STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385117	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
French Prairie Nursing & Rehabilitation Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review it was determined the facility failed to notify a resident's responsible party of a significant change of condition for 1 of 3 sampled residents (#3) reviewed for medication. This placed residents at risk for their responsible party not being informed of the resident's status. Findings include:Resident 3 admitted to the facility in 2025 with diagnoses including epilepsy and dementia. Resident 3's emergency contact was listed as Witness 7 (Family Member). The 9/14/25 12:01 AM Progress Note by Staff 15 (LPN) indicated Patient found having active seizure. Called 911, resident left facility 00:01 [12:01 AM]. Notified on call. Left message on administrators phone.There was no indication in the clinical record to indicate Witness 7 was notified of Resident 3's change of condition and hospitalization. On 9/23/25 at 2:23 PM Witness 7 stated she was unaware of Resident 3's seizure or hospitalization until the hospital staff called and told her. On 9/25/25 at 12:55 PM Staff 2 (DNS) acknowledged Resident 3's emergency contact was Witness 7 and she was not contacted regarding the resident's seizures and hospitalization on 9/13/25.

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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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview and record review it was determined the facility failed to ensure sufficient nursing staff were available to meet resident needs for 1 of 1 facility reviewed for staffing. This placed residents at risk for lack of timely assistance and unmet care needs. Findings include:On 9/22/25 the facility had a census of 53. On 9/25/25 at 10:06 AM Staff 2 (DNS) provided a list of residents who: -Required assistance with bathing: 31;-Were dependent for bathing: 21;-Required assistance with dressing: 39;-Were dependent for dressing: 10;-Required assistance for ADL transfers: 28;-Were dependent for ADL transfers: 17;-Required assistance with ADL toilet use: 26;-Were dependent for ADL toilet use: 18;-Required assistance with eating: 9;-Were dependent with eating: 3.1. Call light observations revealed the following:-On 9/24/25 at 11:11 AM Resident 14's call light was illuminated. At 11:33 AM, Resident 14 stated she/he was waiting for lunch and a drink. At 11:39 AM Staff 30 (CNA) entered the room, exited the room and stated the resident requested water but was unable to have water while in bed. At 11:40 AM Staff 30 re-entered the room to assist the resident, and the call light was turned off (after 29 minutes).-On 9/24/25 at 11:26 AM Resident 13's call light was illuminated. At 11:46 AM Resident 13 stated she/he waited up to an hour at night for assistance and waited a long time for incontinence care. At 11:53 AM Staff 32 (CNA) entered the resident's room to answer the call light (after 27 minutes). Upon exit of the resident's room, Staff 32 stated the facility was fully staffed that shift.-On 9/25/25 at 6:33 AM Resident 13's call light was illuminated. At 6:53 AM, Resident 13 stated she/he was waiting for incontinence care. At 7:06 AM Staff 12 answered the call light (after 33 minutes). At 7:12 AM Staff 12 stated incontinence care was provided to Resident 13.2. Witness interviews revealed the following:-On 9/23/25 at 2:23 PM Witness 7 (Family member) stated medications were often given two and a half hours late, showers were not provided timely, the facility was short staffed, and the dinner meal was missed on a couple occasions for the resident. Witness 7 stated she/he completed a grievance form for the late medications.-On 9/23/25 at 2:30 PM Witness 6 (Family member) stated medications were given as late as four hours after they were due.3. Staff interviews were conducted from 9/22/25 at 11:51 AM through 9/25/25 at 7:51 AM with the following staff members: Staff 12 (CNA), Staff 16 (LPN), Staff 17 (CNA), Staff 10 (CNA), Staff 18 (CNA), Staff 19 (CNA), Staff 4 (RN), Staff 6 (CMA), Staff 20 (CNA), Staff 23 (CMA), Staff 21 (CNA), Staff 7 (CMA), Staff 24 (CNA), Staff 11 (CNA), Staff 4 (RN), Staff 27 (CNA), Staff 5 (LPN), Staff 22 (RN), Staff 29 (CNA), Staff 30 (CNA), Staff 31 (CNA), Staff 8 (CNA), Staff 33 (CNA), Staff 34 (CNA), Staff 35 (CNA), Staff 36 (CNA), Staff 37 (LPN), Staff 38 (LPN), and Staff 39 (LPN). When interviewed, the identified staff members indicated the following concerns:- Daily staff shortages including CNAs, CMAs, and nurses. Nurses and CMAs stated they were often in charge of the entire building by themselves due to short staffing, which left vacancies at the other two open shifts for a nurse and CMA. The staff stated the shortages often occurred on the night shift.-Staff assignments at the start of shift were not made timely and the residents were not divided evenly. -Long call light response times and some residents called the facility's main phone number for assistance.