

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385225	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/16/2025
NAME OF PROVIDER OR SUPPLIER  Evan Terrace Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 421 SE Evans Street McMinnville, OR 97128	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review it was determined the facility failed to follow physician orders for 2 of 5 sampled residents (#s 25 and 26) reviewed for medications. This placed residents at risk for missed medications. Findings include:</p> <p>1. Resident 25 admitted to the facility in 1/2025, with diagnoses including hypothyroidism (low thyroid hormone levels) and diabetes.</p> <p>A 1/17/25 admission Order for Resident 25 included an order for levothyroxine (a thyroid medication) 1 tablet by feeding-tube daily.</p> <p>A 1/20/25 Physician Progress Note indicated Resident 25 was ordered to have levothyroxine once daily but the order was erroneously entered as three times daily. The resident received three doses on 1/19/25 and two doses on 1/20/25.</p> <p>Resident 25's 1/2025 MAR included an order for levothyroxine, 50 mcg, via G-Tube before meals (or three times per day) for hypothyroidism. The order was transcribed incorrectly and should have been for once per day. The resident received three doses on 1/19/25 and two doses on 1/20/25.</p> <p>On 6/16/25 at 9:59 AM, Staff 1 (Administrator) was informed of the findings regarding not following physician orders for Resident 25's levothyroxine medication and provided no additional information.</p> <p>2. Resident 26 was admitted to the facility in 9/2024, with diagnoses including orthopedic aftercare following above the knee surgical amputation, and diabetes with diabetic neuropathy (nerve damage).</p> <p>Resident 26's 11/28/25 Physician Orders included the following medication order:</p> <ul style="list-style-type: none"> <li>-Insulin Lispro Injection Solution, inject as per sliding scale subcutaneously with meals in addition to set dose.</li> <li>-Insulin Lispro Injection Solution, inject 8 units subcutaneously two times a day with breakfast and lunch.</li> <li>-Insulin Lispro Injection Solution, inject 6 units subcutaneously in the evening (5:00 PM).</li> </ul> <p>Resident 26's 11/2024 DAR revealed the following missed insulin medications:</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 11/29/24 - two doses of the resident's lispro sliding scale insulin were missed;</p> <p>-On 11/28/24 and 11/29/24 - three doses of lispro insulin 8 units were missed; and</p> <p>-On 11/28/24 and 11/29/24 - two doses of the lispro insulin 6 units were missed.</p> <p>On 6/16/25 at 12:24 PM, Staff 23 (LPN) stated she had discovered the resident was not administered her/his insulin medications during the day shift on 11/28/25 and on 11/29/25. Staff stated she reported the issue to Staff 2 (DNS).</p> <p>On 6/16/25 at 9:59 AM, Staff 1 (Administrator) was informed of the findings regarding not following physician orders for Resident 26's insulin medication and provided no additional information.</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on interview and record review it was determined the facility failed to provide pressure ulcer care consistent with professional standards of practice for 1 of 5 sampled residents (#6) reviewed for pressure ulcers. As a result, Resident 6 developed multiple facility-acquired pressure ulcers and placed residents at risk for new and worsening pressure ulcers. Findings include:</p> <p>The 2019 NPIAP (National Pressure Injury Advisory Panel) guidelines indicated when an individual had a pressure injury a comprehensive initial assessment should be completed, treatment goals with input from the individual's informal caregivers set, and a treatment plan developed. The wound was to be re-assessed at least weekly to monitor the progress toward healing.</p> <p>Resident 6 admitted to the facility in 1/2025, with diagnoses of dementia and a right lower leg fracture. Resident 6 discharged from the facility on 5/6/25.</p> <p>Resident 6's 1/13/25 Nursing admission Evaluation indicated she/he wore a splint on her/his right lower leg and had no open skin areas.</p> <p>The 1/20/25 admission MDS Assessment indicated Resident 6 had no pressure ulcers, was at risk for developing pressure ulcers, needed partial assistance with bed mobility and was dependent on staff for wheelchair mobility.</p> <p>Resident 6's Pressure Ulcer CAA indicated she/he had no pressure ulcers and was at risk for developing pressure ulcers. The assessment did not include any risk factors that could contribute to the development of pressure ulcers.</p> <p>There was no Baseline Care Plan for Resident 6 to address the resident's skin or risk for pressure ulcers upon admission.</p> <p>Resident 6's 2/7/25 Skin Care Plan indicated she/he was at risk for skin breakdown related to a healing fracture to the right lower leg and dementia. The care plan indicated Resident 6 had pressure ulcers to the right medial foot and bilateral heels. Interventions included to assist the resident to turn and reposition as indicated and as tolerated.</p> <p>Resident 6's Skin and Wound Evaluations indicated the resident had the following wounds:</p> <p>1) Right medial (inner side) foot pressure ulcer identified on 1/23/25. The resident's Wound Evaluations for 2/14/25, 2/24/25 and 4/3/25 had inaccurate information related to the staging and description of her/his pressure ulcer and incorrectly identified the resident's pressure ulcer as being present on admission. There were 11 missing weekly wound assessments from 1/24/25 through 5/6/25.</p> <p>2) Right heel pressure ulcer, no date provided for when pressure ulcer was identified. The resident's Wound Evaluations for 2/14/25, 2/21/25, and 4/9/25 had inaccurate information related to the staging and description of the her/his pressure ulcer. There were nine missing weekly wound assessments from 2/14/25 through 5/6/25.