

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/31/2024
NAME OF PROVIDER OR SUPPLIER  French Prairie Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  601 Evergreen Road Woodburn, OR 97071	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>38139</p> <p>Based on interviews and record review, the facility failed to protect the resident's right to be free from deprivation of goods and services for 2 of 3 sampled residents (#s 17 and 18) reviewed for abuse and neglect. This placed residents at risk for abuse. Findings include:</p> <p>1. Resident 17 was admitted to the facility in 2024, with diagnoses including a fractured femur (leg bone), dementia, and a history of falling.</p> <p>A Facility Reported Incident dated 8/7/24, indicated on the morning of 8/7/24 the in-coming day shift staff reported to administration Resident 17 was found on the floor of her/his room naked and covered in urine and feces.</p> <p>The facility's investigation dated 8/7/24, indicated Resident 17 was left on the floor of her/his room for an extended period by Staff 7 (CNA) and Staff 8 (LPN) because the resident was repeatedly climbing out of bed. The two staff members did not attempt to engage with the resident but left her/him naked on the floor. The resident urinated and defecated and crawled around in the mess on the floor during the night. In the early morning the resident was found by day shift staff completely naked and covered in fecal matter and urine. Based on interviews and documentation the facility substantiated neglect of care of Resident 17 by both Staff 7 and Staff 8.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/25/24 at 9:25 AM, Staff 11 (CMA) arrived to work between 4:30 to 5:30 AM and saw several lights on in the 200 hallway. She was unable to find Staff 7 (CNA) who was assigned to the hall. Staff 11 said she found Resident 17 on the floor of her/his room buck naked and covered in feces. Staff 11 stated she was told by Staff 8 (LPN) they had a problem with the resident for over one and a half hours and they decided to just leave her/him on the floor because she/he was combative. Staff 11 said she had never heard of such a thing. Staff 11 further stated Resident 17 had scooted across the length of the floor leaving a trail of feces from her/his bed to the door. The resident's bottom was red, like she/he had a rug burn and there was a skin tear to her/his forearm. Staff 11 reported the resident was yelling and was combative when she was getting her/him back to bed, but the resident was cold, her/his hands were purple and she couldn't leave the resident on the floor. Staff 7 (CNA) then entered the room and stated she wouldn't complete a witness report about the resident being on the floor because Staff 8 (LPN) had told her to leave the resident there. Staff 11 stated she told Staff 7 she needed to clean the resident up before leaving for the day. About 45 minutes later, the morning CNA did rounds and discovered the resident had not been bathed and strongly smelled of bowel movement. Staff 11 stated, Staff 7 had not cleaned or bathed the resident or cleaned the feces from the resident's room because the resident was combative. Staff 11 stated Staff 8 had told her to leave the resident alone but she believed the resident was in danger from the cold and the feces, so she proceeded to get the resident in bed and clean up.</p> <p>On 10/25/24 at 11:10 AM, Staff 8 (LPN) stated she remembered Resident 17 frequently climbing onto the floor. Staff 11 (CMA) arrived early for her morning shift and found the resident on the floor. The resident had been scooting on her/his butt, was completely naked, and had left a trail of feces on the floor. Staff 8 recalled that the night shift CNA (Staff 7) was upset because the resident would not stay in bed. Staff 8 admitted that she did not assess the resident to understand why the resident kept getting out of bed and did not consider placing the resident one to one care. Staff 8 stated the resident was incontinent of both bowel and bladder, with waste spread all over the floor. Staff 8 recalled an argument during shift change about who should clean the resident up, as this happened during the night shift. Ultimately, the day shift CNA had to clean the resident because the night shift CNA refused. Staff 8 acknowledged that leaving the resident in that condition violated professional standards of care. Staff 8 denied being the one who suggested leaving the resident on the floor.