

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

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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 02/14/2025
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)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40454 Based on observation, interview, and record review, the facility failed to provide a comfortable, homelike environment to two of two sampled residents (Resident 12, and Resident 136) when Residents 12 and Resident 136 shared the same bedroom with a resident in bed C (Resident 68) who repeatedly yelled and screamed. The facility failure to provide comfortable and homelike environment had the potential to negatively impact the psychosocial well-being of Resident 12 and Resident 136. Findings: A review of the admission records indicated Resident 136 was admitted with diagnoses including dementia (a decline in memory or other thinking skills) and hypertension (abnormally high blood pressure). A review of the Minimum Data Set (MDS, a standardized assessment tool) for Resident 136 dated 11/18/24, Brief Interview of Mental Status (a brief memory test to help determine cognitive functioning such as memory/recall ability and decision-making ability) score of 6 indicated severe cognitive impairment. During observation on 2/9/25, at 12:36 PM, Resident 136 was sitting at the foot of her bed, looking towards bed C (Resident 68), grabbing the divider curtain and throwing it back. Resident 68 was yelling and screaming. Resident 136 covered her face and was shaking her head. A review of the physician (Medical Doctor) order for 2/2025, indicated Resident 136 was under hospice services (a specialty care that focuses on comfort and quality of life for people with serious illness). During an interview on 2/12/25, at 9:45 AM, Certified Nurse Assistant (CNA) 1 stated Resident 136 does not talk too much. CNA further stated that Resident 136 spends time outside of her room sitting on her wheelchair in the hallway. CNA 1 acknowledged the resident occupying bed C, Resident 68, repetitively yells and screams. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/14/25, at 1:25 PM, Activity Assistant (AA) 1 stated when spending an in-room activity with Resident 136, Resident 68 was yelling a lot. AA 1 further stated Resident 68 yells even when attending group activities. A review of the admission records indicated Resident 12 was admitted with diagnoses including congestive heart failure (when the heart muscles does not pump as strong as it should), and chronic obstructive pulmonary disease (a lung disease that makes it hard to breath). A review of the MDS dated [DATE], BIMS score of 15 indicated Resident 12 was cognitively intact. During an interview on 2/12/25, at 10:04 AM, Resident 12 stated that her roommate, Resident 68, had been bothering her. Resident 12 stated, [Resident 68] yells and screams all the time. Resident 12 further stated, I wake up from my sleep and she's yelling. I don't like it. I talked to [Social Services Assistant, SSA 1] that I wanted another room. I am still waiting. It's been a long time. A review of the admission records indicated Resident 68, had diagnoses including schizophrenia (a serious mental illness that affects how a person think, feels, and behaves), mood disorder (a serious mental illness that affects emotional state), and dementia. During an interview on 2/12/25, at 2:49 PM, SSA 1 stated, [Resident 68] does not yell constantly. During an interview on 2/13/25, at 2:45 PM the Director of Nursing (DON) stated, If I move [Resident 68] I am just moving the problem. A review of the facility Policy and Procedure titled, Resident's Rights dated 2/2021, indicated, .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence, be treated with respect, kindness, and dignity, .exercise his or her rights as resident of the facility .be supported by the facility in exercising his or her rights .		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 40454 44477 Based on interview, and record review, the facility failed to inform and provide written information to residents or residents' representatives to formulate advance directives (A legal document indicating resident preference on end-of-life treatment decisions) when there was no evidence of offering and educating the advance directives to 13 out of 30 sampled residents (Residents 17, 21, 29, 31, 39, 46, 67, 68, 93, 94, 136, 139, and 317). These failures were likely to result in not following the residents' desired health care decisions when they become unable to make decisions for themselves. Findings: During an interview on 2/12/25 at 11:05 AM with Social Services Assistant (SSA) 1, SSA 1 stated, when a resident comes into the facility, the Social Services asks for a copy of advance directive to the resident. SSA 1 stated, if the resident wants an assist regarding the advance directive, the Social Services helps the resident. Review of Resident 17's Physician Orders for Life-Sustaining Treatment (POLST) dated 12/7/17 indicated, there was no check mark regarding Advance Directive. Review of Resident 31's Physician Orders for Life-Sustaining Treatment (POLST) dated 7/31/20 also indicated, there was no check mark regarding Advance Directive. During a concurrent interview and record review on 2/12/25 at 11:17 AM with SSA 1, Resident 139's document titled, Physician Orders for Life-Sustaining Treatment (POLST) dated 8/22/24 was reviewed. The POLST indicated, there was no check mark regarding Advance Directive. SSA 1 stated, Not yet. No. We