

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

Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555827	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Atherton Park Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1275 Crane Street Menlo Park, CA 94025	
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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43913 Based on observations, interviews and record reviews, the facility failed to assess the resident for self-administration of medications for Resident 1, when four bottles of medications found in her purse. This failure could result in medication overdose or medication interaction, as these medications are not in MD order. Findings: Review of Admission Record, dated 6/26/2024, indicated, admitted on [DATE], readmitted on [DATE], with diagnoses including: Fracture of Right Femur(a break in the right upper leg), Type 2 Diabetes(a condition with poor controlled blood sugar), Peripheral Vascular Disease(a slow progressive disorder and narrowing of blood vessels). During an observation on 6/26/24 at 12:30 PM, Resident 1 in bed, with a leg immobilizer on right leg, a bandage on right foot. Resident alert and has food on the bedside table. my friend brought me home cooked meal. Per patient, she stays most of the time in bed due to pain, taking Tylenol Arthritis for pain on my own. Resident 1 took out 4 bottles from her purse that is hanging on her overbed table. One unlabeled bottle, resident stated is Tylenol Arthritis. I keep them here so I can take it myself, they don ' t give me pain medication. They give Oxy in the morning and no more. The following are the medication bottles found and showed by the resident: 1. Senna-Time 8.6 tablet, Rx take 2 tablets at bedtime- 10 tablets 2. A white unlabeled bottle with white caplets inside, per resident is Tylenol Arthritis -8 tablets 3. [NAME] Omega 50+ with CoQ10 - empty bottle 4. Zegerid OTC - 12 tablets (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: 555827	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Atherton Park Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1275 Crane Street Menlo Park, CA 94025	
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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/24 at 12:30 PM, with Resident 1, per resident, I did not tell them , they will take it and not give to me my pain pill. During a concurrent interview and record review on 6/26/24 at 1 PM, with DON, per DON, Not aware of her having meds in her purse at her bedside. I will go and check. No self -administration assessment found in chart. No care plan for self -administration and no IDT meeting and recommendation found in chart. Review of MDS, section C dated 5/22/24, BIMS (Brief Interview for Mental Status) result is 8, has cognitive impairment. Review of facility Policy, Self-Administration of Medications, dated 2/2021, indicated, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. 1. As part of the evaluation comprehensive assessment, the IDT assesses each resident ' s cognitive and physical abilities to determine whether self -administering medications is safe and clinically appropriate for the resident. 3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan .9. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555827	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Atherton Park Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1275 Crane Street Menlo Park, CA 94025	
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** 43913 Based on observation, interview and record review, the facility did not ensure the resident is informed of her rights and her rights are protected when: Resident 1 did not have a signed admission agreement and resident received opened mails and packages. This failure resulted in resident in resident feeling disrespected. FINDINGS: Review of Admission Record, dated, 6/26/24, indicated, admitted on [DATE] and readmitted [DATE] with diagnoses including: Osteoarthritis Left Hip(a common disease of the hip due to wear and tear with progressive loss of cartilage), Anxiety Disorder, Post- Traumatic Stress Disorder, Unspecified, Morbid Obesity. During an interview on 6/27/24 at 11:15 AM, with resident in her room, per resident, she got the record she requested on 5/1/24, stated, I did get my records, what I ' m concerned about what they don ' t put in the record. Started February 2024, they don ' t bring me my mail, if ever they come with opened mail. Ordered from Amazon, was given notice delivered already, looking all over nobody knows about it. You did not receive it because you ' re not in compliant, you cannot order alcohol The package was with DON. It was eggnog powder, on the package says its nonalcoholic. To be disrespected and spoken to in that manner. I never received rules and regulations here. : you blasted to your group chat, that [NAME] brought alcohol