

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555819	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER Elmwood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p>Deficiency Text Not Available</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain infection control practices during COVID-19 (a contagious virus that mainly affects the lungs and can range from) outbreak when:1. Multiple resident rooms housing COVID-19 positive residents were left with doors open.2. Resident 2 and Resident 3, who were COVID-19 positive, were observed outside of their isolation rooms.3. Certified Nurse Assistant (CNA) 1 who assisted Resident 3 inside the room did not have personal protective equipment (PPE, proper specialized clothing or equipment worn to protect against workplace hazards or diseases).These failures had the potential to expose staff, visitors, and other residents to COVID-19, increasing the risk of transmission and compromising the health and safety of residents and staff during an active outbreak.During a record review of Resident 2's admission Record (AR) printed on 9/18/25, the AR indicated Resident 2 was admitted to the facility in 2024 with diagnoses of type 2 diabetes (high blood sugar) and alcohol dependence with withdrawal (alcohol use disorder with physical or mental withdrawal symptoms). During a record review of Resident 3's AR printed on 9/18/25, the AR indicated Resident 3 was admitted to the facility in 2025 with diagnoses of pleural effusion (excess fluid build-up in the lungs) and essential hypertension (high blood pressure).During an observation on 9/18/25 at 10:47 a.m., the door to room [ROOM NUMBER], which was occupied by a COVID-19 positive resident and had a posted contact precaution (infection control measures, requiring healthcare workers to wear PPE to prevent the spread of microorganisms) sign, was observed left open. During an observation on 9/18/25 at 10:48 a.m., the door to room [ROOM NUMBER], which was occupied by a COVID-19 positive resident and had a contact precaution sign, was observed left open. During an observation on 9/18/25 at 10:49 a.m., the doors to room [ROOM NUMBER] and room [ROOM NUMBER], which were occupied by a COVID-19 positive residents and had a contact precaution sign, were observed left open. During an observation on 9/18/25 at 10:53 a.m., the door to room [ROOM NUMBER], which was occupied by a COVID-19 positive resident and had a posted contact precaution sign, was observed left open. During an observation and interview on 9/18/25 at 10:56 a.m., Resident 2 was walking with no assistance in the hallway using front wheeled walker. Resident 2 stated she was looking for a supervisor to speak with. Resident 2 was assisted to where Licensed Vocational Nurse (LVN) 1 who was right in front of room [ROOM NUMBER]. During an interview on 9/18/25 at 11:00 a.m. with LVN 1, LVN 1 stated Resident 2 was COVID-19 positive and should have remained in the room under isolation, and that the doors to all COVID-19 rooms should have been kept closed to prevent the spread of infection because COVID-19 is managed with contact and droplet transmission (viruses or bacteria spread through coughing, sneezing, or talking).During an observation on 9/18/25 at 11:20 a.m., Resident 1, seated in a wheelchair, was outside of his isolation room with his surgical mask lowered to his chin, leaving both nose and mouth exposed. During an observation on 9/18/25 at 12:01 p.m., CNA 1 was inside an isolation room without wearing complete PPE while assisting Resident 3, who was COVID-19 positive. The isolation room's trash receptacle for disposal of soiled PPE was positioned by the window and away from the door. After providing care, CNA 1 hurriedly exited the isolation room without closing the door.During an interview on 9/18/25 at 12:02 p.m. with LVN 2, LVN 2 stated the trash receptacle for soiled PPE should have been placed near the room's exit door to prevent staff from re-exposing themselves to infection across the room. LVN 2 further stated when CNA 1 removed the PPE and continued to assist Resident 3 before exiting the room, it had the risk for potential spread of infection. During an interview on 9/18/25 at 1:42 p.m. with Infection Preventionist (IP), IP stated the doors to COVID-19 isolation rooms should have been kept closed and that Resident 2 and Resident 3 should have remained in their rooms until completing the required 10-day isolation period to prevent the spread of COVID-19 to other residents and staff. IP further stated without adherence to COVID-19 prevention practices, cases could increase, and the outbreak would continue. During a record review of the facility's undated policy and procedure (P&P), titled, COVID-19 Clinical Protocol, the P&P indicated, 5. Exposed resident/s to symptomatic resident or staff with potential or positive COVID-19 should remain in their respective room.13. Ensure staff adhere to hand hygiene and appropriate use of PPE when going in and coming out of isolation room.19. Room door should be kept closed except when entering or leaving the room, and entry and exit should be minimized.</p>		