

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 06/09/2025
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>Based on interview and record review it was determined the facility failed to provide the risk and benefits for the use of an antipsychotic medication to a resident/responsible party prior to administration for 1 of 5 sampled residents (#20) reviewed for medications. This placed residents at risk for lack of informed consent. Findings include:</p> <p>Resident 20 was admitted to the facility in 9/2024 with diagnoses including dementia with behavioral disturbances and convulsions.</p> <p>A 9/26/24 Informed Consent-Psychoactive Medication form indicated Resident 20 gave verbal consent for the use of her/his psychotropic medications not including divalproex sodium (anticonvulsant medication).</p> <p>The 10/2/24 admission MDS indicated Resident 20 received psychotropic medications to manage the resident's agitation and aggressive behaviors related to her/his dementia.</p> <p>A 12/6/24 IDT (Interdisciplinary Team) Psychotherapeutic Review indicated Resident 20 received divalproex sodium (anticonvulsant medication use as an antipsychotic medication).</p> <p>A review of Resident 20's clinical record revealed no signed consent for the use of divalproex sodium.</p> <p>On 6/5/25 at 9:55 AM, Staff 20 (Regional Director of Clinical Services) and Staff 14 (MDS Coordinator) acknowledged a consent for the risks and benefits of divalproex sodium was not obtained as expected.</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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>Based on observation, interview and record review it was determined the facility failed to promote self determination for 1 of 1 sampled resident (#44) reviewed for choices. This placed residents at risk for lack of honoring choices and room preferences. Findings include:</p> <p>Resident 44 was admitted to the facility in 9/2024 with diagnoses including a stroke and depression.</p> <p>The 9/12/24 admission MDS indicated Resident 44 was cognitively intact.</p> <p>On 6/2/25 at 1:51 PM Resident 44 stated she/he requested a room change as the roommate's television volume was loud and disrupted her/his sleep. The roommate's television was observed to be on and the volume was loud, which made it difficult to hear anything else in the room. Resident 44 stated she/he spoke with Staff 8 (Social Services Director) about the request and no follow up was provided.</p> <p>On 6/4/25 at 9:40 AM Resident 44 was observed in bed with a headphone set on and the roommate's television volume was loud. Resident 44 stated the headphones helped some with the noise, but her/his sleep was still disrupted.</p> <p>On 6/6/25 at 11:59 AM Staff 8 stated about one week ago Resident 44 expressed to her a desire to move rooms due to the roommate's television volume. Staff 8 stated she was more focused on the resident's discharge arrangements than a room move.</p> <p>On 6/6/25 at 1:01 PM Staff 1 (Administrator) stated he was not aware of Resident 44's request to move rooms and it should have been brought his attention.</p>		

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<p>F 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>Based on observations and interviews the facility failed to ensure the state survey inspection results were readily accessible for 1 of 1 facility reviewed for resident council. This placed residents and the public at risk of not being informed of the facility's survey history. Findings include:</p> <p>During a resident council interview on 6/4/25 at 1:00 PM, eight resident attendees indicated they did not know where to find the state survey inspection results in the facility.</p> <p>On 6/4/25 at 1:25 PM, a tour of the facility found no accessible survey results on any of the three halls of the facility or signage to direct residents where to locate this information.</p> <p>On 6/4/25 at 1:31 PM Staff 1 (Administrator) confirmed the the facility did not have the state survey inspection results available for residents or visitors.</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>Based on interview and record review it was determined the facility failed to ensure residents were free from unnecessary psychotropic medications for 1 of 5 sampled residents (#56) reviewed for medications. This placed residents at risk for adverse side effects of medication. Findings include:</p> <p>Resident 56 was admitted to facility in 4/2025 for surgical aftercare with diagnoses including spinal abscess and lower body paralysis.</p> <p>Resident 56's medication orders upon admission indicated the following:</p> <ul style="list-style-type: none"> - Prochlorperazine (used to treat nausea and vomiting) every 6 hours PRN. <p>Resident 56's 5/2025 Note To Attending Physician/Prescriber revealed a letter was sent to the provider, advising that the PRN Prochlorperazine required the prescriber to provide a direct examination and rationale every 14 days.</p> <p>There was no evidence in Resident 56's medical record that indicated the physician reviewed, assessed or evaluated the resident within 14 days for the PRN antipsychotic, as required.</p> <p>On 6/9/25 at 11:44 AM Staff 18 (LPN Resident Care Manager) stated his understanding of regulations around antipsychotic orders included PRN orders were only allowed for 14 days at a time, and the prescriber was required to provide a face-to-face evaluation and rationale for continuing the medication. Staff 18 reviewed Resident 56's PRN Prochlorperazine orders and acknowledged the orders went beyond the 14 days without review and evaluation.