here She never came to apologize. Patient crying in between. mad at opening my mail Don ' t remember getting an admission agreement. I have depression, and this is affecting my mental health. I did not tell my doctor cause I thought they all know about this in their chat Did not receive Rules and Regulations here so I don ' t know what not to do and people coming after me why I ' m doing what I ' m doing. why no mention of group chat visit with DON about alcohol. Administrator does not know about alcohol because he does not read our group chat according to the lady downstairs in the front. Books are my life, they took away my books. I can stay in my room and read books and be happy. During an interview on 6/26/24 at 1:25 PM, with ADON (Assistant Director of Nursing) per ADON, we try to clean her room, a friend came to help and talk her into it. She gets upset at times. She orders packages from Amazon, someone brings it to her room, either the activity or social service brings her mail. She has the eggnog powder with her. During an interview on 6/26/24 at 1:28PM, with CNA, per CNA, she has been working for nine years in facility, AM shift. No problem with resident, not complaining, mostly in the room, goes out sometimes. Has daughter coming to visit sometimes. Every Sunday she goes to church someone picks her up. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555827	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Atherton Park Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1275 Crane Street Menlo Park, CA 94025	
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	During an interview on 6/27/24 at 11:33AM, with Admissions Director, per AD, resident was given the admission packet on 8/2023 and 4/2024 No follow up and no protocol for when to go back to resident for the signed agreement. Regarding receiving packages, policy is with Social Services, verbal given to patient. When a package comes for her, the team is made aware thru the chat, that includes the Kaiser Case manager and all department heads. Administrator does not usually read the chat but he is in the group. During an interview on 6/27/24 at 12:08 PM, with Social Services, per SS, resident is a hoarder, we had a plan to clean her room a team plus a friend. Friend took knives and sharp objects that she ordered, that was mistakenly given to a different patient. That patient opened the package and stated it 's not hers. Was then delivered to resident already opened, was educated about safety. February 2024, when she ordered from Amazon again, plan by Administrator to have nursing give her package and open in front of her. Resident was told verbally about plans but none in writing. Regarding PTSD, patient declined to share her traumatizing event. Per SS, I will start with an apology and rebuild the trust with her, sorry to hear that made her upset. Review of clinical records on 6/27/24 with SS, per SS no signed admission agreement found on chart. No written policy on online ordering and receiving packages. NO IDT (Interdisciplinary Team) meeting documented but we have met with family and resident and discussed these issues. During an interview on 6/27/24 at 1 PM, with Administrator, per Administrator, I see the patient almost every day, put in a lot of time to this resident. She was not paying the share of cost and buying a lot from online orders. Daughter is applying for POA to be able to have control over her credit card use. She is paying her share of cost now. About the chat group, I don ' t know why someone would tell a resident about it, it ' s an internal communication. The plan is if she receives a package, the AIT (Administrator in Training) will bring to her and take out one item from her room to avoid hoarding and clutter. Had family meetings about this and the expectation from the resident, no documentation of those meetings. Review of MDS, section C- indicates, BIMS (Brief Interview for Mental Status) result is 15, as of May 2024 quarterly assessment. Review of facility Policy, Admission Agreement ,dated 8/2018, indicated, All residents have a signed and dated Admission Agreement on file. 1. At the time of admission, the resident must sign an Admission Agreement (contract). 4. A copy of the Admission Agreement is provided to the resident or his/her representative (sponsor), and a copy placed in the resident ' s permanent file. Review of facility Policy Resident Rights and Responsibilities, dated 3/2017, indicated, Our facility shall inform the resident both orally and in writing of his or her rights as a resident, and the rules and regulations governing the resident ' s conduct and responsibilities during his or her stay in the facility. 1. Prior to or upon admission, a representative of the admitting office will provide the resident with a written copy of resident ' s rights and a copy or synopsis of rules and regulations governing the resident ' s conduct and responsibilities during his /her stay in the facility. 2. A representative from Social Services will be responsible for reviewing these rights and responsibilities orally with the resident. 3. The resident will be required to sign a statement acknowledging that he or she was informed of his or her rights and responsibilities .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555827	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Atherton Park Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1275 Crane Street Menlo Park, CA 94025	
