STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555819	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmwood Care Center	2829 Shattuck Avenue Berkeley, CA 94705

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interviews and record reviews, the facility failed to report of suspected allegations of abuse for two of two sampled residents (Resident 1 and Resident 2) within the required 24-hour time frames when:Resident 1 who had a bruise of unknown origin on the right upper arm was not reported to the State Survey Agency and Long-Term Care Ombudsman (LTCO, resident advocate) within the reporting time frame. Resident 2's suspected allegation of verbal abuse from an employee was not reported to the LTCO. These failures had a potential to delay protective investigations and placed Resident 1 and Resident 2 at risk for ongoing unaddressed abuse and potential harm. During a record review of Resident 1's admission Record (AR), printed on 9/29/25, the AR indicated Resident 1 was admitted to the facility in June 2025 with diagnoses of dementia (a condition that affects memory and thinking), age-related cognitive decline, and major depressive disorder (a condition where someone feels very sad, tired, hopeless for a long time. and it affects daily activities).During a record review of Resident 1's SBAR (Situation, Background, Appearance, Review and Notify) Communication Form, dated 11/25/25, the SBAR record indicated at around 9:00 a.m., Resident 1 was observed to have a bruise on her right upper arm and Resident 1 did not know how she got it. During a record review of the facility's Unusual Occurrence report, dated 11/27/24, the Unusual Occurrence report showed the investigation for Resident 1's bruise on the right upper arm from an unknown source was only initiated two days later after the bruise was first observed. The Unusual Occurrence report also showed the required notifications to the State Survey Agency were not made within the 24-hour reporting time frame. During a record review of Resident 2's AR, printed on 9/29/25, the AR indicated Resident 2 was admitted to the facility in December 2024 with diagnoses of cellulitis (skin infection) of abdominal wall and ileostomy status (presence of an opening in the stomach where waste comes out into a bag).During a record review of Resident 2's SBAR record, dated 1/27/25, the SBAR record indicated Resident 2 verbalized that a Certified Nurse Assistant (CNA) was verbally inappropriate and rude towards Resident 2. SBAR showed Resident had verbalized that the CNA told her, You're here because God doesn't like you.During an interview on 9/29/25 at 11:39 a.m. with the Infection Preventionist (IP) also Director of Nursing designee, IP stated they were unable to locate copies of notification receipts that should have been sent to the LTCO regarding the allegations of abuse for Resident 1 and Resident 2. The IP further stated the LTCO should have been notified of the allegations of abuse so the LTCO could conduct their own investigation, as they serve as an advocate for the residents.During an interview on 9/29/25 at 2:36 p.m. with the Administrator (ADM), ADM stated if there was an unknown source of an injury, she would have initiated an investigation and interviewed the staff immediately. ADM stated she would have also notified the State Survey Agency, LTCO, and the police department immediately or within 24 hours, as required by the regulation, in order to rule out rule out abuse. ADM further stated LTCO should have been notified of the allegations of abuse because LTCO may obtain additional information or a different perspective from residents during their interviews. ADM stated it was important to initiate a thorough investigation summary to ensure no other residents had experienced the similar allegation of abuse and to ensure safety of all residents. During a phone interview on 9/30/25 at 10:50 a.m. with LTCO 1, LTCO 1 confirmed they did not receive notifications of the alleged abuse of Resident 1 and Resident 2. LTCO 1 stated they checked their records found no documentation or reports related to the alleged incidents.During a record review of the facility's policy and procedure (P&P), titled Abuse Investigation and Reporting, dated March 2017, the P&P indicated, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies.and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.Role of the Administrator.1. If an incident of resident abuse.neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual.The Administrator will ensure any further potential abuse.Role of the investigator.3. The investigator will notify the ombudsman that an abuse is being conducted. The ombudsman will be invited to participate in the review process.Reporting.1. All alleged violations involving abuse.including injuries of an unknown source.will be reported by the facility Administrator, or his/her designee to the following agencies.a. The State licensing/certification agency.b. The local/State Ombudsman. 2. Suspected abuse, neglect, .or mistreatment (including injuries of unknown source.) will be reported within two hours.If the events that cause the allegation do not involve abuse or not resulted in serious bodily injury, the report must be made in twenty-four hours

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interviews and record reviews, the facility failed to ensure a thorough investigation was conducted and completed within five working days following an allegation of abuse for one sampled resident (Resident 2) and the facility did not not have an investigation summary documenting the findings and result of the investigation.This failure had the potential for the allegation of abuse to remain uninvestigated and placed Resident 2 at risk for ongoing abuse due to the absence of protective interventions and corrective actions. During a record review of Resident 2's admission Record (AR), printed on 9/29/25, the AR indicated Resident 2 was admitted to the facility in December 2024 with diagnoses of cellulitis (skin infection) of abdominal wall and ileostomy status (presence of an opening in the stomach where waste comes out into a bag. During a record review of Resident 2's SBAR (Situation, Background, Appearance, Review and Notify) record, dated 1/27/25, the SBAR record indicated Resident 2 verbalized that a Certified Nurse Assistant (CNA) was verbally inappropriate and rude towards Resident 2. SBAR showed Resident had verbalized that the CNA told her, You're here because God doesn't like you.During an interview on 9/29/25 at 11:39 a.m. with the Infection Preventionist (IP) also Director of Nursing designee, IP stated they were unable to locate the investigation summary for Resident 2. IP stated the investigation summary should have been done and completed within five working days to ensure there was sufficient time to conduct a thorough investigation of the alleged abuse. The IP further stated she could not determine what transpired during the investigation because there was no documentation showing the findings or results of the investigation.During an interview on 9/29/25 at 2:36 p.m. with the Administrator (ADM), ADM stated if there was an allegation of abuse, an investigation would be conducted. ADM stated she would also notify the State Survey Agency, Long-Term Care Ombudsman (LTCO) and the Police Department immediately or within 24 hours, as required by regulation, to rule out abuse. ADM stated she had five working days to complete a thorough investigation of an allegation of abuse. ADM stated it was important to have the investigation summary completed to ensure no other residents had experienced the same allegation of abuse and to ensure the residents involved were protected from further harm.During a record review of the facility's policy and procedure (P&P), titled, Abuse Investigation and Reporting, dated March 2017, the P&P indicated, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies.and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.6. The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five working days of the occurrence of the abuse.