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Resident 66 admitted to the facility in 10/2024 with diagnoses including Huntington's Disease (a genetic disorder which causes a progressive breakdown of nerve cells in the brain).</p> <p>An 10/18/24 admission MDS revealed Resident 66 had a BIMS of 10, which indicated her/his cognition was moderately impaired.</p> <p>On 6/2/25 at 12:30 PM Witness 4 (Complainant) stated in 11/2024 Resident 66 reported to her a staff member at the facility fondled her/him. Witness 4 did not indicate if this was reported to the facility and did not have additional information related to the allegation.</p> <p>Resident 66 was unable to be interviewed due to being discharged from the facility and poor cognition.</p> <p>No evidence was found to indicate the incident was reported to the state agency.</p> <p>On 6/2/25 at 1:02 PM Staff 2 (DNS) stated the facility did not have an investigation into an allegation of sexual abuse related to Resident 66.</p> <p>On 6/4/25 at 11:57 PM Staff 23 (CNA) stated she assisted Resident 66 with a shower and unintentionally brushed Resident 66's breast and Resident 66 felt uncomfortable. Staff 23 stated the facility management notified her at that time there was an abuse allegation related to the incident.</p> <p>On 6/6/25 at 11:53 AM Staff 22 (Former Administrator) stated he recalled Resident 66 and the allegation of sexual abuse. Staff 22 stated Resident 66 was given a shower by Staff 23 and Resident 66 became upset. Staff 22 stated he did not know if the incident was investigated and was unable to provide additional information.</p> <p>On 6/9/25 at 9:02 AM Staff 1 (Administrator) confirmed the sexual abuse allegation was not reported to the state agency.</p> <p>Based on interview and record review it was determined the facility failed to ensure allegations of abuse were reported to the State Agency within two hours for 3 of 6 sampled residents (#s 43, 61 and 66) reviewed for abuse. This placed residents at risk for continued abuse. Findings include:</p> <p>1. Resident 43 admitted to the facility in 2025 with diagnoses including schizophrenia (a brain disorder that affects a person's ability to think, feel, and behave clearly).</p> <p>Resident 43's admission MDS dated [DATE] revealed a BIMS score of 15 which indicated the resident had no cognitive impairment.</p> <p>On 6/2/25 at 1:56 PM Resident 43 stated her/his breasts were grabbed by an unidentified male caregiver one time.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/6/25 at 8:38 AM Staff 8 (Social Services Director) indicated she was aware Resident 43 alleged a male caregiver touched her/his breasts and it was reported to Staff 1 (Administrator) for further investigation.</p> <p>A record review on 6/6/25 revealed no evidence the allegation was reported to the State Agency.</p> <p>On 6/6/25 at 11:12 AM Staff 1 (Administrator) confirmed he was aware of the allegation made by Resident 43 and did not report it to the State Agency.</p> <p>2. Resident 61 admitted to the facility in 2025 with diagnoses including a stroke.</p> <p>Resident 61's admission MDS dated [DATE] revealed a BIMS score of 15 which indicated the resident had no cognitive impairment.</p> <p>On 6/2/25 at 12:53 PM Resident 61 stated an unidentified male caregiver grabbed her/his breasts one time.</p> <p>On 6/6/25 at 8:38 AM Staff 8 (Social Services Director) indicated she was aware Resident 61 alleged a male caregiver touched her/his breasts and it was reported to Staff 1 (Administrator) for further investigation.</p> <p>A record review on 6/6/25 revealed no evidence the allegation was submitted to the State Agency.</p> <p>On 6/6/25 at 11:12 AM Staff 1 (Administrator) confirmed he was aware of the allegations made by Resident 43 and did not report it to the State Agency.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to investigate allegations of sexual, physical, and verbal abuse for 4 of 6 sampled residents (#s 11, 43, 61, and 66) reviewed for abuse. This placed residents at risk for further abuse. Findings include:</p> <p>1. Resident 11 was admitted to the facility in 8/2023 with diagnoses including depression and stroke.</p> <p>The 2/25/25 Quarterly MDS indicated Resident 11 had a BIMS score of 14 which indicated the resident was cognitively intact.</p> <p>Resident 20 was admitted to the facility in 9/2024 with diagnosis including dementia with behavioral disturbances.</p> <p>The 4/4/25 Quarterly MDS indicated Resident 20 had a BIMS score of 3 which indicated severe cognitive impairment.</p> <p>On 3/5/25 a public complaint was received by the State Agency which alleged Resident 11 was punched by Resident 20.</p> <p>On 5/30/25 at 4:39 PM, Resident 11 stated Resident 20 hit and swore at her/him in the dining room and also slapped Resident 11 a month earlier in the day room. Resident 11 stated she reported the issue to management.</p> <p>On 6/2/25 at 4:49 PM and 6/3/25 at 7:58 AM, Staff 1 (Administrator) acknowledged Resident 11 spoke to him about Resident 20 around 2/2025. Staff 1 stated Resident 11 asked, What are you going to do about the pervert, [Resident 20]? Staff 1 stated he spoke to one other resident about the incident who Resident 11 indicated was a witness but did not document interviews. Staff 1 stated there was no additional interviews or full investigation because the conversation with the alleged witness did not pan out. Staff 1 acknowledged he did not conduct a full abuse investigation to rule out abuse.</p> <p>On 6/3/25 at 8:27 AM, Staff 30 (CNA) confirmed an incident occurred in the dining room between Resident 11 and Resident 20 around 3/2025 or 4/2025. Staff 30 stated she heard yelling and saw fists, separated Resident 11 and Resident 20, and reported the incident to an agency nurse the same day.