

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/17/2026
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)		
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. Based on interviews and record review it was determined the facility failed to report an injury of unknown origin to the State Agency for 1 of 7 sampled residents (#1) reviewed for safety. This placed residents at risk for a delay in the investigation and continued injuries. Findings include: Resident 1 was admitted to the facility in 4/2026 with diagnoses including Parkinsons with hand tremors and dementia. Resident 1's 4/17/26 Admissions Care Plan indicated the resident required a two-person assist with their ADLs and had meals in the assisted dining room. Resident 1's 4/21/26 MDS revealed a BIMS score of 7 which indicated severe cognitive impairment. On 7/16/26 at 2:21 PM, Witness 1 (Resident 1's Spouse) spouse stated she had arrived after breakfast and observed swelling and blistering on Resident 1's right hand, and informed Staff 4 (LPN). Witness 1 stated that Staff 4 assessed Resident 1's right hand and found red discoloration in the palm of the resident's hand. Witness 1 requested the resident be sent to the hospital for evaluation. A 4/21/26 emergency room record indicated Resident 1 was treated for a second degree burn to her/his right hand. On 7/16/26 at 1:12 PM, Staff 3 (LPN) stated she assessed Resident 1's right hand and found it warm, with blisters and tender when touched. Staff 3 stated Resident 1 was not aware of what had happened. Staff 3 stated Resident 1 had no complaints of hand pain or swelling or blisters the previous night on 4/20/26. Staff 3 stated she would have reported the incident to the State Agency. On 7/16/26 at 1:15 PM, Staff 10 (CNA) stated she had assisted Resident 1 back to her/his room around 9:00 AM and had not noticed any injury to Resident 1's right hand. On 7/16/26 at 1:34 PM, Staff 4 (LPN) stated she assessed Resident 1's right hand and thought it was inflammation with redness. Staff 4 stated she was trained to report a burn of unknown origin to the State Agency. She stated that because the injury did not appear to be a burn, it was not reported. On 7/17/26 at 10:10 AM, Staff 2 (DNS) stated an injury of unknown injury should be reported to the State Agency and the facility failed to report it.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 385225
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interviews and record review it was determined the facility failed to provide ADL assistance for 1 of 5 sampled residents (# 7) reviewed for ADLs. This placed residents at risk for not receiving ADL assistance for hygiene care. Resident 7 was admitted to the facility in 6/2026 with diagnoses including a stroke with right sided hemi-paralysis and aphasia (the inability to speak). Resident 7's 6/29/26 Care Plan indicated Resident 7 was dependent on staff for all ADLs. Resident 7's 6/2026 MDS Assessment indicated the resident was severely impaired. Resident 7's 6/2026 and 7/2026 Point of Care record indicated the resident was dependent for brushing teeth, washing face, combing hair, and shaving. On 7/15/26 at 10:07 AM, Staff 6 (CNA) charted in the Point of Care document she had provided oral care and a warm washcloth to Resident 7 on 7/15/26. Staff 6 stated she had charted in the wrong chart and stated she did not provide oral care or give a warm washcloth to Resident 7. On 7/15/26 at 10:18 AM, Resident 7 was observed lying in bed. Resident 7's spouse was present. Resident 7 appeared disheveled, hair was unbrushed and her/his eyes had dried eye discharge, and her/his nails were long and appeared to have dirt underneath them. Resident 7's spouse stated no one had provided the resident with a warm washcloth to wipe her/his face. The spouse also stated the resident did not have their teeth brushed. On 7/15/26 at 11:03 AM, Staff 2 (DNS) stated she expected staff to provide nail care, grooming and warm washcloths in the morning. Staff 2 acknowledged Resident 7 did not receive a warm washcloth or oral care on this day.		