</p> <p>On 10/25/24 at 11:30 AM, Staff 7 (CNA) recalled the night shift on 8/6/24 had been very chaotic. She was assigned to Resident 17, who was very confused and would not stay in bed, although the resident was not combative. Staff 7 described the night as extremely stressful. She explained that the resident kept removing her/his brief, and it was a struggle to keep it on. The resident was incontinent, and there was feces all over. Staff 7 felt that the resident should have had a one to one caregiver. The resident was always on the floor, when Staff 7 placed the resident back in bed, she would be standing there gasping for air from lifting the resident, only to find the resident crawling back onto the floor. Staff 7 stated she did not feel frustrated, only tired, and mentioned there was limited help available. Around 5:00 AM, Staff 11(CMA) found the resident on the floor. Staff 11 and another CNA assisted the resident, told Staff 7 she needed to clean up the resident and the room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/28/24 at 9:41 AM, Staff 20 (RA/CNA/AD) stated she assisted with Resident 17. The resident was naked and the bed was covered in feces. The room was a mess and there was a trail of dried feces on the floor. The resident had a skin tear on her/his arm. Staff 20 stated, from the way the resident was found, there was no way it had just happened given the resident had no clothes or brief on and the feces was dry. Staff 20 stated the resident was buck naked and covered in waste, and stated why would she/he be left in that condition?</p> <p>On 10/28/24 at 3:34 PM, Staff 17 (day shift/LPN) stated Staff 8 (night shift/LPN) told her, you have a crawler because Resident 17 had been crawling all over the floor and got feces on everything. Staff 17 stated the use of that term was not acceptable and was undignified. Staff stated she had many residents with many challenges to keep in bed but would never leave them naked on the floor.</p> <p>On 10/25/24 at 11:55 AM, Staff 1 (Administrator) and Staff 2 (DNS) acknowledged facility staff failed to provide proper incontinent care and failed to ensure the safety of Resident 17 by leaving the resident on the floor naked and covered in waste. They acknowledged they had substantiated that neglect of care had occurred in their investigation of the incident.</p> <p>2. Resident 18 was admitted to the facility in 2024, with diagnoses including muscle weakness and a hip fracture.</p> <p>The facility's investigation dated 8/7/24, indicated on the morning of 8/7/24 Resident 18 was left unchanged for an extended period, with urine and dried feces on her/him when the resident was found at the start of day shift. The facility determined Resident 18 was neglected by both the assigned CNA (Staff 7) and the shift nurse (Staff 8). The resident's call light was not responded to timely, and the resident tried to go to the bathroom without the assist needed and she/he fell . Resident 18 was left on the floor in the bathroom until shift change. No timeframe was included in the investigation.</p> <p>The facility's investigation dated 8/7/24, included a witness statement completed by Staff 17 (LPN). The statement indicated Staff 8 (LPN) reported to Staff 17 that Resident 18 was on the floor. While giving report, Staff 8 told a CNA to go and get vitals on the resident and get her/him up off the floor. Staff 17 stated she had to tell Staff 8 she was required to check the resident for injuries before the resident could be moved. Staff 17 stated she was appalled the nurse was giving report instead of assisting the resident who was on the floor.</p> <p>The facility's Unwitnessed Fall Incident Report dated 8/7/24 and prepared by Staff 7 (LPN) indicated Resident 18 was found on her/his knees in the bathroom. The resident yelled and said that her/his attorney would hear about this situation because she/he could not get help fast enough and was very concerned that she/he was going to be incontinent of bowel if she/he did not try to go, without staff help, to the bathroom.</p> <p>The incident report did not include an assessment by Staff 8, which included, level of pain, mental status, mobility, predisposing environmental factors, predisposing physiological factors, predisposing situation factors, and no staff statements were completed. In addition, there was no summary of the incident and Staff 8 failed to identify a skin tear from the resident's fall.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/25/24 at 9:07 AM, Staff 1 (Administrator) stated Resident 18 was on the floor for an unknown amount of time and Staff 8 failed to assess the resident. Staff 8 was giving report to the day shift nurse and she just left the resident on the floor. The resident stated she/he was on the floor for quite a while and no one came to help her/him. Staff did notice there was dry feces on the floor so the resident likely had been there for a while.