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	02/18/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide adequate supervision to one of three sampled residents (Resident 1), when Resident 1, with a history of repeated falls, sustained another fall while ambulating (walking) on his own in the facility's hallway.This failure resulted in Resident 1's falling on the ground, sustaining a fracture (broken bone) to the right hip, and transferring to the acute care hospital for right hip surgery.During a review of Resident 1's admission Record (a record with basic information) printed on 11/3/25, the record indicated Resident 1 was admitted on the facility on 04/07/25.During a review of Resident 1's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 10/12/25, indicated Resident 1's Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information), score was 10 out of 15, indicating moderate cognitive (mental status) impairment. The record indicated Resident 1 had a diagnosis of Schizophrenia, (a severe chronic mental disorder that results in disorganized thinking and behavior). Review of Functional Abilities section indicated Resident 1 required a manual wheelchair and was able to wheel at least 50 feet, was able to sit to stand, and walk at least 50 feet with supervision/touching assistance (where staff provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity). The assessment also indicated facility did not attempt to assess Resident 1 to walk 150 feet due to his medical conditions or safety concerns.During a review of Resident 1's Fall Risk Assessment, (an evaluation used to identify a resident's likelihood of falling and suffering injury), dated 10/12/25, the assessment indicated Resident 1's fall score as 50 related to Resident 1's history of falls, unsteady and weak gait (balance during walking), and the need to use wheelchair for mobility. During a review of Resident 1's undated Fall Care Plan, the care plan indicated Resident 1 was at risk for falls. The record indicated an intervention dated 9/10/25, stating, staff was to admit Resident 1 to high risk unit, anticipate and meet resident's needs, and to follow facility's fall protocol. During an observation on 02/18/26 at 09:30 a.m. in the facility hallway where Resident 1 was found on the floor on 11/01/25, it was noted that residents would make at least one turn to 2nd hallway to enter the patio, where Resident 1 was coming from on the day of his fall. During concurrent observation and interview of Resident 1's room, on 2/18/26 at 1:00 p.m., Resident 1 was in bed. Resident 1 stated he did not remember anything about the fall incident that occurred on 11/1/25.During an interview on 2/18/26 at 12:00 p.m., Certified Nursing Assistant (CNA 1) stated facility had a designated high fall risk unit for residents who were high fall risk for close monitoring. CNA 1 stated staff assigned in that area conducted every 15 mins rounds on high fall risk residents.During a telephone interview on 2/23/26 at 9:20 a.m., CNA 2, who worked in the facility on 11/1/25, stated she did not witness Resident 1 falling on that day. CNA 2 stated, however she knew (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 0689 Level of Harm - Actual harm Residents Affected - Few	that Resident 1 required one staff's assistance for mobility while he was in wheelchair and/or needed a ride to get to facility patio. CNA 2 stated Resident 1 was unstable while walking independently.During a telephone interview on 2/23/26 at 1:38 p.m., CNA 3, who worked in the facility on 11/1/25, stated she did not witness Resident 1 falling on that day. CNA 3 stated on 11/1/25 around 3:00 a.m., she saw Resident 1 was sitting on the ground near his room, next to his wheelchair. CNA 3 stated that she, along with Registered Nurse (RN 1) assisted Resident 1 from the ground to the wheelchair. During a phone interview on 2/20/26 at 2:06 p.m., RN 1 stated on 11/1/25 at around 2:50 a.m., he responded to a distress call from a staff stating Resident 1 was sitting on the ground in the hallway. RN 1 stated he could not recall which staff called his attention to Resident 1, however Resident 1 had an unwitnessed fall. RN 1 stated when he arrived Resident 1 was awake, alert, sitting on the ground. RN 1 stated he assessed Resident 1's neuro status (assessment of mental status), assessed for injury and pain. RN 1 stated Resident 1 complained of pain in the right hip area. RN 1 stated him and CNA 3 moved Resident 1 to the wheelchair. RN 1 stated he called Resident 1's Doctor, who ordered to complete an X-ray (imaging test primarily for bones and internal organs) of Resident 1's right lower extremity. RN 1 stated X-ray results came back and indicated Resident 1 had an acute hip fracture, so Resident 1 was sent to acute care for further evaluation.During a review of Resident 1's nursing progress notes dated 11/1/25, RN 1 documented [Resident 1] had an unwitnessed [not observed by anyone directly] fall in the hallway while returning from the patio after smoking, [him] landing on his right buttock .he complained of pain in his right leg groin, and near the hip joint 6/10 [moderate pain] especially with movement of the right leg .STAT [immediate] X-ray [completed] . During a review of Resident 1's X-Ray report dated 11/01/25, the report indicated acute comminuted fracture of the right intertrochanteric femur, (right upper thigh broken bone). During a review of Resident 1's Acute care hospital Discharge summary dated [DATE] indicated Resident 1 had surgery to right hip on 11/2/25 and was not discharged from acute care to the facility until 11/8/25.During a telephone interview on 2/23/26 at 3:00 p.m. with Acting Director of Nursing (ADON), the ADON stated Resident 1's fall could have been prevented if facility staff monitored Resident 1 closely and provided constant supervision while he was walking by himself on 11/1/25. During a concurrent phone interview and record review on 3/2/26 at 10:23 a.m., Director of Nursing (DON), Administrator (Adm) and ADON, Resident 1's post fall Interdisciplinary (IDT, a team that includes staff members from multiple disciplines such as nursing, therapy, physicians, and other advanced practitioners) progress note dated 11/4/25 was reviewed. The DON stated she was the one who documented the IDT note, while facility's Adm, DON, ADON, Resident 1's doctor was part of the IDT meeting. The IDT note indicated Resident 1 had falls on 5/3/25, 8/14/25, 9/3/25, 9/10/25 and 11/1/25 within a six-month period. The note indicated on 9/10/25, Resident 1 fell due to loss of balance while ambulating and the IDT recommended to admit Resident 1 to high risk unit. The DON stated Resident 1 was not admitted to high-risk unit until 11/8/25. The Adm stated facility decided not to move Resident 1 to high-risk unit because he did not have any injuries from 9/10/25 fall. The IDT note further indicated that Resident 1's fall on 11/1/25 was witnessed (directly observed by someone) fall. The DON stated she thought CNA 4 witnessed Resident 1's fall on 11/1/25. During a phone interview on 3/2/26 at 2:26 p.m., CNA 4 stated she was assigned to Resident 1 on 11/1/25. CNA 4 stated she was with another resident at the time Resident 1 had a fall. CNA 4 also stated she did not witness Resident 1 falling on that day and did not recall anything related to the fall.During the review of the facility's policy and procedure titled, Fall Prevention, dated 12/2015, indicated, all residents will receive adequate supervision and assistive devices to prevent accidents.