-Residents did not receive quality care due to short staffing. Showers did not get done as scheduled, vital signs and weights were not completed. -Difficulty providing incontinence care every two hours for all residents.-Residents who were out of bed since 4:00 PM, were not assisted back to bed until 10:00 PM due to short staffing.-The facility was not staffed to address the high acuity needs for residents resulting in delayed in care for multiple hours at a time, lack of timely incontinence care, and late meals.-Medications were administered late, including seizure medications. -Staff complained to management about the lack of additional staff, and there was no response. -Staff felt overwhelmed while working due to short staffing.-There was short staffing on weekends that resulted in two CNAs on night shift to care for the entire facility. Resident rounds were not completed until five hours after the start of the shift.-Staff 7 (CMA) stated she often had to work on the floor to answer call lights, in addition to administering medications which resulted in untimely medications.-The lack of timely care caused residents to fall. -Several residents required a mechanical lift transfer that required two staff, and it was difficult to have residents up timely for meals.-Staff 4 (RN) stated inexperienced staff were orienting each other, which resulted in residents not receiving incontinent care.-Residents often did not receive restorative care as scheduled.-Staff 1 (Administrator) was aware of the staff's concerns about staffing. 4. Public complaints received by the State Agency revealed the following staffing concerns:On 5/2/25 a public complaint was received by the State Agency which alleged residents experienced untimely toileting assistance, long call light response times, and medications not given timely On 5/5/25 a public complaint was

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on interview and record review it was determined the facility failed to post accurate and complete staffing information for 1 of 1 facility reviewed for required staff postings. This placed residents and the public at risk for incomplete and inaccurate staffing information. Findings includeA review of the Direct Care Staff Daily Reports from June 2025 through 9/23/25 revealed 47 days when portions of the form were left blank or were inaccurate. The incomplete or inaccurate information included daily census, the number of working staff and staff hours worked. The dates included:7/6/257/9/257/22/25 8/1/25 8/5/25 8/10/25 8/11/25 8/12/25 8/13/25 8/14/25 8/15/25 8/16/25 8/17/25 8/21/25 8/22/25 8/23/25 8/24/25 8/25/25 8/26/25 8/27/25 8/28/25 8/29/25 8/30/25 8/31/25 9/1/25 9/2/5 9/3/25 9/4/25 9/5/25 9/6/25 9/7/25 9/8/25 9/9/25 9/11/25 9/12/25 9/13/25 9/14/25 9/15/25 9/16/25 9/17/25 9/18/25 9/19/25 9/20/25 9/21/25 9/22/25 9/23/25On 9/25/25 at 11:15 AM Staff 1 (Administrator) acknowledged the Direct Care Staff Daily Reports were incomplete and inaccurate for the identified dates.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review it was determined the facility failed to ensure residents were free from significant medication errors for 1 of 3 sampled residents (#3) reviewed for medication. This placed residents at risk for reduced efficacy of medications. Findings include:Resident 3 admitted to the facility in 7/2025 with diagnoses including epilepsy (a neurological disorder characterized by unprovoked seizures) and dementia. The 8/20/25 physician order indicated Resident 3 was to receive the following medications twice daily for epilepsy:-levetiracetam (antiepileptic drug) 750 mg 3 tablets;-lamotrigine (anticonvulsant medication used to prevent or control seizures) 200 mg 2 tablets;-zonisamide (anticonvulsant medication used to prevent or control seizures) 100 mg 3 tablets. The 9/2025 MAR indicated the following:-Resident 3 was to receive levetiracetam, lamotrigine and zonisamide at 8:00 AM and 8:00 PM.-On 9/13/25 Staff 15 (LPN) administered levetiracetam, lamotrigine and zonisamide to Resident 3 at 11:47 PM (three hours and 47 minutes late). On 9/24/25 at 9:55 AM Staff 15 stated she administered levetiracetam, lamotrigine and zonisamide to Resident 3 on 9/13/25 at 10:30 PM (two and a half hours late) and did not document the administration time until 11:47 PM. Staff 15 stated after she administered the medications at 10:30 PM, Resident 3 was fine and was not having any issues. Staff 15 further stated later on that evening, the CNA staff reported the resident did not look right and when Staff 15 responded to the room the resident was actively having seizures. Staff called 911 and sent the resident to the hospital via ambulance. The 9/14/25 12:01 AM Progress Note by Staff 15 indicated Patient found having active seizure. Called 911, resident left facility 00:01 [12:01 AM]. Notified on call. Left message on administrator's phone.The 9/14/25 4:14 AM Hospital Records indicated on 9/13/25 Resident 3's first seizure