</p> <p>On 10/25/24 at 11:10 AM, Staff 8 (LPN) stated Resident 18 put her/his call light on to go to the bathroom but staff did not respond timely and the resident went to the bathroom without assistance and she/he fell . Staff stated she did not know who found the resident but knew the resident was on the floor for a while. Staff 8 stated although she knew the resident was on the floor she did not document the fall or assess the resident's condition because it was the end of her shift. Staff 8 stated she should have documented the incident and the normal procedure was to write a statement which she also did not complete.</p> <p>On 10/25/24 at 9:25 AM, Staff 11 (CMA) stated in addition to finding Resident 17 on the floor the morning of 8/7/24, they also found Resident 18 on the floor. The morning CNA also found Resident 18 wet and covered in feces.</p> <p>On 10/25/24 at 11:55 AM, Staff 1 (Administrator) and Staff 2 (DNS) acknowledged facility staff failed to provide proper incontinent care and failed to respond to Resident 18's call light timely. They acknowledged neglect of care by Staff 7 and Staff 8 had occurred in their incident investigation.</p> <p>On 10/28/24 at 4:19 PM, Witness 26 (Resident 18's significant other) stated the resident was on the floor for a long time and no one came to help her/him. The resident's roommate started yelling help for the resident. Witness 26 stated the resident was humiliated due to being incontinent and having a bowel movement on herself/himself and all over the floor.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>38139</p> <p>Based on interview and record review it was determined the facility failed to ensure Staff 8 (LPN) adhered to professional standards of practice related to deprivation of goods and services for 2 of 3 sampled residents (#s 17 and 18) reviewed for abuse and neglect. This placed residents at risk for abuse. Findings include:</p> <p>1. Resident 17 was admitted to the facility in 2024, with diagnoses including a fractured femur (leg bone), dementia, and a history of falling.</p> <p>A Facility Reported Incident dated 8/7/24, indicated on the morning of 8/7/24 the in-coming day shift staff reported to administration Resident 17 was found on the floor of her/his room naked and covered in urine and feces.</p> <p>The facility's investigation dated 8/7/24, indicated Resident 17 was left on the floor of her/his room for an extended period by Staff 7 (CNA) and Staff 8 (LPN) because the resident was repeatedly climbing out of bed. The two staff members did not attempt to engage with the resident but left her/him naked on the floor. The resident urinated, defecated, and crawled through the mess on the floor during the night. In the early morning the resident was found by day shift staff completely naked and covered in fecal matter and urine. The investigation substantiated neglect of care of Resident 17 by both Staff 7 and Staff 8.</p> <p>On 10/25/24 at 9:25 AM, Staff 11 (CMA) stated she found Resident 17 on the floor of her/his room buck naked and covered in feces. Staff 11 stated she was told by Staff 8 (LPN) they had a problem with the resident for over one and a half hours and they decided to just leave the resident on the floor because she/he was combative. Staff 11 further stated Resident 17 had scooted across the length of the floor leaving a trail of feces from her/his bed to the door. The resident's bottom was red, like she/he had a rug burn and there was a skin tear to her/his forearm. Staff 11 reported the resident was cold, her/his hands were purple and she couldn't leave the resident on the floor. Staff 11 stated Staff 8 told her to leave the resident alone but she believed the resident was in danger from the cold and the feces, so she proceeded to get the resident in bed and cleaned up. Staff 11 stated as she was the morning CMA she knew the resident had medication to reduce agitation or pain but Staff 8 had not considered that option. Staff 11 reported at the beginning of her first med pass she gave the resident pain medication and the resident had calmed down.