STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525678	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careview Health and Rehab of Minocqua	9969 Old Hwy 70 Rd Minocqua, WI 54548

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and policy review, the facility licensed staff failed to ensure that cardiopulmonary resuscitation (CPR) was provided when resident was found unresponsive for one of three residents (Resident (R)1) reviewed for deaths out of a total sample of 11 residents. This failure had the potential to decrease the chance of survival for residents who required CPR. Findings include:Review of R1's admission Record located under the Profile tab in the electronic medical record (EMR) revealed R1 was admitted to the facility on [DATE]. R1 was discharged from the facility on [DATE] to a funeral home. R1 had diagnoses of gram-positive bacteremia (bacteria in the bloodstream), Parkinson's disease, seizure disorder or epilepsy, and difficulty in walking. Record review of R1's undated Clinical Physician Orders located in the EMR under the Orders tab, reflected an order entered on [DATE] for Full Code-CPR (the healthcare team will perform CPR and all possible life-saving measures in the event of a cardiac or respiratory arrest). Review of R1's undated Care Plan Report located in the EMR under the Care Plan tab, revealed entries initiated on [DATE] that indicated Advanced Directive Full Code. The Goal reflected [R1's] code status will be honored. The Interventions/Tasks included In the event of a code call 911 and begin CPR . Honor code status wishes . Review code status quarterly and As Needed [PRN]. Review of a Health Status Note entered by Registered nurse (RN)1, dated [DATE] at 7:55 PM, located in the EMR under the Progress Notes tab reflected the following: Writer was called to [R1's] room by CNA [Certified Nursing Assistant] at approximately 1600 [4:00 PM] with concerns for [R1's] wellbeing. CNA reported that during rounds she found [R1] face down in her room halfway on the floor and halfway on the bed and was not responsive. Upon entry into [R1's] room writer [RN1] visualized [R1] face down and appearing pale with no respirations. [RN1] checked [R1's] pulse and was not successful on finding one. [RN1] and staff immediately worked to get [R1] supine [flat on their back] on the ground and into position to start CPR. CPR was started and additional staff located crash cart. Once staff arrived with crash cart [RN1] briefly paused CPR to apply the Automated External Defibrillator [AED] pads and CPR continued. Police and Emergency Medical Services [EMS] arrived shortly thereafter, approximately 15 minutes later and took over with a mechanical chest compression device. Staff continued assisting EMS and police with resuscitation efforts until EMS called patients time of death. Questions answered to coroner at best of [RN1's] ability along with additional staff that witnessed event. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:09 PM, CNA1 said that she conducted rounds before going on break on [DATE] at 3:30 PM, and R1 was observed in bed in her room. CNA1 said she conducted rounds of the two assigned halls around 4:00 PM when she returned from break. CNA1 said when she conducted rounds on R1's hall, she could not see R1 in bed from the hallway and stepped into the room. CNA1 said that she discovered R1 in a face-down back bending position (up-and-down direction), perpendicular to the bed, like the letter 'T'. R1's chin and neck pressed against the metal bedframe on the side of the bed, with an excessive backwards bending of the head, neck, and shoulders towards the upper midline region of the back. R1's upper body was lifted off the floor and her legs rested on the floor. CNA1 said that she visually inspected R1 for movement and listened for sounds of breathing. CNA1 said that R1 was unresponsive, her eyes were half-open, and there were no visual or audible signs of breathing. CNA1 said that she immediately left the room, without shouting for help, to get Registered Nurse (RN)1, the nurse assigned to R1. CNA1 said that she did not see RN1 at the centralized nurses' station (direct view from each hall) and asked Licensed Practical Nurse (LPN)1 to assess and evaluate R1. CNA1 was unable to provide a timeframe of events and stated that everything happened quickly, and it all was a blur. CNA1 said that she and LPN1 returned to R1's room. LPN1 checked R1 for a pulse and sent CNA1 to retrieve RN1. CNA1 said that when RN1 entered the room, it took three people to reposition R1 to the floor on her back, and RN1 started CPR. During a phone interview on [DATE] at 5:19 PM, LPN1 said that she worked on [DATE] but was not assigned to R1. LPN1 said that she was asked by CNA1 to assess R1. LPN1 said she saw R1 in a face down position with her head and neck against the bed when she entered the room. LPN1 said that R1 appeared to have sustained a critical neck injury how her head and neck hyperextended (was bent beyond its normal, safe range of motion) backward. LPN1 said that R1 was unresponsive, was not breathing, and she could not feel a pulse. LPN1 said that she told CNA1 to get RN1 and to call 911. LPN1 said that she called out for help, RN1 entered the room, and it took a few people to turn R1 over onto her back. LPN1 said that RN1 started chest compressions while she (LPN1) provided breaths with the Ambu bag until EMS arrived. Review of RN1's progress note and CNA1 and LPN1's interviews verified that CPR was not started until RN1 entered R1's room resulting in a delay in initiating CPR. (continued on next page)

