STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385274	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mirabella Portland	3550 S Bond Ave Portland, OR 97239

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review it was determined the facility failed to ensure a resident's fall investigations were completed timely for 1 of 5 sampled residents (#1) reviewed for unnecessary medications. This placed residents at risk for continued falls and injury. Findings include: Resident 1 was admitted to the facility in 8/2022 with a diagnosis of heart disease. The facility Abuse and Incident Reporting Policy and Procedure revised on 5/2024 revealed an investigation was to be completed within five working days after an incident was reported. a. Resident 1's 10/8/25 Unwitnessed Fall investigation revealed on 10/8/25 she/he tried to move a swivel chair, lost balance, and fell. The investigation indicated at the time of the fall Resident 1's care plan was followed and abuse and neglect were ruled out two hours after the incident occurred. The investigation was not completed until 11/1/25. On 3/26/26 at 10:07 AM and 12:55 PM Staff 2 (DNS) stated investigations were to be completed and submitted to her and Staff 1 (Administrator) five days after an investigation was initiated. Staff 2 stated at the time of Resident 1's fall there was no resident care manager and the paperwork was not completed timely. On 3/27/26 at 8:28 AM Staff 1 stated if a resident fell, the nurses were to initiate an investigation, start obtaining interviews with witnesses, implement new interventions if indicated, and notify Staff 2 of the incident. Staff 1 stated the investigation was to be completed within five days, including the root cause analysis, and then submitted to him for a final review.b. Resident 1's 11/21/25 Witnessed Fall investigation revealed she/he fell while being assisted to bed. Staff 2 (DNS) completed the fall investigation on 12/2/25. Staff 1 (Administrator) signed off on the completed investigation on 12/16/25. On 3/26/26 at 10:07 AM and 12:55 PM Staff 2 (DNS) stated investigations were to be completed and submitted to her and Staff 1 (Administrator) five days after an investigation was initiated. Staff 2 stated at the time of Resident 1's fall there was no resident care manager and the paperwork was not completed timely, but the staff ensured Resident 1 needs were met. On 3/27/26 at 8:28 AM Staff 1 stated if a resident fell, the nurses were to initiate an investigation, start obtaining interviews with witnesses, implement new interventions if indicated, and notify Staff 2 of the incident. Staff 1 stated the investigation was to be completed within five days, including the root cause analysis, and then submitted to him for a final review.

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure the resident / representative was provided the bed hold policy and the State Ombudsman Office was notified of residents' discharge for 2 of 2 sampled residents (#s 4 and 27) reviewed for hospitalization. This placed residents at risk for right to return and lack of advocacy. Findings include: 1. Resident 4 was admitted to the facility in 5/2024 with diagnoses including pulmonary embolism without acute cor pulmonale (a blood clot in the lung artery that does not cause immediate right-sided heart failure) and vascular dementia (a decline in cognitive function caused by conditions that block or reduce blood flow to the brain). Resident 4's 1/21/26 Annual MDS revealed she/he had moderate cognitive impairment. A review of Resident 4's health record revealed she/he was admitted to the hospital on [DATE] due to pain in her/his left flank (side of the torso between the lower ribs and the top of the hip) and decreased blood oxygen saturation. No evidence was found in Resident 4's health record to indicate the facility notified the State Longterm Care Ombudsman of her/his discharge or provided Resident 4 or her/his representative with a copy of the facility's bed hold policy. On 3/26/26 at 3:17 PM Staff 9 (RN) stated she made the decision to send Resident 4 to the hospital because of her pain and low oxygen levels after speaking with her/his provider and family representative. Staff 9 stated she did not provide the resident or her/his family with a copy of the facility's bed hold policy and she did not contact the office of the State Longterm Care Ombudsman. On 3/30/26 at 1:02 PM Witness 1 (family member) stated the facility did not provide him or Resident 4 with a notification of the bed hold policy when she/he was discharged to the hospital. On 3/27/26 at 9:46 AM Staff 1 (Administrator) stated staff did not notify the State Longterm Care Ombudsman of Resident 4's discharge to the hospital nor did they provide Resident 4 or her/his representative with a copy of the facility's bed hold policy when she/he was discharged to the hospital on 1/25/26 because he was unaware this was a requirement. 