</p> <p>On 6/9/25 at 2:28 PM, Staff 21 (Regional Director of Clinical Services) acknowledged a comprehensive investigation was to begin the moment Staff 1 was aware which did not occur.</p> <p>4. Resident 66 admitted to the facility in 10/2024 with diagnoses including Huntington's Disease (a genetic disorder which causes a progressive breakdown of nerve cells in the brain).</p> <p>An 10/18/24 admission MDS revealed Resident 66 had a BIMS of 10, which indicated her/his cognition was moderately impaired.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/2/25 at 12:30 PM Witness 4 (Complainant) stated in 11/2024 Resident 66 reported to her a staff member at the facility fondled her/him. Witness 4 did not indicate if this was reported to the facility and did not have additional information related to the allegation.</p> <p>Resident 66 was unable to be interviewed due to being discharged from the facility and poor cognition.</p> <p>A review of Resident 66's medical record revealed nothing related to an allegation of sexual abuse.</p> <p>On 6/02/25 at 1:02 PM Staff 2 (DNS) stated the facility did not have an investigation into an allegation of sexual abuse related to Resident 66.</p> <p>On 6/4/25 at 11:57 PM Staff 23 (CNA) stated she assisted Resident 66 with a shower and while she assisted her/him she unintentionally brushed Resident 66's breast and Resident 66 felt uncomfortable. Staff 23 stated facility management notified her after the shower that there was an allegation that she abused Resident 66.</p> <p>On 6/5/25 at 12:13 PM Staff 8 (Social Services) stated she recalled Resident 66 made an allegation related to care provided by Staff 23 and thought it was investigated. Staff 8 was unable to provide additional information.</p> <p>On 6/6/25 at 11:53 AM Staff 22 (Former Administrator) stated he recalled Resident 66 and the allegation of sexual abuse. Staff 22 stated Resident 66 was given a shower by Staff 23 and Resident 66 became upset. Staff 22 stated he did not know if the incident was investigated and was unable to provide addition information.</p> <p>On 6/9/25 at 9:44 AM during a joint interview Staff 20 (Regional Director of Clinical Services) and Staff 21 (Regional Director of Clinical Services) stated the facility did not complete an investigation into Resident 66's allegation of sexual abuse.</p> <p>2. Resident 43 admitted to the facility in 2025 with diagnoses including schizophrenia (a brain disorder that affects a person's ability to think, feel, and behave clearly).</p> <p>Resident 43's admission MDS dated [DATE] revealed a BIMS score of 15 which indicated the resident had no cognitive impairment.</p> <p>On 6/2/25 at 1:56 PM Resident 43 stated her/his breasts were grabbed by an unidentified male caregiver one time.</p> <p>On 6/6/25 at 8:38 AM Staff 8 (Social Services Director) indicated she was aware Resident 43 alleged a male caregiver touched her/his breasts and it was reported to Staff 1 (Administrator) for further investigation.</p> <p>A record review on 6/6/25 revealed no evidence an investigation into the allegations made by Resident 43 was completed.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/6/25 at 11:12 AM Staff 1 (Administrator) confirmed an investigation into the allegations made by Resident 43 was not completed.</p> <p>3. Resident 61 admitted to the facility in 2025 with diagnoses including a stroke.</p> <p>Resident 61's admission MDS dated [DATE] revealed a BIMS score of 15 which indicated the resident had no cognitive impairment.</p> <p>On 6/2/25 at 12:53 PM Resident 61 stated an unidentified male caregiver grabbed her/his breasts one time.</p> <p>On 6/6/25 at 8:38 AM Staff 8 (Social Services Director) indicated she was aware Resident 61 alleged a male caregiver touched her/his breasts and it was reported to Staff 1 (Administrator) for further investigation.</p> <p>A record review on 6/6/25 revealed no evidence an investigation into the allegations was completed.</p> <p>On 6/6/25 at 11:12 AM Staff 1 confirmed an investigation into the allegations made by Resident 61 was not completed.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to develop a comprehensive care plan for 1 of 1 sampled resident (#43) reviewed for choices. This placed residents at risk for unmet needs. Findings include:</p> <p>Resident 43 admitted to the facility in 2025 with diagnoses including schizophrenia.</p> <p>Resident 43's admission MDS dated [DATE] revealed a BIMS score of 15 which indicated the resident was cognitively intact.</p> <p>A 4/30/25 Social History Assessment indicated the resident had trauma of rape/sexual assault/uncomfortable and unwanted sexual experience.</p> <p>A review of Resident 43's 6/2/25 updated comprehensive care plan revealed no evidence she/he was to receive care from females only.</p> <p>On 6/2/25 at 1:56 PM Resident 43 stated she/he experienced uncomfortable interactions with male caregivers. Resident 43 stated she/he did not want male caregivers coming into her/his room.</p> <p>On 6/5/25 at 9:36 AM Staff 38 (CNA) stated Resident 43 preferred female caregivers based upon conversations she had with the resident and believed this information was included in the resident's care plan.</p> <p>On 6/6/25 at 11:12 AM Staff 1 (Administrator) confirmed Resident 43's care plan was not updated to reflect female caregiving staff only.