

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/03/2026
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)		
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on interview and record review it was determined the facility failed to ensure tube feeding supplies were provided for 1 of 3 sampled residents (# 8) reviewed for nutrition. This placed residents at risk for poor nutrition and a delay in enteral feeding. Findings include: Resident 8 was admitted to the facility in 4/2026 with diagnoses including hemiplegia and hemiparesis following cerebral infarction (paralysis of one side of the body and mild to moderate weakness of one side of the body following a stroke caused by a blood clot in the brain). A 4/26/26 Hospital After Visit Summary indicated Resident 7 was to receive tube feeding through nasogastric (NG) tube daily for 18 hours, with a start time of 4:00 PM and end time of 10:00 AM, at a rate of 70 ml/hour. Resident 7's 4/2026 TAR instructed staff to administer Diabetisource AC via Pump- at 70 ml/hr for 18 hours via NG tube starting at 4:00 PM and continuing until 10:00 AM Resident 7's 4/2026 TAR indicated Resident 7's 4/29/26 at 4:00 PM tube feeding was not administered. Resident 7's Progress Note dated 4/29/26 indicated Resident 7 was due for NG feeding to resume at 4:00 PM today. The feeding did not take place due to lack of supplies. Several unsuccessful attempts were made to obtain the necessary supplies. Resident 7 was transported to the emergency department to receive the required tube feeding. On 6/3/26 at 1:35 PM, Staff 1 (Administrator) and Staff 2 (DNS) confirmed the facility was unable to secure the supplies necessary to administer Resident 7's tube feeding, which resulted in the resident missing her/his 4/29/26 at 4:00 PM tube feeding. Resident 7 was transported to the hospital to receive tube feeding.		

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review it was determined the facility failed to ensure food was palatable and served at an appropriate temperature for 1 of 1 lunch meal service reviewed for dietary concerns. This placed residents at risk for unpalatable meals. Findings include: On 6/2/26 at 11:50 AM, an observation of the lunch tray service which included a surveyor test tray began. This observation revealed the following: -12:00 PM: the first resident meal was plated for the 300 Hall Cart. -12:15 PM: The 300 hall cart trays were complete, and the cart was taken to the 300 hall. -From 12:15 PM to 12:43 PM: The 100 hall cart, the main dining room residents, and the 200 Hall cart was completed. -12:43 PM: The 200 Hall cart, which included the pureed surveyor test tray, was taken to the 200 Hall. -12:44 PM: The first resident tray was passed. -12:47 PM: The last resident tray was passed. The test tray was brought to the conference room. On 6/2/26 at 12:47 PM, a review of the pureed test tray was completed by the survey team. The tray consisted of pureed peas, pureed sweet potatoes, and a pureed white to tan colored substance, and a bowl of applesauce. The observation found the pureed peas and the pureed white to tan colored substance to be lukewarm. The survey team was unable to determine what food the white to tan colored substance was from taste or smell. On 6/2/26 at 12:48 PM, Staff 2 (DNS) declined to taste the food on the test tray but did test the temperature and verified the pureed peas and the pureed white to tan colored was lukewarm. On 6/2/26 at 12:50 PM, Staff 13 (Cook) stated the unknown white to tan colored substance was a pureed roll. On 6/2/26 at 12:51 PM, Staff 1 (Administrator) and Staff 12 (Dietary Manager) acknowledged the food was served lukewarm. On 6/2/26 at 1:00 PM, Resident 10 stated the meals were frequently late, the food tasted horrible and was cold. On 6/2/26 at 1:02 PM, Resident 11 stated the food is crap. Resident 11 further stated the food tasted terrible and was cold. On 6/2/26 at 1:04 PM, Resident 12 stated the food tasted bad and was cold. Resident 12 stated the poor quality of the food made her/him not want to eat.		