episode lasted one to two minutes, followed by another seizure that did not last long, then around 11:40 PM the resident had another seizure that lasted about 10 minutes. When the medics arrived the patient was seizing. A review of Resident 3's clinical record revealed no indication the resident experienced seizures in the facility prior to 9/13/25. On 9/25/25 at 12:55 PM Staff 2 (DNS) stated she became aware of Resident 3's seizure and hospitalization after Witness 7 (Family Member) made a comment about the resident not receiving her/his medications on time. Staff 2 stated the resident was hospitalized for a few days as a result of the seizure. Staff 2 stated it was important for anti seizure medication to be given timely, especially levetiracetam, because if the resident was at a subtherapeutic level, seizures could occur. Staff 2 stated the facility was not completing labs for routine levetiracetam levels and she did not find labs in the resident's clinical record. Staff 2 stated she did not talk to Staff 15 about the incident and an incident report was not completed. Staff 2 acknowledged Resident 3 did not have seizures in the facility prior to 9/13/25 when the medication was administered late.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interview and record review the facility failed to ensure facility administration used the facility's resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident related to lack of sufficient staffing, lack of a facility assessment, and significant medication errors for 1 of 1 facility reviewed for effective administration.1. Observations on 9/24/25 and 9/25/25 revealed delayed responses to call lights, staff appeared and reported to be rushed, and residents were waiting for assistance from staff and appeared frustrated from the lack of timely assistance. Facility documentation including grievances and Direct Care Staff Daily Reports revealed chronic concerns spread across multiple months related to insufficient staffing, which resulted in delayed assistance or assistance not provided at all.Interviews with residents and witnesses during from 9/22/25 through 9/24/25 revealed concerns related to sufficient staffing including delayed call light times, and lack of assistance. Interviews with facility staff from 9/22/25 through 9/25/25 revealed the facility was often staffed below state minimum staffing ratios, and was not staffed according to resident acuity. Many of the residents required two-person assistance. The lack of staffing to the acuity of residents resulted in outcomes including delayed assistance, improper assistance, lack of assistance and increased stress of staff due to their inability to provide sufficient care. Staff reported the concerns were shared with facility administration, but no changes were made to the staffing levels.On 9/25/25 at 11:15 AM and 1:54 PM Staff 1 (Administrator) acknowledged the ongoing concerns related to insufficient staffing.Refer to F725.2. The 3/24/25 Facility Assessment failed to comprehensively and accurately include information how the facility assessment was used to address staffing needs and resident acuity and the high usage of agency staff.On 9/25/25 at 1:54 PM, Staff 1 (Administrator) acknowledged the assessment was not comprehensive and did not have accurate information related to staffing.Refer to F838.3. Resident 3 was to receive medications for epilepsy two times a day at 8:00AM and 8:00PM. On 9/24/25 Staff 15 (LPN) did not administer the medication to Resident 3 until 10:30 PM. A 9/14/25 at 12:01 AM a Progress Note indicated Patient found having active seizure. Called 911, resident left facility 00:01 [12:01 AM]. Notified on call. Left message on administrator's phone.On 9/25/25 at 12:55 PM Staff 2 (DNS) stated she became aware of Resident 3 being sent out to the hospital after Witness 7 (Family Member) made a comment about the resident not receiving her/his medications on time. Staff 2 acknowledged the expectation was for seizure medications to be administered on time, as the medications were to prevent seizures. Staff 2 stated she did not to speak to Staff 15 about the incident, and an incident report was not completed. Refer to F760.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, it was determined the facility failed to conduct and complete a comprehensive facility assessment to care for its residents competently during day-to-day operations. This placed residents at risk for unidentified and unmet needs. Findings include:The 3/24/25 Facility Assessment was reviewed. The assessment was not comprehensive and failed to accurately include information on the following:- How the facility assessment was used to address staffing needs and resident acuity.- The high usage of agency staff.On 9/25/25 at 1:54 PM, Staff 1 (Administrator) reviewed the Facility Assessment and acknowledged the assessment was not comprehensive and did not have accurate information related to the area of staffing. No further information was provided.