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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 obtain treatment orders and provided treatment for diabetic ulcers for 1 of 1 sampled resident (#8) reviewed for pressure ulcers. This placed residents at risk for lack of timely treatment. Findings include:</p> <p>Resident 8 was admitted to the facility in 2015 with diagnoses including diabetes and osteomyelitis (bone infection).</p> <p>A 1/10/25 Quarterly MDS revealed Resident 8 had a BIMS score of 12 which indicated the resident had moderate cognitive impairment. Resident 8 had surgical wounds and 6 arterial ulcers (wounds due to lack of adequate blood flow) including diabetic foot ulcers.</p> <p>The 1/2025 TAR revealed the following treatment orders for Resident 8:</p> <ul style="list-style-type: none"> -Between the first and second toes, cleanse wound vigorously to patient's tolerance with house wound cleanser, apply gauze and paint with betadine (solution to prevent infections). The order started on 12/11/24. -Right lower leg: wash lower leg with warm water, pat dry, apply ointment (except to surgical site) and apply two-layer compression every day shift. The order started on 11/8/24. <p>A 1/28/25 wound clinic Physician Orders Details instructed the facility to: fax orders and progress notes to the clinic, not use compression wraps or wrap all the way up Resident 8's leg, and apply DriGo (skin protection textile to prevent bacterial growth) between the resident's toes to prevent moisture.</p> <p>A 1/29/25 Note Text revealed Resident 8 refused her/his diabetic foot ulcer treatment between her/his toes because the resident recently returned from the wound clinic where treatment was completed.</p> <p>The 2/2025 TAR revealed no additional implementation of the 1/28/25 wound care clinic orders related to Resident 8's toes and legs.</p> <p>On 6/4/25 at 9:13 AM Resident 8 stated she/he preferred the wound clinic for wound care and indicated orders from the wound clinic were not always implemented by the facility.</p> <p>On 6/4/25 at 3:34 PM, Staff 5 (RNCM) stated communication between the wound clinic and the facility was challenging, and indicated the wound clinic orders were at times requested and not received.</p> <p>On 6/5/25 at 12:42 PM, Staff 25 (Former LPN) stated Resident 8 had diabetic foot ulcers which were treated by an outside provider as early as 1/2025. Staff 25 stated, when Resident 8 returned from the wound clinic, the resident's new orders were to be scanned.</p> <p>On 6/5/25 at 3:57 PM, Staff 28 (LPN) confirmed nurses were to check for new treatments when Resident 8 returned from the wound clinic. Staff 28 stated the system to ensure new orders were implemented was not consistent and agency staff were not aware of the process.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/6/25 at 8:40 AM, Staff 32 (NP) stated she did not coordinate communication between Resident 8's multiple providers.</p> <p>On 6/9/25 at 10:24 AM, Staff 21 (Regional Director of Clinical Services) expected staff to verify wound care for Resident 8 was addressed timely and treatments orders were in place.</p> <p>On 6/9/25 at 1:51 PM, Witness 3 (Wound Clinic Program Director) stated the clinic was often unable to connect with the facility related to needed follow-up for Resident 8's leg and foot treatments.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on interview and record review it was determined the facility failed to complete a timely assessment after a fall and conduct a thorough investigation for 2 of 6 sampled residents (#s 20 and 66) reviewed for accidents. Findings include:</p> <p>1. A 9/2024 facility Accident/Incident Policy and Procedure indicated persons with knowledge of events surrounding an incident were to complete a witness statement and to implement a plan to prevent re-occurrences after a thorough investigation was completed.</p> <p>Resident 20 was admitted to the facility in 9/2024 with diagnoses including dementia with behavioral disturbances and fracture of the left hip bone.</p> <p>The 10/2/24 admission MDS indicated Resident 20 had a history of falls with injuries, was dependent on staff for toileting and transfers, and had a BIMS score of 6 which indicated the resident had severe cognitive impairment.</p> <p>A 11/5/24 revised care plan indicated Resident 20 required minimal assistance to transfer, to anticipate the resident's needs, and monitor the resident for complications after a fall.</p> <p>A 11/25/24 Un-witnessed Fall report, completed by Staff 26 (Former RN), indicated Resident 20 was found on the floor with her/his head towards the wall and an injury to her/his left hip. The report indicated a fall mat was in place and the floor in the resident's room was wet. The report revealed Resident 20 was assisted back to bed by three staff after vitals were obtained and her/his bed linens were changed. The report contained no additional staff interviews or conclusion to the investigation.</p> <p>A 12/11/24 revised care plan indicated to place a fall mat on the right side of Resident 20's bed.</p> <p>The 4/4/25 Quarterly MDS indicated Resident 20 had two or more falls during the previous quarter.</p> <p>On 6/3/25 at 11:11 AM, Staff 26 recalled Resident 20's fall on 11/25/24 and stated the floor was wet because there was urine on the floor since the resident refused toileting. Staff 26 stated she was surprised when Resident 20 stood up and urinated. Staff 26 indicated she had to complete the nightly medication pass and was unable to complete the fall report and protocol.</p> <p>On 6/5/25 at 1:48 PM, Staff 27 (Former CNA) stated she worked with Resident 20 on 11/25/24 but was in another room when she/he fell. Staff 27 stated no witness statement was requested related to the 11/25/24 incident.