don't have a file for him when asked if there was evidence of offering and educating Advance directive to Resident 139. During a concurrent interview and record review on 2/12/25 at 12:26 PM with SSA 1, Resident 29's Physician Orders for Life-Sustaining Treatment (POLST) dated 11/27/24 was reviewed. The POLST indicated, there was no check mark regarding Advance Directive. SSA 1 stated, POLST was discussed but did not go into detail about Advance Directive . SSA 1 stated, No when asked again if there was evidence of offering and educating advance directive to Resident 29. During an interview on 2/12/25 at 12:47 PM with SSA 1, SSA 1 stated, No. We don't have the specific to Advance directives . when asked if there was evidence of offering and educating Advance directives to Resident 17, and Resident 31. During an interview on 2/12/24, at 2:49 PM, SSA 1 acknowledged there were no proof of documentation of advance directives for Resident 93, Resident 68, Resident 94, Resident 136, Resident 46, Resident 317, Resident 21, Resident 67, and Resident 39. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedure (P&P) titled, Advance Directives revised in September 2022 indicated, . The resident has the right to formulate an advance directive . The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 3. Written information about the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive is provided in a manner that is easily understood by the resident or representative. 4. Written information includes a description of . policies to implement advance directives and applicable state law . 1. If the resident or representative indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. a. The resident or representative is given the option to accept or decline assistance, and care will not be contingent on either decision. b. Nursing staff will document in the medical record the offer to assist and the residents decision to accept or decline assistance . Review of the facility's P&P titled, Social Services revised in September 2021 indicated, . m. assisting residents with advance care planning, including but not limited to completion of advance directives .		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 44477 Based on observation, interview and record review, the facility failed to develop and implement comprehensive care plans that included measurable objectives and specific interventions for four of 30 sampled residents (Residents 77, 143, 93, and 136) when: 1. For Resident 77, there was no evidence of comprehensive care plan for his hearing difficulty. 2. For Resident 143, there was no evidence of comprehensive care plan for the use of Eliquis (anticoagulant, commonly known as a blood thinner, drugs that prevent blood clots from forming). 3. For Resident 93, there was no evidence of comprehensive care plan for suicidal ideation. 4. For Resident 136, there was no evidence of comprehensive care plan for depressed mood. These deficient practices were likely to fail to meet the residents' nursing needs and goals to attain their highest practicable well-being. Findings: 1. Review of Resident 77's clinical record indicated, Resident 77 was admitted to the facility with diagnoses including influenza (commonly known as the flu, a contagious respiratory illness caused by influenza viruses), diabetes (high blood sugar), and hypertension (high blood pressure). Review of Resident 77's Minimum Data Set (MDS, resident assessment tool) dated 1/8/25 indicated, he was cognitively moderately impaired. During an interview on 2/11/25 at 12:38 PM, with Resident 77, Resident 77 stated, he could not hear well when asked. During an observation on 2/12/25 at 2:09 PM, in Resident 77's room, Licensed Vocational Nurse (LVN) 2 was changing Resident 77's pressure ulcer dressings on the sacral area. When LVN 2 spoke to the resident, because Resident 77 was hard of hearing, she had to get close to his ear and speak to him per his request. During a concurrent interview and record review on 2/12/25 at 2:38 PM, with LVN 1, Resident 77's care plans were reviewed. There was no care plan for Resident 77's hearing difficulty. LVN 1 stated, No care plan that I saw, when asked if Resident 77 had a care plan for his hearing problem. LVN 1 acknowledged, Resident 77 was somewhat hard of hearing, and needed a care plan for his hearing difficulty. 49373 2. Review of Resident 143's Admission Record, indicated Resident 143 was admitted with diagnoses including long term use of anticoagulants. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 143's Physician's Progress Note, dated 12/18/24, indicated Resident 143 had a history of Deep Vein Thrombosis (DVT, a blood clot that forms in a deep vein, usually in the leg, which can cause swelling, pain, and redness). Review of Resident 143's Order Summary, dated 12/24/24, indicated an order for Resident 143 to receive, Eliquis Oral Tablet 5 MG (milligram, unit of weight) .Give 1 tablet by mouth two times a day for DVT. During a concurrent interview and record review on 2/11/25 at 2:12 PM, with the Director of Nursing (DON), Resident 143's care plan titled, The resident is on anticoagulant therapy (use of ASPIRIN [a medication to treat pain, fever, reduce the risk of heart attack and stroke]) r/t (related to) DVT, last revised on 12/17/24 was reviewed. The care plan indicated Resident 143 uses Aspirin and not Eliquis for DVT. The DON stated the resident was never on Aspirin and Eliquis is the anticoagulant medication Resident 143 has been taking since admission. The DON further stated, the care plan is not person centered and the resident's specific medication should reflect on the care plan for proper implementation of the intervention. 