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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43913 Based on observation, interview and record review, the facility did not ensure that Resident 1 was provided pain management based on a comprehensive assessment after the incident, incident 1, when her right foot got caught while CNA wheeling resident in her wheelchair without foot rest inside the room, incident 2, while coming out of third floor elevator, right foot got caught again in the wheel of the wheelchair, incident 3, resident complained of pain, wanted to go back to bed, not able to do bike exercise due to pain. Resident 1 called 911 due to pain. This failure resulted in Resident 1 suffering from severe pain. Findings: Review of Admission Record, dated 6/26/2024, indicated, admitted on [DATE], readmitted on [DATE], with diagnoses including: Fracture of Right Femur (a break in the right upper leg), Type 2 Diabetes(a condition with poor controlled blood sugar), Peripheral Vascular Disease(a slow progressive disorder and narrowing of blood vessels). Review of facility Summary of Investigation, undated, indicated, On May 20th, resident called 911 herself to report uncontrolled pain in her right leg which was spreading to her left leg. The patient was transferred to acute setting for further evaluation and treatment. Based on hospital records, it was noted that resident presented with a closed fracture of distal end of right femur. This patient hasn ' t had any falls during her entire stay in this facility. However, the only potential event that could be related to this injury happened last Thursday 5/16/24, the patient had an incident while being wheeled in her wheelchair and her right leg was caught between one of the wheels and the floor . The patent was taken to her room, was assessed, VS ., no physical injuries noted besides pain 8/10 in her right knee. MD/NP informed, STAT x-rays ordered for right leg and ankle .no visualized acute fracture or dislocation in the right ankle .Patient was stable without concerns until 5/20/24 when she called herself 911 . returned 5/21/24, no surgery done, referred to orthopedic follow up in two weeks, the patient has new pain management, but no further precautions or orders. Will monitor. Review of hospital document, Progress Notes, dated,6/13/24 visit, indicated, patient is three weeks now status post injury . treated non operatively. She is essentially bedbound. She does endorse knee pain, 9/10 and is only taking Tylenol and oxycodone as needed. Right knee range of motion was deferred due to pain. Instructions: take 1000 mg Tylenol every 6 hrs, add 600mg Motrin, take with food, prescribed Opiate narcotic medication every 6 hrs for pain. Wear knee immobilizer for comfort and pain, may participate in PT as tolerated maintain non weight bearing status of the leg, elevate leg when resting ffup with ortho in 2 weeks. During an interview on 6/26/24 at 11 AM with Certified Nursing Assistant (CNA)1, CNA 1 was in resident ' s room, stated, she was not my patient on 5/20/24, heard her screaming from a lot of pain. I told the nurse, CNA assigned to her was doing her care, was yelling at the patient. Patient said, you ' re breaking my leg don ' t do that. I told the nurse, a male nurse came about 9 PM then I left. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555827	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Atherton Park Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1275 Crane Street Menlo Park, CA 94025	
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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/24 at 11:15 AM, with Resident 1, stated, I was up in a wheelchair in the morning, CNA 3 pulled the wheelchair and twisted my leg, around 9 AM to go to bicycle in rehab gym. Not able to do bicycle because my leg was twisted, they put me back to bed, I was in pain. The PM shift CNA was changing my diaper and I told her don ' t push my leg like that. During an interview on 6/26/24, at 12:30 PM, with Resident 1, per Resident 1, that night my regular CNA 4 needed help to change me. Lady CNA 2 came to help, she was pushing me to his side. They finished cleaning me and I was in a lot of pain. I called 911 myself, they don ' t do anything for me. Took me to the hospital and took a lot of tests then came back here. During