</p> <p>On 6/6/25 at 9:14 AM, Staff 20 (Regional Director of Clinical Services) expected the fall investigation to include witness statements and an updated care plan for Resident 20 after a root cause was determined. Staff 26 and Staff 1 (Administrator) acknowledged the 11/25/24 fall investigation for Resident 20 was not thorough and the revised care plan did not correctly address the correct fall prevention which could aid to reduce further falls.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident 66 admitted to the facility in 10/2024 with diagnoses including Huntington's Disease (a genetic disorder which causes a progressive breakdown of nerve cells in the brain).</p> <p>An 10/18/24 admission MDS revealed Resident 66 had a BIMS of 10, which indicated her/his cognition was moderately impaired.</p> <p>A 11/7/24 fall care plan revealed Resident 66 was at risk for falls due to medication side effects, Huntington's disease, incontinence, confusion, arthritis, and epilepsy.</p> <p>A Fall Risk Management dated 11/23/24, but completed on 1/6/25, revealed Resident 66 was found on the floor at 12:45 AM on 11/23/24. The fall investigation was not completed until 1/6/25 and no updates were made to the fall care plan.</p> <p>In interviews on 6/5/25 at 9:30 AM and 6/9/25 at 9:44 AM Staff 21 (Regional Director of Clinical Services) stated she completed the investigation into the fall late when the resident was discharging from the facility.</p>

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 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 1 sampled resident (#60) reviewed for feeding tubes. This placed residents at risk for complications related to the use of a feeding tube including bacterial growth. Findings include:</p> <p>According to Best Practices for Managing Tube Feeding, a Nurse's Pocket Manual published by [NAME] Nutrition in May 2015 an open system tube feeding container and tubing should be changed at least every 24 hours.</p> <p>Resident 60 was admitted to the facility in 4/2025 with diagnoses including acute respiratory failure with hypoxia, pneumonia, nontraumatic subarachnoid hemorrhage from right middle cerebral artery (stroke) and tracheostomy status.</p> <p>A review of Resident 60's 5/6/25 admission MDS revealed she/he had a feeding tube (TF) and received 51% or more of total calories through TF and an average fluid intake of 501 CC/day or more.</p> <p>A 5/25/25 physician order revealed Resident 60 was to receive [NAME] Farms 1.5 or equivalent at 67 mL/hr x 18 hours from 1600-1000 (providing 1206 mL total volume) house equivalent TF - Jevity 1.5 or Isosource 1.5 per RD two times a day for nutrition with new bag set-up daily when starting at 4:00 PM.</p> <p>On 6/3/25 at 9:51 AM a bag containing Resident 60's tube feeding formula was observed running and had a sticker-label dated 5/30/25.</p> <p>On 6/3/25 at 10:17 AM Staff 33 (Agency LPN) was observed re-filling the tube feeding bag with cartons of formula.</p> <p>On 06/3/25 at 10:39 AM Staff 33 confirmed the tube feeding bag was dated 5/30/25.</p> <p>On 06/6/25 at 8:19 AM Staff 34 (LPN) stated Resident 60's tube feeding bag and tubing was to be placed daily at 4pm. She further stated it was not changed on 5/31/25, 6/1/25 or 6/2/25 though she documented on the TAR it was completed. She explained the risks of not changing the bag as ordered were bacterial growth and the resident experiencing nausea or vomiting.</p> <p>On 6/6/25 at 12:20 PM Staff 18 (LPN RCM) stated the bag should be changed every 24 hours or when it doubt, change it out and the resident was at risk for infection, aspiration, pneumonia and sepsis if not completed. He further stated he was aware the tube feeding bag was not changed on 5/31/25, 6/1/25 and 6/2/25.</p> <p>On 6/9/25 at 9:24 AM Staff 2 (DNS) stated the tube feeding bag and tubing should have been changed every day at 4:00 PM and the risks associated with this not being done were bacterial growth in the bag, clogging and potential for gastro intestinal issues or sepsis.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>Based on interview and record review it was determined the facility failed to ensure accurate staffing information was posted for 10 of 31 days reviewed for staffing reports. This placed residents and the public at risk for lack of staffing information. Findings include:</p> <p>A review of the Direct Care Staff Daily Reports dated 5/1/25 through 5/31/25 revealed 10 out of 31 days the registered nurse information was not documented.</p> <p>On 6/9/25 at 9:50 AM Staff 1 (Administrator) acknowledged the identified staffing forms were incomplete.</p>

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>Based on observation, interview, and record review it was determined the facility failed to comprehensively assess and revise a resident's care plan related to dementia for 1 of 1 sampled resident (#20) reviewed for dementia. This placed residents at risk for unaddressed dementia and behavioral needs. Findings include:</p> <p>Resident 20 was admitted to the facility in 9/2024 with diagnoses including dementia with behavioral disturbances.</p> <p>The 10/2/24 admission MDS indicated revealed a BIMS score of 6, which indicated Resident 20 had severe cognitive impairment. The MDS also indicated the resident received psychotropic medications to manage the resident's agitation and aggressive behaviors related to her/his dementia.</p> <p>A 12/23/24 Care Conference Meeting indicated Staff 8 (Social Services Director) met with Resident 20 and her/his representative to discuss facility and discharge goals.</p> <p>The 5/6/25 through 6/3/25 CNA Task: Focused Behaviors revealed Resident 20 kicked, yelled, rejected care, threatened or grabbed others on 16 of 32 days.