2. Resident 27 was admitted to the facility in 12/2025 with a diagnosis of left hip replacement. Resident 27's 1/21/26 Progress Note revealed she/he was transported to the hospital. Resident 27's clinical record revealed she/he did not return to the facility and there was no documentation to indicate the State Longterm Care Ombudsman office was notified of her/his discharge. On 3/26/26 at 10:52 AM and 3/27/26 at 8:33 AM Staff 1 (Administrator) stated Staff 3 (Social Services Director) was responsible for notifying the State Longterm Care Ombudsman office when residents were discharged from the facility. Staff 1 also stated the facility did not notify the ombudsman unless a resident was discharged involuntarily. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/26 at 10:53 AM Staff 3 stated she did not notify the State Longterm Care Ombudsman office when residents were discharged from the facility, including Resident 27.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, interview and record review it was determined the facility failed to ensure the resident was assisted to wear glasses for 1 of 2 sampled residents (#13) reviewed for activities. This placed residents at risk for impaired vision. Findings include:Resident 13 was admitted to the facility in 6/2018 with diagnoses including intracranial injury with loss of consciousness (traumatic brain injury) and aphasia (a language disorder caused by brain damage and resulting in impaired communication and comprehension).Resident 13's care plan dated 1/2/20 indicated staff were to ensure her/his glasses were available to support her/his participation in activities and staff were to provide assistance to place and remove them.Resident 13's 1/21/26 annual MDS revealed she/he had severe cognitive impairment, was dependent on staff for assistance with ADLs including dressing and completing personal hygiene tasks and had adequate vision with the use of glasses.Random observations on 3/23/26 through 3/26/26, between 8:30 AM and 4:03 PM Resident 13 was observed not wearing her/his glasses when she/he was in the living room with other residents, or during group activities or while sitting in her/his room. Resident 13's glasses were observed in their case on the shelf above her/his dresser.On 3/25/26 at 12:21 PM Staff 4 (CNA) stated he referred to Resident 13's care plan to know how much assistance to provide her/him. Staff 4 stated Resident 13 was not able to ask for assistance and was completely dependent on staff assistance for completion of her/his ADLs. Staff 4 stated he never saw Resident 13 wear glasses and he was not sure if she/he had glasses.On 3/25/26 at 3:40 PM Staff 5 (CNA) stated she referred to Resident 13's care plan whenever she worked with the resident because she/he was not able to communicate verbally and was not able to complete any personal care tasks for herself/himself. Staff 5 stated she didn't think Resident 13 wore glasses.On 3/26/26 at 10:08 AM Staff 6 (CNA) stated Resident 13 was completely dependent on staff to provide assistance and was unable to ask for help. Staff 6 stated she referred to Resident 13's care plan to know what assistance to provide for her/him. Staff 6 stated she was not aware Resident 13 needed to wear glasses.On 3/26/26 at 10:33 AM staff 7 (RN) stated Resident 13 was, Totally dependent and did not do anything on her/his own. Staff 7 stated Resident 13 had glasses and he saw her/him wear them occasionally. Staff 7 stated it was important for staff to assist Resident 13 with her/his glasses because she/he needed them and she/he could not ask for anyone to help her/him put them on or take them off.On 3/26/26 at 11:53 AM Staff 2 (DNS) stated Resident 13's spouse wanted her/him to wear her/his glasses. Staff 2 stated she expected staff to assist Resident 13 to use her/his glasses because she/he was not able to place and remove them herself/himself and she/he was not able to communicate requests to her/his caregivers.