

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 02/27/2026
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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to administer medications according to physician orders for 1 of 3 sampled residents (#3) reviewed for medications. This placed residents at risk for not receiving medications as ordered and potential side effects. Findings include: Resident 3 admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease. Resident 3's 12/26/25 admission Orders included the following orders:-Combivent 1 puff BID (a respiratory inhaler);-Symbicort 2 puffs BID (a respiratory inhaler); and-Apixaban 5 mg BID (an anticoagulant to prevent blood clots). Resident 3's 12/2025 MARS documented the evening doses of Combivent, Symbicort, and apixaban were not administered on 12/26/25. On 2/27/26 at 9:39 AM, Staff 2 (Interim DNS) stated Resident 3's medications for Combivent, Symbicort, and apixaban were not administered as ordered on 12/26/25.</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
---	-------	-----------