</p> <p>A 5/8/25 revised care plan indicated to analyze and document key times, places, circumstances, and triggers related to what deescalated Resident 20's behavior. The care plan instructed staff to engage calmly with Resident 20 and explain care before care was provided to reduce tension. No additional behavior triggers were identified.</p> <p>On 6/3/25 at 8:27 AM, Resident 20 was observed to attempt to grab another resident's food tray. Staff 30 (CNA) redirected Resident 20 and stated the resident grabbed anything she/he wanted if not redirected. Staff 30 stated consistent CNAs and care for Resident 20 was helpful to reduce her/his behaviors. Staff 30 acknowledged Resident 20 became calm when her/his spouse visited and became angry and agitated when her/his spouse left.</p> <p>On 6/4/25 at 12:44 PM, Staff 24 (CNA) stated Resident 20 was less resistive to care when her/his spouse was present. Staff 24 indicated Resident 20 routinely hit female care givers if the approach was unexpected.</p> <p>On 6/6/25 at 9:14 AM, Staff 20 (Regional Director of Clinical Operations) and Staff 1 (Administrator) expected a more detailed resident-centered care plan for Resident 20, especially related to her/his spouse.</p> <p>On 6/6/25 at 10:56 AM, Staff 31 (LPN) stated Resident 20 often asked for her/his spouse. Staff 31 stated she calmed Resident 20 when she reassured her/him of the spouse's pending visit.</p> <p>On 6/9/25 at 11:16 AM Staff 8 stated she was responsible for Resident 20's dementia care plan. Staff 8 indicated she updated the resident's care plan based on her observations and relied on staff to come to her to provide additional insight. Staff 8 acknowledged additional staff feedback was necessary to address the behavioral and dementia needs for Resident 20.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure pharmacist recommendations were considered for 4 of 5 sampled residents (#s 20, 31, 44 and 56) reviewed for medications. This placed residents at risk for unnecessary medication. Findings include:</p> <p>A 4/2025 Drug Regimen Review Policy and Procedure indicated the pharmacy was to review each resident's medication regime to ensure that risk and problems were identified and acted upon in a timely manner.</p> <p>1. Resident 20 was admitted to the facility in 9/2024 with diagnoses including dementia with behavioral disturbances and fracture of the left hip bone.</p> <p>The 10/2/24 admission MDS indicated Resident 20 received psychotropic medications to manage the resident's agitation and aggressive behaviors related to her/his dementia and the pharmacist consultant was to review her/his medications quarterly.</p> <p>A 12/6/24 IDT (Interdisciplinary Team) Psychotherapeutic Review indicated Resident 20 was not scheduled for a GDR until 3/2025. A review of Resident 20's clinical record found no additional quarterly review completed related to Resident 20's psychotropic medications.</p> <p>The 4/4/25 Quarterly MDS revealed no GDR (Gradual Dose Reduction) was attempted for Resident 20.</p> <p>The 4/21/25 pharmacy Nursing Recommendations indicated Resident 20's fluoxetine (antidepressant medication) and quetiapine (antipsychotic medication) were due for a GDR and the notification was a repeated recommendation from 3/2025. Psychotropic IDT meeting notes on the form indicated no discussion related to Resident 20's GDR.</p> <p>The 5/25/25 pharmacy Nursing Recommendations indicated Resident 20's fluoxetine and quetiapine were due for a GDR and the notification was a repeated recommendation from 3/2025.</p> <p>On 6/5/25 at 9:55 AM and 6/6/25 at 9:14 AM, Staff 20 (Regional Director of Clinical Services) stated there was no indication all aspects of Resident 20's psychotropic medications were addressed quarterly as expected and pharmacy recommendations should be submitted to Resident 20's physician and resolved within 30 days once the notice was received.</p> <p>On 6/9/25 at 2:20 PM, Staff 32 (NP) confirmed she received no communication from the facility related to a need for a GDR for Resident 20's fluoxetine and quetiapine which should be addressed.</p> <p>2. Resident 31 was admitted to the facility in 2022 with diagnoses including chronic diastolic congestive heart failure, hypertensive heart disease with heart failure and hyperkalemia (high potassium in blood).</p> <p>A review of pharmacy recommendations for 3/2025, 4/2025 and 5/2025 revealed on 4/25/25 and 5/25/25 the facility was notified the pharmacist recommended a periodic assessment of Resident 31's potassium level.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There was no evidence in Resident 31's clinical record the facility responded to or followed-up on this recommendation.</p> <p>On 6/9/25 at 12:31 PM Staff 2 (DNS) stated 3/2025 and 4/2025 pharmacist recommendations were not responded to or followed-up on in error.</p> <p>3. Resident 44 was admitted to the facility in 9/2024 with diagnoses including depression and PTSD (Post Traumatic Stress Disorder).</p> <p>a. A 2/25/25 Pharmacy review indicated the resident had three PRN pain opioid orders and the recommendation was to simplify the orders. There was no physician response.</p> <p>-A 3/24/25 Pharmacy review indicated it was a repeat recommendation from February 2025 due to no response. There was still no physician response.