</p> <p>On 10/25/24 at 11:10 AM, Staff 8 (LPN) stated she remembered Resident 17 was frequently on the floor. Staff 11 (Med Aide) arrived early for her morning shift and found the resident on the floor. The resident had been scooting on her/his butt, was completely naked, and had left a trail of feces on the floor. Staff 8 acknowledged that she did not assess the resident to understand why the resident kept getting out of bed and did not consider placing the resident on one to one care. Staff 8 stated the resident was incontinent of both bowel and bladder, with urine and feces spread all over the floor. Staff 8 also stated she did not document any of the issues related to the resident. Staff 8 recalled an argument during shift change about who should clean the resident up, as this happened during the night shift. Staff 8 acknowledged that leaving the resident in that condition violated professional standards of care. Staff 8 denied being the one who suggested leaving the resident on the floor.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/28/24 at 3:34 PM Staff 17 (day shift/LPN) stated Staff 8 (night shift/ LPN) told her, you have a crawler because Resident 17 had been crawling all over the floor and got feces on everything. Staff 17 stated the use of that term was not acceptable and was undignified. Staff 17 stated she had many residents with many challenges to keep in bed but would never leave them naked on the floor.</p> <p>On 10/25/24 at 11:55 AM, Staff 1 (Administrator) and Staff 2 (DNS) acknowledged facility staff failed to provide proper incontinent care and failed to ensure the safety of Resident 17 by leaving the resident on the floor naked and covered in waste. They acknowledged they had substantiated that neglect of care had occurred in their investigation of the incident.</p> <p>2. Resident 18 was admitted to the facility in 2024 with diagnoses including muscle weakness and a hip fracture.</p> <p>The facility's investigation dated 8/7/24, indicated on the morning of 8/7/24 Resident 18 was left unchanged for an extended period, with urine and dried feces on her/him when the resident was found at the start of day shift. The facility determined Resident 18 was neglected by both the assigned CNA (Staff 7) and the shift nurse (Staff 8). The resident's call light was not responded to timely, and the resident tried to go to the bathroom without the assist needed and she/he fell . Resident 18 was left on the floor in the bathroom until shift change. No timeframe was included in the investigation.</p> <p>A witness statement in the facility investigation dated 8/7/24 completed by Staff 17 (LPN), indicated Staff 8 (LPN) told her during report Resident 18 was on the floor. Staff 8 stopped giving report long enough to tell a CNA to go and get vitals on the resident and get her/him up off the floor. Staff 17 had to stop Staff 8 and tell her she was required to check the resident for injuries before the resident could be moved. Staff 17 was appalled the nurse was giving report instead of assisting a resident who was on the floor.</p> <p>The facility's Unwitnessed Fall Incident Report dated 8/7/24 prepared by Staff 8 (LPN), indicated Resident 18 was found on her/his knees in the bathroom. The resident's Foley catheter was disconnected from the bed. No noted injuries. The report indicated the resident yelled and was embarrassed due to being incontinent of bowel all over the floor. The fall was not witnessed.</p> <p>The incident report was not complete and did not include an assessment of the resident by Staff 8, which included, pain level, mental status, mobility, predisposing environmental factors, predisposing physiological factors, predisposing situation factors, and no staff statements were completed. In addition, the report did not include a summary of the incident completed by management staff. Staff 8 indicated no injuries were observed for Resident 18, however, staff checked on the resident and found a skin tear from the incident which Staff 8 failed to identify.</p> <p>On 10/25/24 at 9:07 AM, Staff 1 (Administrator) stated Resident 18 was on the floor for an unknown amount of time and Staff 8 failed to assess the resident. Staff 8 was giving report to the day shift nurse and she just left the resident on the floor.</p> <p>On 10/25/24 at 9:25 AM, Staff 11 (CMA) stated on the morning of 8/7/24 Resident 18 was found on the floor. The morning CNA found Resident 18 wet and covered in feces.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/25/24 at 11:10 AM, Staff 8 (LPN) stated Resident 18 put her/his call light on to go to the bathroom but staff did not respond timely and the resident went to the bathroom without assistance and she/he fell . Staff stated she did not know who found the resident but knew the resident was on the floor for a while. Staff 8 stated although she knew the resident was on the floor she did not document the fall or assess the resident's condition because it was the end of her shift. Staff 8 stated she should have documented the incident and the normal procedure was to write a statement which she also did not complete.