40454 3. A review of the face sheet indicated, Resident 93 was admitted with diagnoses including major depressive disorder (a mental illness characterized by severe sadness, loss of interest, and hopelessness). A review of Minimum Data Set (MDS, a standardized assessment tool) Brief interview of Mental Status (BIMS, a brief memory test to help determine cognitive functioning including memory/recall and decision-making ability) score of 15 indicated Resident 93 was cognitively intact. During observation and interview on 2/10/25, at 2:24 PM, Resident 93 claimed severe no interest to do things, does not want to socialize, and has no appetite. A review of the physician order dated 2/2025, indicated, Resident 93 receives duloxetine (a medication used to treat depression) and quetiapine (a medication used to treat severe mental illness) and was monitored for insomnia (difficulty falling asleep or staying asleep), verbalization of sadness and paranoid delusion (fixed irrational thoughts and beliefs). A review of the psychiatrist consultation notes dated 1/8/25, indicated, Resident 93 had anxiety symptoms that included excessive worry, anxious, and feeling nervous or on edge . During an interview on 2/13/25, at 2:45 PM, with Director of Nursing (DON), DON stated that the psychiatrist consultation reports were handles by the facility (Case Manager, CM). The DON acknowledged the psychiatrist communication report was not communicated with the interdisciplinary team members. 4. A review of the admission records indicated Resident 136 was admitted with diagnoses including dementia (a decline in memory or other thinking skills) and hypertension (abnormally high blood pressure). (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 2/9/25, at 12:36 PM, Resident 136 was sitting at the foot of her bed, looking towards bed C, grabbing the divider curtain and throwing it back. Residents romate in bed C was yelling and screaming. Resident 136 covered her face and was shaking her head. During an observation on 2/13/25, at 10:04 AM, Resident 136 has flat affect (no expression of emotion). Registered Nurse (RN) 1 stated Resident 136 does not talk too much. A review of the Minimum Data Set (MDS, a standardized assessment tool) dated 11/18/24, Brief Interview of Mental Status (a brief memory test to help determine cognitive functioning such as memory/recall ability and decision-making ability) score of 6 indicated severe cognitive impairment. Resident 136's mood indicated: Feeling down, depressed, or hopeless. Trouble falling asleep or staying asleep or sleeping too much. Feeling tired or having little energy. Trouble concentrating on things such as reading newspaper or watching television. A review of the physician (Medical Doctor) order for 2/2025, indicated Resident 136 was under hospice services (a specialty care that focuses on comfort and quality of life for people with serious illness). During an interview on 2/13/25, at 3:47 PM, Social Services Assistant (SSA) 1 acknowledged the assessment completed indicating Resident 136 experiencing distressed mood. SSA 1 acknowledged there were no care plan developed with interventions implemented for the identified signs of distressed mood for Resident 136. During an interview on 2/14/25, at 2:45 PM, the Director of Nursing acknowledged there were no care plan developed, and no intervention implemented to address the signs of distressed mood for Resident 136. A review of the facility Policy and Procedure titled Behavioral Assessment, Intervention and Monitoring dated 3/2019, indicated, The facility will provide, and residents will receive behavioral health services as needed to attain and maintain the highest practicable physical, mental, and psychosocial well-being in accordance with comprehensive assessment and plan of care. Behavioral symptoms will be identified using facility approved behavioral screening tools and the comprehensive assessment . As part of the comprehensive assessment, staff will evaluate, based on input from the resident, family and caregivers, review of medical records . The nursing staff will identify, document, and inform the physician about specific details, regarding changes in an individual's mental status, behavior, and cognition, including onset, duration, intensity and frequency of behavior symptoms .The interdisciplinary team with thoroughly evaluate new or changing behavioral symptoms to identify underlying causes and address any modifiable factors that may have contributed to the residents change in condition . A review of the facility Policy and Procedure titles, Care Plans, Comprehensive Person -Centered dated 3/2022, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, mental, psychosocial and functional needs is developed and implemented for each resident. The 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 .		