</p> <p>b. A 3/25/25 Pharmacy review indicated Resident 44 was on the following psychotropic regimen and was due for a GDR (gradual dose reduction):</p> <ul style="list-style-type: none"> -bupropion (an Anti-depressant) 150 mg once a day for depression, start date of 9/2024. -escitalopram (an Anti-depressant) 5 mg once a day for depressing, start date 11/2024. -quetiapine (an Anti-psychotic) 50 mg in the morning and 250 mg at bedtime for bipolar, start date 11/14/24. -liothyronine (a thyroid medication) 12.5 mg once a day for adjunct depression, start date 12/2024. -propranolol (a beta blocker) 10 mg twice daily for headache and anxiety, start date 11/2024. <p>There was no response from the physician.</p> <p>-A 4/21/25 Pharmacy review revealed it was a repeat recommendation from March 2025. There was still no response from the physician.</p> <p>-A 5/25/25 Pharmacy review revealed it was a repeat recommendation from March and April 2025 and there was no response from the physician.</p> <p>On 6/9/25 at 12:37 PM Staff 2 (DNS) stated pharmacy recommendations for February, March, April, and May 2025 were not sent to Resident 44's physician.</p> <p>4. Resident 56 was admitted to the facility on [DATE] for surgical aftercare with diagnoses including spinal abscess and paralysis.</p> <p>Resident 56's 4/30/25 physician orders indicated the following active medications:</p> <ul style="list-style-type: none"> -Oxycodone 10mg every 24 hours as needed for pain -Lidocaine 4% 2 patches every 24 hours for pain <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Albuterol-Budesonide 2 puffs every 4 hours as needed for shortness of breath</p> <p>In Resident 56's 5/2025 Note To Attending Physician/Prescriber and Nursing Recommendations the following recommendations were made:</p> <p>-Oxycodone 10mg every 24 hours as needed for pain - specify if medication should be given a certain amount hours from the other PRN Oxycodone.</p> <p>-Lidocaine patch add to schedule: Lidocaine patch to be worn for 12 hours and patient is to be patch free for 12 hours.</p> <p>-Albuterol-Budesonide: Please confirm that the correct med is actually albuterol-budesonide and not supposed to be albuterol only.</p> <p>-Hydroxyzine (used to treat anxiety) PRN orders may be extended beyond 14 days if rationale is provided and duration for the PRN order is indicated.</p> <p>-Prochlorperazine (used to treat nausea and vomiting) PRN orders are limited to 14 days and cannot be renewed without a physical evaluation.</p> <p>Review of Resident 56's 5/2025 MARs revealed the pharmacy recommendations were not implemented.</p> <p>On 6/9/25 12:31 PM Staff 2 (DNS) stated the facility's regular pharmacist went on leave in late 1/2025 through early 5/2025 and the interim pharmacist did not send recommendations to the providers. Staff 2 acknowledged recommendations were not acted upon in that time and stated the facility discovered the problem about a week ago.</p>

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p>Based on interview and record review it was determined the facility failed to ensure physician orders were followed for 1 of 3 sampled residents (#59) reviewed for rehabilitative and restorative services. This placed residents at risk for not receiving physical therapy services. Findings include:</p> <p>Resident 59 was admitted to the facility in 4/2025 with diagnoses including fracture of right and left heel bones, and multiple fractures of ribs.</p> <p>The 4/14/25 admission MDS identified Resident 59 with lower extremity impairment on both sides, and indicated resident was cognitively intact.</p> <p>On 6/5/25 at 1:08 PM the resident stated she/he went to a physician visit on 6/2/25 and received hard copy orders from the bone specialist for continued physical therapy, and she/he gave the orders to a nurse when she/he returned to the facility. Resident 59 stated she/he was not scheduled for more physical therapy yet. Resident 59's physical therapy order was observed and indicated physical therapy two times a week for eight weeks.</p> <p>A 6/2/25 physician order indicated Resident 59 was to receive physical therapy two times a week for eight weeks.</p> <p>A review of Resident 59's health record revealed no current order for physical therapy.</p> <p>On 6/5/25 at 12:35 PM Staff 19 (OT) reviewed Resident 59's health records and stated the resident did not have therapy orders.</p> <p>On 6/6/25 11:07 AM Staff 18 (LPN Resident Care Manager) stated when a resident returned from a physician visit with a new order, the charge nurse was responsible for entering the orders. Staff 18 confirmed there were no new orders for continued physical therapy communicated to him or entered in Resident 59's health record.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on observation, interview and record review, it was determined the facility failed to accurately document feeding tube treatments for 1 of 1 sampled resident (#60) reviewed for feeding tube. This placed the residents at risk for inaccurate records. Findings include:</p> <p>Resident 60 was admitted to the facility in 4/2025 with diagnoses including acute respiratory failure with hypoxia, pneumonia, nontraumatic subarachnoid hemorrhage from right middle cerebral artery (stroke) and tracheostomy status.</p> <p>A 5/25/25 physician order revealed Resident 60 was to receive feeding tube (TF) formula with new bag set-up daily when starting at 4:00 PM.</p> <p>On 6/3/25 at 9:51 AM a bag containing Resident 60's tube feeding formula was observed running and had a sticker-label dated 5/30/25.</p> <p>On 06/3/25 at 10:39 AM Staff 33 (Agency LPN) confirmed the tube feeding bag was dated 5/30/25.</p> <p>A review of Resident 60's TAR revealed Staff 34 (LPN) completed the feeding tube formula and new bag setup on 5/31/25, 6/1/25 and 6/2/25.</p> <p>On 6/6/25 at 8:19 AM Staff 34 (LPN) stated Resident 60's tube feeding bag and tubing was not changed on 5/31/25, 6/1/25 or 6/2/25 though she documented on the TAR it was completed.