an observation on 6/26/24 at 12:30 PM, Resident 1 in bed, with a leg immobilizer on right leg, a bandage on right foot. Resident alert and has food on the bedside table. My friend brought me home cooked meal. Per patient, she stays most of the time in bed due to pain, taking Tylenol Arthritis for pain on my own. Resident 1 took out 4 bottles from her purse that is hanging on her overbed table. One unlabeled bottle, resident stated is Tylenol Arthritis. I keep them here so I can take it myself, they don ' t give me pain medication. They don ' t want to take care of my legs. Sometimes I don ' t feel secure with the CNAs but better now. ' I have fallen a lot at home but never broke a bone. I want to get better and go home. During an interview on 6/27/24 at 1:20 AM, with CNA 2, per CNA2, patient needs two persons assist to change and clean her. That day CNA 4 asked me to help him, could be Sunday 5/19/24. Patient was in pain and knee and legs were swollen. After dinner patient needed change of diaper, CNA 4 is her regular PM CNA. He was cleaning and I was helping turn to my side. Patient was not yelling but complaining of pain. Patient told me that her leg got hit on the wheelchair by CNA 3. During an interview on 6/27/24 at 11:20 Am, with CNA 3, per CNA 3, who has worked for three months, she was assigned to resident on 5/16/24 AM shift. Patient was up in the wheelchair using Hoyer lift with two-person transfer. Patient has as appointment to rehab gym for bicycle exercise on the third floor. Going out of the room, her foot went inward the wheel, no footrest. The second time, on the third floor getting out of the elevator, her foot got caught again in the wheelchair. Told RNA about the incident and the RN on the second floor. Patient did not go for her exercise, came back to the room and wanted to go back to bed complaining of pain. During an interview on 6/27/24 at 2:24PM, with CNA 4, per CNA 4, on 5/19/24, CNA 2 was the morning shift, worked double so I asked her for help with Resident 1. Resident 1 has been in pain since 5/16/24. That day, resident was not yelling but complaining of pain, ouch when touched. The Licensed nurse knows. Review of clinical document, Progress Notes, dated 5/16/24 at 13:18, indicated, Resident accidentally caught her right leg from chair and into the floor, while CNA wheeling her to RNA room. Currently c/o 8/10 knee pain, no redness or swelling at this moment. VS .RP (brother) made aware and also MD/NP notify. NP came and visit and assess patient with order of STAT leg/ankle x-ray to R/O fracture. No nursing assessment and pain documentation that address the 5/16/24 incident, from 5/17/24 to 5/20/24. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555827	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Atherton Park Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1275 Crane Street Menlo Park, CA 94025	
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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Progress Notes, dated 5/20/24 at 16:00, indicated, patient called 911 and has been taken to acute due to right leg pain which she states has spread to her left. She did not report to AM nurse or myself. When I went to check in on her at start of PM shift she was already on the phone with 911. MD aware. During an interview on 6/27/24 at 2:14PM, with Director of Nursing (DON), per DON, she is one of our long term care patient, I go visit her sometimes. She is a Hoyer lift 2 person -assist during transfer. Incident on her leg was twisted on 5/16/24 and was stable till 5/20/24 when sent to ER, patient called 911 self. There was no daily documented assessment of the incident prior to resident calling 911. I did not further investigate as I linked the cause of fracture to the 5/16 incident. Review of Care plan, no care plan found for 5/16/24 incident. Review of facility Policy and Procedure, Pain Assessment and Management, dated 10/22, indicated, 4. Comprehensive pain assessments are conducted upon admission to facility .whenever there is a significant change of condition, and when there is onset of new pain or worsening of existing pain. Review of facility Policy and Procedure, Comprehensive Assessments, dated 10/22, indicated, Comprehensive assessments are conducted to assist in developing person-centered care plans. 5. A significant change is a major decline or improvement in a resident ' s status: a. will not normally resolve itself without intervention . b. impacts more than one areas the resident ' s health status and 3. Requires interdisciplinary review and/or revision of the care plan. Review of facility Policy and Procedure, Change on a Resident ' s Condition or Status, dated 2/21, indicated, 9. If a significant change in the residents physical or mental condition occurs, a comprehensive assessment of the resident ' s condition will be conducted as required by current OBRA regulations .		