

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 05/09/2025
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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44477</p> <p>Based on observation, interview and record review, the facility failed to develop and implement a person-centered comprehensive care plan (a detailed approach to care customized to an individual resident's needs) for one of 2 sampled residents (Residents 1) when the elopement (the act of leaving a facility unsupervised and without prior authorization) care plan was not applicable for Resident 1 after he eloped the facility on 4/14/25.</p> <p>This deficient practice was likely to fail to meet Residents 1's nursing needs and goals to attain his highest practicable well-being.</p> <p>Findings:</p> <p>Review of Resident 1's clinical record indicated, Resident 1 was admitted to the facility with diagnoses including dementia (a progressive state of decline in mental abilities), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and hypertension (high blood pressure).</p> <p>Review of Resident 1's Nurse's Notes dated 4/14/25 at 7:56 PM indicated, Elopement: The patient was found at Crane Street (the street where the facility is located) being wheeled back to ***** (the facility's name) by 2 gentlemen that serves (sic) in the nearby Catholic Church @ (at) 1938 (7:38 PM). Upon Interview statement from the gentlemen, the patient was found along University Dr. (one block away from the facility) asking for help dueto (sic) being loss (sic). The writer then wheeled the patient back to ***** (the facility's name) . First time the patient eloping from facility. The patient stated that he just wanted to go outside due to the nice warm weather .</p> <p>During a concurrent observation and interview on 5/9/25 at 10:47 AM with Resident 1 in his room, Resident 1 was sitting in a wheelchair without an injury. He was confused with place and time, and forgetful. But he stated, he remembered the incident when asked. Resident 1 stated, he left the facility in his wheelchair without telling staff simply because he wanted to go for a walk outside. Resident 1 stated, he had to use the wheelchair because he could not walk. Resident 1 stated, he was probably out about an hour when asked.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 5/9/25 at 12:38 PM with Director of Nursing (DON) and Maintenance Director in front of the main entrance of the facility building, the main entrance was observed. DON stated, after 8 PM, the main entrance automatically locks, so from the outside, staff must enter a PIN number and visitors must call the 2nd floor to get into the facility building, but people can leave from the inside. Maintenance Director demonstrated how the main entrance door works after 8 PM. There was no issue.</p> <p>During a concurrent interview and record review on 5/9/25 at 12:45 PM with DON, Resident 1's Care Plan Report dated 4/14/25 was reviewed. The elopement care plan indicated, . Disguise exits: cover door knobs and handles, tape floor . DON stated, this care plan meant for the main entrance when asked. DON acknowledged, there was no cover on the doorknob and no tape on the floor when asked. DON stated, this care plan was not applicable for Resident 1 when asked. She stated, Not personalized when asked about the care plan.</p> <p>During a concurrent interview and record review on 5/9/25 at 1:25 PM with DON, Resident 1's Minimum Data Set (MDS, resident assessment tool) dated 1/21/25 and 4/14/25 were reviewed. The MDS dated [DATE] indicated, Resident 1 was cognitively intact, and the MDS dated [DATE] indicated, he was cognitively moderately impaired. DON stated, Resident 1's cognition varies from day to day due to his dementia.</p> <p>During an interview on 5/9/25 at 1:40 PM with Receptionist, Receptionist stated, she saw Resident 1 was in the lobby when she was helping one resident back to the elevator on 4/14/25 around 7 PM, then she helped another resident, then around 7:30 PM, she realized Resident 1 was missing.</p> <p>Review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered revised in March 2022, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative develops and implements a comprehensive, person-centered care plan for each resident . The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .</p>		