

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  11/18/2025
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>Based on interview and record review it was determined the facility failed to ensure residents received appropriate care and services for a feeding tube for 1 of 3 sampled residents (#2) reviewed for feeding tubes. This placed residents at risk for complications related to the use of a feeding tube. Findings include: The facility's incident report dated 7/29/25 indicated Staff 12 entered Resident 2's room and observed feeding tube formula was running at a rate of 300 ml/hr and observed the resident's formula was coming out of the resident's trach area. Resident 2's Physician Order dated 7/18/25 noted, enteral feed every shift, diet Jevity (liquid nutrition formula for tube feeding) 1.5, 66 ml/hr x 18 hours, on at 4:00 AM and off at 10:00 PM, feeding via pump for a total of 1206 ml. On 10/1/25 at 12:58 PM, Staff 12 (LPN) stated after receiving report from Staff 9 (LPN) she found Resident 2's feeding tube running at a rate of 300 ml/hour. She stated there was feeding tube formula bubbling out of Resident 2's tracheostomy site. On 10/2/25 at 9:11 AM, Staff 9 stated she had left Resident 2's feeding tube running at a rate of about 300 ml/hour by mistake during her shift on 7/28/25. On 10/2/25 at 9:52 AM, Staff 13 (LPN) stated Staff 12 found Resident 2's tube feeding running at 300 ml/hour on 7/29/25. On 10/2/24 at 10:48 AM, Staff 2 (DNS) stated she expected nurses to follow physician orders for feeding tubes.</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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