

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 12/12/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review it was determined the facility failed to report an allegation of abuse to the State Agency within the required timeframe for 1 of 4 sampled residents (#9) reviewed for abuse. This placed residents at risk for abuse. Findings include: Resident 9 admitted to the facility in 5/2025, with a diagnosis of dementia with agitation. On 11/27/25 at 3:30 PM, a Progress Note indicated a CNA was physically struck by Resident 9 several times in the face, shoulder and knee. On 11/27/25 at 3:39 PM, a Progress Note indicated Staff 21 (LPN) went to Resident 9 who admitted to hitting and kicking the CNA but then alleged the CNA abused her/him first. The State Agency received the facility's FRI for an allegation of abuse on 11/27/25 at 7:25 PM. On 12/10/25 at approximately 12:00 PM, Staff 2 (DNS) verified the FRI was not submitted within the two-hour required timeframe of the abuse allegation. On 12/11/25 at 6:01 PM Staff 21, verified once Resident 9 verbalized the allegation of abuse he assessed the resident and reported the allegation to the facility management staff. Staff 21 stated no staff came to the facility to investigate the allegation the same day and the allegation of abuse was not ruled out within the two-hour required timeframe.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review it was determined the facility failed to thoroughly investigate an allegation of abuse for 1 of 4 sampled residents (#9) reviewed for abuse. This placed residents at risk for physical abuse. Findings include: Resident 9 admitted to the facility in 5/2025 with a diagnosis including dementia with agitation. Resident 9's 11/22/25 Care Plan indicated the resident had verbal and physical behaviors towards staff and staff were to provide care in pairs. The 11/27/25 at 3:30 PM Progress Note indicated a CNA was physically struck by Resident 9 several times in the face, shoulder and knee. The 11/27/25 at 3:39 PM Progress Note indicated Staff 21 (LPN) went to Resident 9 who admitted to hitting and kicking the CNA but then alleged the CNA abused her/him first. Staff 21 notified the facility management of the allegation of abuse. The 11/27/25 Facility Investigation revealed a CNA reported being struck in the face, shoulder, and knee while performing care. The resident reported to the nurse he did to the CNA what she did to her/him. The resident later apologized to the CNA. The investigation did not include staff witness statements, investigation notes, or a summary of the incident. On 12/10/25 at approximately 12:00 PM Staff 2 (DNS) and Staff 3 (Regional Director of Clinical) verified the facility investigation for Resident 9's 11/27/25 incident was not thorough or complete. Resident 9 admitted to the facility in 5/2025, with a diagnosis including dementia with agitation. Resident 9's 11/22/25 Care Plan indicated the resident had verbal and physical behaviors towards staff and staff were to provide care in pairs. On 11/27/25 at 3:30 PM, a Progress Note indicated a CNA was physically struck by Resident 9 several times in the face, shoulder and knee. On 11/27/25 at 3:39 PM, a Progress Note indicated Staff 21 (LPN) went to Resident 9 who admitted to hitting and kicking the CNA but then alleged the CNA abused her/him first. Staff 21 notified the facility management of the allegation of abuse. The 11/27/25 Facility's Investigation revealed a CNA reported being struck in the face, shoulder, and knee while performing care. The resident reported doing to the CNA what the staff member had done to her/him. The resident later apologized to the CNA. The investigation did not include staff witness statements, investigation notes, or a summary of the incident. On 12/10/25 at approximately 12:00 PM, Staff 2 (DNS) and Staff 3 (Regional Director of Clinical) verified the facility's investigation for Resident 9's 11/27/25 incident was not thorough or complete.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation and interview it was determined the facility failed to ensure meals were palatable for 1 of 1 kitchen observed for food services. This placed residents at risk for receiving food that was unpalatable. Findings include: On 12/9/25 at 11:06 AM, Resident 12 stated breakfast was often cold, and she/he disliked the food. On 12/9/25 at 11:17 AM, Resident 13 stated she/he disliked the food. On 12/10/25 at 7:19 PM, Resident 14 stated the food was nasty. On 12/11/25 at 12:30 PM, Resident 10 stated her/his chicken was very dry. On 12/9/25 at 9:59 AM, Staff 17 (CNA) stated residents often complained of the food and purchased food from delivery services every day. On 12/10/25 at 7:10 PM, Staff 7 (LPN) and Staff 31 (LPN) both stated residents would frequently order food delivery when they disliked the meal served to them. On 12/11/25 at 6:05 PM, Staff 21 (LPN) stated several residents complained about the food and its taste. On 12/12/25 at 12:15 PM, a test tray was completed with Staff 1 (Administrator). The tray consisted of a fish filet which was cold and bland in taste and not served with any sauce.</p>

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>Based on observation and interview, it was determined the facility failed to provide residents with alternative meals for 1 of 1 kitchen reviewed for food service. This placed residents at risk for not receiving nourishing meals. Findings include. On 12/9/25 the facility's Alternative Menu indicated residents could request tomato soup, chicken noodle soup, deli sandwich, chicken Caesar salad, or a hamburger with lettuce and tomato. On 12/9/25 at 10:35 AM, Staff 19 (Dietary Manager) stated if residents do not indicate an alternative meal two hours before meal service, residents must wait until the end of meal service to get their meal. On 12/9/25 at 11:06 AM, Resident 12 stated she/he was unable to get an alternative meal if she/he did not like what was served. On 12/10/25 at 10:50 AM, Staff 14 (CNA) stated she was only able to get an alternative meal for a resident if she requested the meal at least two hours in advance. On 12/10/25 at 11:45 AM, Staff 32 (LPN) stated for a resident to receive an alternative meal it had to be ordered at least two hours in advance. On 12/10/25 at 7:10 PM, Staff 7 (LPN) and Staff 31 (LPN) both stated residents were not able to request alternative meals. On 12/10/25 at 7:19 PM, Resident 14 stated she/he had requested alternative meals many times in the past and only received a second tray one time. On 12/11/25 at 10:54 AM, Staff 9 (CNA) stated residents could only get an alternative meal if they asked for it two hours in advance. Staff 9 further stated that residents who request an alternative evening meal are often told their requests are too late. On 12/11/25 at 5:55 PM, a hamburger was requested as an alternative meal. Staff 20 (Cook) stated she was unable to make a hamburger as an alternative meal. Staff 20 stated alternative meals needed to be requested at minimum two hours in advance, and she was only allowed to cook what was on her product list. Staff 20 verified the hamburger was not on her food product list.</p>		