and feces like substance around the inside rim (top potion of inside portion of the toilet bowl) of the toilet commode. During an interview on 6/4/2026 at 12:55 pm with DON, DON stated, Resident would not want to use the restroom. It is a sanitation issue. It is infection issue. (Resident 79) can get an infection from dirty commode. During an interview on 06/05/2026 at 11:24 am with Infection Prevention Nurse (IPN)/licensed vocational nurse LVN) 3, LVN 3 stated that Resident 79 can get infection from using the dirty toilet bowl. LVN 3 stated that the resident's condition can potentially get worse, the resident might have to receive treatment for infection or get hospitalized . LVN 3 stated that it is important for Resident 79 to have sanitary toilet. During a review of the facility's policy and procedures (P&P) titled ,Infection Control – Policies & Procedures, P&P indicated, a) Intent: The facility's Infection Control policies and procedures are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.b) Objective: Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Terrace Healthcare & Wellness Centre, LP	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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on observation, interview, and record review, the facility failed to ensure one of one staff (Licensed Vocational Nurse (LVN) 7) completed Elder Abuse Mandated Reporter training according to the facility's policy and procedures (P&P) titled, Training Requirements dated reviewed, January 2026. had proof in the personnel file of the necessary training to care for residents in a safe and secure manner. This deficient practice had the potential for LVN 7 not to be able to identify and report suspected/allegation of abuse and placed the residents in the facility at increased risk for abuse. Findings: During a concurrent interview and record review on 6/5/26 at 12:04 PM of LVN 7's personnel file. The personnel file indicated LVN 7 did not have Elder Abuse Mandated Reporter training upon hire. The Director of Staff Development (DSD)/LVN 2, stated, there is no Elder Abuse Mandated Reporter training in this staff members' file. DSD/LVN 2 checked and reviewed the facility electronic system but was not able to provide any additional information regarding abuse training for LVN 7. DSD/LVN 2 stated she was not aware that the LVN 7's personnel file did not have the Elder Abuse Mandated Reporter training as evidence that LVN 7 was trained on Elder Abuse Mandated Reporting. During an interview on 6/5/26 at 11:08 AM, the Director of Nursing (DON) stated that if the abuse training is not in the file, then there is no way to verify the Elder Abuse Training was done. The abuse training provided to new employees should remain in the file to prove they have received the training they are supposed to have to safely perform their duties for the residents in the facility. If it is not in the file, then they (staff) may not have received the training, and they (staff) will not know what to do when they start working with residents in the facility. The DON stated that lack of Elder Abuse Training may put the residents in the facility at risk for abuse. A review of the facility's policy and procedures titled Training Requirements dated reviewed: January 2026, indicated:PolicyThe facility must develop, implement, and maintain an effective training program for new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. The facility must determine the amount and types of training necessary based on a facility assessment and special needs of the residents.PurposeTo provide required education and training in accordance with federal and state regulations.ProcessTraining topics must include but are not limited to:Communication: effective communication as mandatory training for direct care staff.Resident's rights and facility responsibilities: educate on the rights of the resident and the responsibilities of the facility to properly care for its residents.Abuse, neglect, and exploitation: In addition to the freedom from abuse, neglect, and exploitation requirements, education should also include:The types of actions that constitute abuse, neglect, exploitation, and misappropriation of resident propertyProcedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property.Dementia Management and resident abuse prevention.