STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056451	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheviot Hills Post Acute	3533 Motor 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 observation, interview, and record review, the facility staff failed to ensure the residents and/or responsible party (RP) were informed in advance, of the risks and benefits of Quetiapine (Seroquel - a prescription medication used to treat mental health conditions by balancing certain natural substances - neurotransmitters in the brain) for one of three sampled residents (Resident 1). This deficient practice violated the residents' right to make an informed decision regarding the use of Seroquel.During a review of Resident 1's admission record, the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought), hypertension (HTN-high blood pressure), and major depressive disorder (MDD - a mood disorder that causes a persistent feeling of sadness and loss of interest).ˆ During a review of Resident 1's physician's order dated 3/11/2026, the order indicated Quetiapine Fumarate Oral Tablet (Quetiapine Fumarate) Give 100 mg by mouth one time a day for MDD with Psychotic [a mental state characterized by a severe loss of contact with reality] features. During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool) dated 3/6/2026, the MDS indicated Resident 1 was severe cognitive impairment (a significant decline in mental abilities-such as memory, thinking, and judgment-that prevents a person from living independently and managing daily tasks). The MDS indicated Resident 1 required substantial/maximal assistance from staff for most of his Activities of Daily Living (ADLs such as, toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, personal hygiene, lower/upper body dressing). During a concurrent interview and record review of Resident 1's consents with the Assistant Director of Nursing (ADON) on 4/27/2026 at 11:06 am, the ADON stated consents for antipsychotics are completed upon admission and when there is a new order. The ADON stated that a consent must include the name of the medication, dosage, route, and frequency of the administration. The ADON confirmed that there was no consent for Seroquel 100mg. The ADON stated that the importance of having a consent ensures that the resident would be getting that medication and that the resident/RP (Resident 1's mom) understood the risks and benefits of the ordered antipsychotic. During a review of a policy and procedures (P&P) titled, Informed Consent for Psychotropic Drugs, reviewed 2/2026 indicated, This policy outlines responsibilities for obtaining, verifying, and documenting informed consent to protect resident rights, promote safety, and facilitate appropriate use of these medications for residents with behavioral or psychotic symptoms, such as those associated with dementia. The same P&P defined informed consent as, Disclosure of material information (e.g., reasons for use, benefits, risks including black box warnings, alternatives including nonpharmacological approaches) to the residents or their representative allowing them to accept, refuse, or revoke consent.

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
	056451	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheviot Hills Post Acute	3533 Motor Avenue Los Angeles, CA 90034

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility to develop and implement and individualized and comprehensive care plan for one out of three sampled residents (Resident 1), who was on Quetiapine (Seroquel - a prescription medication used to treat mental health conditions by balancing certain natural substances - neurotransmitters in the brain) and monitoring for psychotic behaviors manifested by inconsolable screaming. This deficient resulted in Resident 1's behaviors being unmonitored as well as unmonitored adverse drug reactions (undesired and harmful effects that occur because of a medication, treatment, or procedure).During a review of Resident 1's admission record, the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought), hypertension (HTN-high blood pressure), and major depressive disorder (MDD - a mood disorder that causes a persistent feeling of sadness and loss of interest).ˆ During a review of Resident 1's physician's order dated 3/11/2026, the order indicated Quetiapine Fumarate Oral Tablet (Quetiapine Fumarate) Give 100 mg by mouth one time a day for MDD with Psychotic [a mental state characterized by a severe loss of contact with reality] features. During a review of Resident 1's physician's order dated 3/18/2026, the order indicated Quetiapine Fumarate Oral Tablet (Quetiapine Fumarate) Give 150 mg by mouth at bedtime for MDD with Psychotic [a mental state characterized by a severe loss of contact with reality] features M/B inconsolable screaming. ˆ ˆ During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool) dated 3/6/2026, the MDS indicated Resident 1 was severe cognitive impairment (a significant decline in mental abilities-such as memory, thinking, and judgment-that prevents a person from living independently and managing daily tasks). The MDS indicated Resident 1 required substantial/maximal assistance from staff for most of his Activities of Daily Living (ADLs such as, toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, personal hygiene, lower/upper body dressing). During a review of Resident 1's care plans, there was no care plan for Seroquel and no care plan for Resident 1's monitoring for his (Resident 1), psychotic behavior. During a concurrent interview and record review of Resident 1's care plans with the Assistant Director of Nursing (ADON) on 4/27/2026 at 11:06 am, the ADON stated that care plans must be developed for residents being monitored for behavioral issues such as aggressive behaviors and yelling. The ADON stated that care plans must be developed for medications to ensure that the care team is aware about what interventions to carry out for the resident. The ADON confirmed that there was neither a care plan for Resident1's behavior monitoring nor Seroquel. During a review of the policy and procedure (P&P) titled, CARE PLAN COMPREHENSIVE) reviewed 10/20/2025, the P&P indicated An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident ' s medical, physical, mental and psychosocial needs shall be developed for each resident. During a review of a P&P titled, Behavior Management, reviewed 10/20/2025, the P&P indicated, Residents exhibiting behavioral symptoms will be individually evaluated to determine the behavior. The interdisciplinary team identifies underlying medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes that contribute to changes in the residents' behavior. The P&P indicated, Staff will use non-pharmacological interventions as the first line of approach to managing challenging behaviors. behaviors and interventions will be addressed in the care plan.1. The facility will monitor identified residents who:a. Exhibit behavioral symptoms (e.g., verbally or physical abusive, socially inappropriate/disruptive, resist care, wandering, etc.).b. Implement non-pharmacologic interventions as initial interventions.c. Obtain informed consent.d. Refer to mental health services, if necessary.