</p> <p>Refer to F 600</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>33179</p> <p>Based on interview and record review, it was determined the facility failed to assess and monitor pressure ulcers for 3 of 6 sampled residents (#s 13, 15 and 22) reviewed for pressure ulcers. This placed residents at risk for worsening wounds. Findings include:</p> <p>1. Resident 22 readmitted to the facility in 9/2024, with diagnoses including diabetes and dementia.</p> <p>The 9/5/24 Nursing Readmission Evaluation revealed an unstageable coccyx wound and no other pressure injuries.</p> <p>The Skin and Wound Evaluations revealed the following:</p> <p>-9/6/24: Deep Tissue Injury (persistent non-blanchable deep red, maroon or purple discoloration) to the rear, distal right malleolus. There was no assessment completed for the resident's right heel.</p> <p>-9/6/24: Coccyx wound stalled, approximately one month old. The wound assessment did not include measurements or description of the resident's wound.</p> <p>-10/11/24: Coccyx wound. The wound assessment did not have any measurements or description of the resident's wound.</p> <p>The 10/29/24 Hospital Records revealed Resident 22 had the following wounds:</p> <p>-Foot Anterior, Right, Medial</p> <p>-Foot anterior, right</p> <p>-Right heel</p> <p>Resident 22's October 2024 TARS revealed wound treatment orders for the right heel wound, the right great toe and the coccyx. The coccyx treatment discontinued on 10/15/24. There was no treatment in place for the right anterior foot wound.</p> <p>Review of Resident 22's medical record revealed no wound treatment for the right, anterior foot and the coccyx wounds, and the right anterior medial, the right anterior and the right heel wounds were not monitored and comprehensively assessed weekly.</p> <p>On 10/31/24 at 9:36 AM, Staff 1 (Administrator), Staff 3 (MDS Coordinator) and Staff 6 (Regional Director of Clinical) acknowledged the coccyx, the right anterior medial, the right anterior and the right heel wounds were not monitored and comprehensively assessed weekly and the right anterior foot wound did not have a wound treatment order in place.</p> <p>2. Resident 15 admitted to the facility in 4/2024, with diagnoses including dementia.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 5/30/24 Progress Note revealed Resident 15 readmitted to the facility from a hospital stay and was admitted to hospice services. A head to toe skin assessment was completed and the resident did not have any pressure wounds.</p> <p>The 6/13/24 Skin and Wound Evaluation indicated Resident 15 had a right heel unstageable pressure ulcer. The evaluation did not include wound measurements.</p> <p>The 9/26/24 Hospice Visit Note revealed the right heel pressure ulcer was healed.</p> <p>Review of Resident 15's medical record revealed no wound monitoring or wound assessments from 6/13/24 through 9/26/24.</p> <p>On 10/23/24 at 12:20 AM, Staff 2 (DNS) verified weekly wound assessments and monitoring was not completed for Resident 15's right heel pressure ulcer.</p> <p>38139</p> <p>3. Resident 13 was admitted to the facility in 2024, with diagnoses including diabetes and a Stage 4 sacral (base of the spine) pressure ulcer (full-thickness tissue loss that exposes bone, tendon, or muscle.</p> <p>A Progress Note dated 6/19/24 at 11:42 PM, indicated the resident had a big wound on the coccyx that was prone to infection due to bowel movement falling inside the wound, redness to the groin and a left heel pressure ulcer.</p> <p>A Nursing Admission/Readmission Evaluation dated 6/19/24, indicated Resident 13 had a pressure ulcer of unspecified site, unspecified stage on the coccyx. No additional wound information was provided.</p> <p>Review of Resident 13's medical record revealed the following weekly Skin and Wound assessments:</p> <p>-6/2024 No Skin and Wound Assessments were completed.</p> <p>-7/30/24: Only one Skin and Wound Assessment was completed, with limited characteristics of the wound included.</p> <p>-8/2024: No Skin and Wound Assessments were completed.</p> <p>-9/6/24: Only one Skin and Wound Assessment was completed with no characteristics of the wound. Wound measurements increased in size but progress was listed as improving.</p> <p>-10/11/24: The Skin and Wound Assessment was completed with no measurements of the wound, and infection was suspected.</p> <p>-10/18/24: The Skin and Wound Assessment was completed with no measurements or characteristics of the wound.</p> <p>(continued on next page)</p>		

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