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40454 Based on observation, interview, and record review, the facility failed to provide adequate plan for staff monitoring and intervention for Resident 93 who had suicidal ideation when the facility did not develop a plan and coping skills and update assessments which should have led to timely updating of resident care plan for safety. The facility failure had the potential for resident harm. Findings: A review of the face sheet indicated, Resident 93 was admitted with diagnoses including major depressive disorder (a mental illness characterized by severe sadness and hopelessness). A review of Minimum Data Set (MDS, a standardized assessment tool) Brief interview of Mental Status (BIMS, a brief memory test to help determine cognitive functioning including memory/recall and decision-making ability) score of 15 indicated Resident 93 was cognitively intact. During observation and interview on 2/10/25, at 2:24 PM, Resident 93 stated experiencing severe depression. Resident 93 further stated having no interest to do things, does not want to socialize, and has no appetite. A review of the physician order dated 2/2025, indicated, Resident 93 receives duloxetine (used to treat depression) and quetiapine (used to treat severe mental illness) and was monitored for insomnia (difficulty falling asleep or staying asleep), verbalization of sadness and paranoid delusion (fixed irrational thoughts and beliefs). A review of the psychiatrist notes dated 1/8/25, indicated, Resident 93 has been experiencing persistent depression. The psychiatrist notes further indicated, .They report feeling very depressed, rating their depression as a 10 on a scale of 1 to 10, with 10 being the worst. They expressed feelings of hopelessness and worthlessness, and also report significant anxiety (excessive and persistent worry and fear) . She has been more isolative and reports amotivation (lack of interest). Depressive symptoms including . thoughts of wanting to die . During an interview on 2/24/25, at 2:45 PM , Director of Nursing (DON) acknowledged Resident 93 had thoughts of wanting to die and stated that the psychiatrist consultation notes was not communicated to the Interdisciplinary Team (IDT). (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility Policy and Procedure titled Behavioral Assessment, Intervention and Monitoring dated 3/2019, indicated, .Behavioral symptoms will be identified using facility approved behavioral screening tools and the comprehensive assessment. As part of the comprehensive assessment, staff will evaluate, based on input from the resident, family and caregivers, review of medical record and general observations . The interdisciplinary Team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to resident and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm . Intervention and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior .		

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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. 40454 Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety when the chopping boards were in poor condition. The facility failure had the potential to cause food borne illness for 153 residents who received food from the kitchen. Findings: During concurrent observation and interview on 2/9/25, at 10:01 AM, with Dietary Aide 1, three cutting boards were found with significant amount of deep scratch marks. The three cutting boards were discolored with dark brown and black residue. DTA 1 acknowledged the cutting boards were scratched and had rough surfaces, with dark brown and black discolorations, and stated, It's old and these are stains. According to the 2017 Federal Food Code, food contact surfaces are to be smooth, free of inclusions, pits and similar imperfections, and are to be clean to sight, and touch.		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 49373 Based on interview, and record review, the facility failed to ensure one of three sampled residents (Resident 138) understood the arbitration agreement (a contract in which parties agree to resolve disputes), signed during admission to the facility. This deficient practice resulted in Resident 138 signing the facility's arbitration agreement without full understanding. Findings: Review of Resident 138's Admission Record, indicated Resident 138 was admitted with diagnoses including Cerebral Infarction (a condition when a blood clot stopped the blood flow to the brain) and Cognitive Communication Deficit (difficulty in communicating clearly due to problems with speaking and understanding). Review of Resident 138's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 1/7/25, Brief Interview for Mental Status (BIMS, MDS tool that measures resident cognition) score of 2 indicated severe cognitive impairment. During an interview on 2/12/25 at 12:00 PM, Resident 138 responded with sounds that cannot be understood and no words were spoken when asked about knowing an arbitration agreement and remembering signing one at the facility. During a concurrent interview and record review on 2/12/25 at 2:19 PM with the Administrator (ADM), the Arbitration Agreement (AA), was reviewed. The AA indicated Resident 138 signed the agreement on 1/7/25. The ADM stated the resident's BIMS score is 2 and the AA will be terminated. During a concurrent interview and record review on 2/12/25 at 2:35 PM with the Director of Admission and Marketing (DAM), the Arbitration Agreement (AA), was reviewed. The AA indicated Resident 138 signed the agreement on 1/7/25. The DAM stated it was inappropriate for a resident with a BIMS score of 2 to sign an AA, as the resident was not cognitively aware, and did not comprehend the agreement. During an interview on 2/13/25 at 3:28 PM, the DON stated BIMS score of 2 indicated severe cognitive impairment with the resident being alert and oriented only to self. The DON further stated the resident did not understand what was being signed when asked if the resident with a severe cognitive impairment could sign an agreement.		