</p> <p>On 6/6/25 at 12:20 PM Staff 18 (LPN RCM) stated the the tube feeding bag was not changed 5/31/25, 6/1/25 and 6/2/25.</p> <p>On 6/9/25 at 9:24 AM Staff 2 (DNS) stated the record was not accurate.</p> <p>Refer to F693.</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>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review it was determined the facility failed to follow proper infection control protocols related to transmission based and enhanced barrier precautions for 2 of 4 sampled residents (#s 48 and 60) reviewed for feeding tube and infection control. This placed residents at risk for cross-contamination and infection. Findings include:</p> <p>1. Resident 48 was admitted to the facility in 10/2024 with diagnoses including multiple pressure ulcers and contractures.</p> <p>A 6/2021 Center for Disease Control Consideration for Use of Enhanced Barrier Precautions (EBP) in Skilled Nursing Facilities identified that EBP was an approach of targeted gown and glove use for residents with wounds, regardless of the multidrug-resistant organism status of the resident, due to the common existence of organisms in nursing facilities.</p> <p>A 5/30/25 revised care plan indicated Resident 48 had a Stage 4 (full-thickness skin loss with exposed bone or tendons) pressure ulcer on her/his sacrum (bone at the base of the spine).</p> <p>On 6/2/25 at 1:32 PM, an EBP sign, with instructions to don gown and gloves, was observed in the hall and outside the door of Resident 48's room. No supply of gowns were observed near the sign.</p> <p>On 6/2/25 at 1:33 PM and 1:41 PM, Staff 37 (CNA) and an unidentified CNA donned gloves only and entered Resident 48's room to turn and adjust the resident in her/his bed. Staff 37 was unsure why Resident 48 was on EBP and stated a cart with a supply of gowns at the door was needed to alert staff to use gowns. Staff 37 confirmed she was to don both gloves and gowns to move Resident 48 in her/his bed.</p> <p>On 6/6/25 at 2:26 PM Staff 20 (Regional Director of Clinical Services/IP) confirmed staff were to don gown and gloves during all direct care for residents on EBP.</p> <p>2. Resident 60 was admitted to the facility in 4/2025 with diagnoses including acute respiratory failure with hypoxia, pneumonia, nontraumatic subarachnoid hemorrhage from right middle cerebral artery (stroke) and tracheostomy status.</p> <p>A review of Resident 60's 5/1/25 care plan indicated: Isolation precautions: Resident requires droplet, enhanced standard precautions (ESP) single room isolation precautions due to MRSA infection, pneumonia. Maintain isolation droplet enhanced standard precautions. Requires strict single bed isolation due to infection. Staff will perform hand washing after completing care and leaving the room/ Use of PPE as recommended for type of infection.</p> <p>On 6/2/25 at 10:19 AM and throughout the survey a sign was observed outside of Resident 60's room that read: STOP Droplet Precautions Everyone must: clean their hands, including before entering and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry. Remove face protection before room exit.</p> <p>a. On 6/2/25 at 10:19 AM Staff 34 (LPN) was observed to enter Resident 60's room without a mask or eye covering.</p> <p>(continued on next page)</p>		

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 06/09/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/6/25 at 8:36 AM Staff 34 (LPN) stated Resident 60 was on droplet precautions because she/he had MRSA in his/her tracheostomy and in wounds. She further stated she did not need an eye covering unless the resident was going to cough in her eyeballs. She said on 6/2/25 she entered Resident 60's room without PPE because the tube feeding alarm was sounding but she should have put on a mask and eye covering.</p> <p>b. On 6/3/25 at 10:17 AM Staff 33 (Agency LPN) was observed to enter Resident 60's room without a mask or eye covering.</p> <p>On 6/3/25 at 10:21 AM Staff 33 exited Resident 60's room, did not perform hand hygiene and used her computer. She re-entered without a mask or eye covering and put on gloves without using sanitizer.</p> <p>On 6/3/25 at 10:28 AM Staff 33 entered Resident 60's room with a glucometer and CBG supplies without performing hand hygiene, a mask or eye covering.</p> <p>On 6/3/25 at 10:39 AM Staff 33 stated she had not noticed the sign by Resident 60's door, was not aware Resident 60 was on droplet precautions, and had been in and out of Resident 60's room all day without using a mask or shield.</p> <p>c. On 6/4/25 8:50 AM Staff 35 (LPN) was observed providing care to Resident 60 without an eye covering.</p> <p>On 6/4/25 at 9:09 AM Staff 35 stated staff and visitors were to use a mask and eye covering to enter the room. She stated she took her face shield off while she was in the room because she couldn't see what she was doing with it on due to fog. She explained the mask and eye covering was to protect Resident 60 and staff.</p> <p>On 6/6/25 at 11:36 AM Staff 20 (Regional Director of Clinical Services and Infection Preventionist) stated for residents on droplet precautions staff were to use a mask and shield to prevent the spread of diseases through respiratory droplets. She stated she was aware some staff did not wear a mask and face shield in Resident 60's room and staff needed education on what precautions were. She also stated staff were to encourage and educate Resident 60's visitors to use PPE because it would put them at risk of infection.</p> <p>On 6/9/25 at 9:30 AM Staff 2 (DNS) stated staff were to follow contact precautions.</p>		