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>3) Left heel pressure injury identified on 2/25/25. The resident's Wound Evaluations for 2/25/25 and 4/3/25 had inaccurate information related to the wound type and staging of her/his pressure ulcer. There were 8 missing weekly wound assessments from 2/25/25 through 5/6/25.</p> <p>4) Left, third toe pressure injury identified on 2/25/25. The resident's Wound Evaluations for 4/3/25 indicated inaccurate information related to the wound type and location of the pressure ulcer. There were nine missing weekly wound assessments from 2/25/25 through 5/6/25.</p> <p>5) Right foot, second toe pressure injury identified on 4/3/15. There were four missing weekly wound assessments from 4/3/25 through 5/6/25.</p> <p>6) Right foot pressure injury identified on 4/22/25 by the wound clinic. There were two missing weekly wound assessments from 4/22/25 through 5/6/25.</p> <p>Resident 6's 4/2025 Wound Clinic Notes revealed her/his wounds were staged as follows:</p> <ol style="list-style-type: none"> <li>1) Right medial foot, Stage 3 (full-thickness skin loss).</li> <li>2) Right heel, Stage 4 (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer).</li> <li>3) Left heel, Stage 3.</li> <li>4) Left, third toe, unstageable (obscured full-thickness skin and tissue loss).</li> <li>5) Right, second toe, unstageable.</li> <li>6) Right proximal, lateral, Stage 2 (partial-thickness skin loss).</li> </ol> <p>The facility did not have and did not request Resident 6's Wound Clinic notes until 6/12/25.</p> <p>Resident 6's 5/6/25 Discharge MDS indicated the resident discharged home with three Stage 3 pressure ulcers. The MDS incorrectly identified the number of pressure ulcers. Resident 6 discharged home with six pressure ulcers.</p> <p>Review of Resident 6's clinical record found no documented evidence the facility evaluated and assessed the development of the resident's pressure ulcers to determine causative factors, to evaluate current interventions or to determine if the pressure ulcers were avoidable or unavoidable.</p> <p>On 6/10/25 at 8:16 PM, Staff 29 (CNA) was unable to recall Resident 6.</p> <p>On 6/10/25 at 8:24 PM, Staff 28 (CNA) was unable to recall Resident 6.</p> <p>On 6/10/25 at 8:27 PM, Staff 27 (CNA) was unable to recall Resident 6.</p> <p>On 6/11/25 at 9:25 AM, Staff 25 (CNA) was unable to recall Resident 6.</p> <p>On 6/11/25 at 9:27 AM, Staff 26 (CNA) was unable to recall Resident 6.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/12/25 at 8:05 AM, Staff 19 (LPN) was unable to recall Resident 6.</p> <p>On 6/16/25 at 2:20 PM, Staff 1 (Administrator), Staff 2 (DNS), Staff 3 (Regional RN) and Staff 24 (MDS Coordinator) verified all six facility acquired pressure ulcers had inaccurate and/or missing weekly wound assessments and the Discharge MDS incorrectly identified the number of pressure ulcers upon discharge.</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p>Based on interview and record review it was determined the facility failed to implement and maintain an effective tracheostomy training program for 1 of 1 sampled resident (#19) reviewed for respiratory care. This placed residents at risk for inappropriate tracheostomy care and the potential for a decline in respiratory status. Findings include:</p> <p>Resident 19 admitted to the facility in 4/2024, with diagnoses including acute respiratory failure and tracheostomy (a surgical opening through the front of the neck and into the windpipe, which a tube is placed into the hole to keep it open for breathing).</p> <p>A 5/5/25 Progress Note revealed Resident 19 was transferred to the hospital for vomiting.</p> <p>A 5/5/25 Fire District Incident Report revealed EMS (Emergency Medical Services) responded to the facility for Resident 19 and observed Resident 19's humidifier tubing taped to the resident's bed. EMS noted if Resident 19 had moved, the humidified oxygen would have disconnected. In addition, EMS observed the resident's humidifier to be partially filled with water (having water in a tracheostomy tube would be similar to having water poured directly into the lungs and provides less available oxygen for a resident to breath).</p> <p>On 6/10/25 at 8:23 PM, Staff 15 (Agency LPN) stated she had not received any tracheotomy training from the facility.</p> <p>On 6/10/25 at 8:31 PM, Staff 16 (CMA) stated only the 100 hall nurse worked with Resident 19 and no other staff. Staff 16 stated if the 100 hall nurse went to break or left the building he would not know who could assume care for the resident.</p> <p>On 6/11/25 at 11:53 AM, Staff 12 (Physician Assistant) stated he was unsure how well the staff were trained to care for a resident with a tracheostomy and questioned if the staff knew how to correctly suction Resident 19. Additionally, Staff 12 stated he would ask different staff the same question about Resident 19 and get different answers.</p> <p>On 6/12/25 at 8:05 AM, Staff 19 (Agency LPN) verified she was Resident 19's nurse the morning she/he was transferred to the hospital. Staff 19 stated the facility gave her no tracheostomy training prior to working with Resident 19 and had told the Resident Care Manager (RCM) she had not had any hands-on experience with tracheotomies for over 10 years and did not feel qualified to care for any resident with a tracheotomy. Staff 19 stated she was told the resident's CNA would tell her what to check and when to check it, which is what occurred. Staff 19 stated she knew she needed more training but there was no one in the building to help her. Staff 19 was unable to recall the set-up of the humidified oxygen tubing.</p> <p>On 6/12/25 at 11:07 AM, Staff 1 (Administrator) and Staff 2 (DNS) both stated they were unable to find any documentation to show staff were trained to care for a resident with a tracheotomy.</p>		