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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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 7:20 PM, the Assistant Director of Nursing (ADON)1 said if a resident was discovered unresponsive, the nurse should check if the resident is breathing or has a heartbeat. If the nurse did not know the resident's code status, the nurse should check the chart. If the resident was not breathing or was gasping for breaths and had no heartbeat, then the nurse should call for help and start CPR. The nurse should tell someone to call 911 and to get the AED/crash cart. All the steps should happen at the same point or as quickly as possible.During an interview on [DATE] at 7:15 PM, the Assistant Administrator and the Regional Support Administrator indicated their expectations were to start CPR as soon as possible and per the policy.Review of the police department Incident Report on paper, dated [DATE], written by Police Officer (PO)1, provided by the Regional Support Administrator reflected On [DATE] at approximately 4:01 PM, dispatch received a 911 call from [facility]. The caller stated there was a female resident [R1] who was on the ground and was unresponsive. [PO1] arrived on scene at approximately 4:06 PM. [PO1] observed a nurse performing CPR and staff bagging for air. an AED was attached to [R1]. PO1 took over CPR for the nurse. PO1 performed CPR for a few minutes until [EMS] arrived . a mechanical chest compression device was set up and took over the CPR and [PO1] assisted medical professionals with bagging air. During lifesaving efforts, a staff member came into the room and said [R1] had a do not resuscitate, filed with the [hospital] but not with the [facility]. The [facility] paperwork showed [R1] as a full code/CPR. [R1] never signed paperwork with [facility] for the DNR. [EMS staff] contacted a doctor at [hospital] and confirmed the on file DNR. All lifesaving efforts were ceased [by EMS] Review of the facility's policy titled, Cardiopulmonary Resuscitation [CPR] and Basic Life Support [BLS], revised [DATE], indicated: The facility's procedure for administering CPR shall incorporate the steps covered in the American Heart Association 2020 Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care or facility BLS training material. They include the following areas: 1. Check victim for responsiveness, breathing and pulse. 2. Shout for nearby help. 3. Activate emergency response system via mobile device (if appropriate) or designate staff member to call 911, then call resident's Attending Physician and the resident's family. 4. Call a code as designated by facility protocol. 5. Send someone to get AED and emergency equipment. 6. Check victim for pulse and respirations: No breathing, pulse not felt within 10 seconds, Start CPR . Use AED as soon as it is available.

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and policy reviews, the facility failed to enter orders and/or document routine flushes, dressing changes, and monitoring for complications of a peripherally inserted central catheter (PICC) single lumen line (a thin, flexible tube that delivers treatments through a vein) for one of one resident (Resident (R)1) reviewed for intravenous (IV) medication out of a total of 12 residents. This failure had the potential to increase the risk of line occlusion, infections, and unnoticed complications. Findings include:Review of R1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/02/25, located under the MDS tab in the electronic medical record (EMR) revealed R1 was admitted to the facility on [DATE] with diagnoses of gram-positive bacteremia (bacteria in the bloodstream). R1 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated moderately impaired cognition. The MDS reflected that R1 had an IV access placed and IV antibiotics administered within the last 14 days while R1 was a resident at the facility.Review of R1's undated hospital Discharge Summary located in the EMR under the Misc tab, revealed R1 discharged from an acute care hospital. The discharge summary revealed R1 received IV antibiotics during the hospital course (06/11/25 - 06/29/25) via a PICC line that was placed on 06/26/25.Record review of R1's undated Clinical Physician Orders located in the EMR under the Orders tab, did not reflect PICC line care orders for monitoring the site for infection, dislodgement, flushing to maintain patency, or dressing changes. There was an order dated 07/04/25 to send R1 to the emergency room (ER) for a PICC line occlusion.Review of R1's June 2025 and July 2025 Medication Administration Records (MARs) and Treatment Administration Records (TARs) located in the EMR under the Orders tab revealed no orders nor documentation that her PICC line was flushed or PICC dressing was changed. Review of the Progress Notes tab of the EMR revealed that no PICC line flushes or dressing changes were documented.Review of R1's July 2025 Medication Admin Audit Report provided on paper by the facility reflected vancomycin intravenous solution 750 milligrams (mg)/150 milliliter (ml) was administered by Registered Nurse (RN)2 on 07/02/25 at 4:24 PM and on 07/03/25 at 4:57 PM via the PICC line to the right upper arm.During a phone interview on 10/20/25 at 2:45 PM, RN2 said that the previous Director of Nursing (DON) approached her on 07/02/25 and asked if she could administer the IV antibiotic to R1 because the antibiotic had not been administered for a few days and the assigned nurse was not comfortable with accessing the PICC line. RN2 said that she did not recall if there were orders in place for PICC line care, but she assessed the site and flushed per best practice. Cross Reference: F760D Significant Medication Error. During an interview on 10/22/25 at 10:52 AM, nurse practitioner (NP)1 stated that R1 was sent out on 07/04/25 to the ER for a PICC line occlusion. NP1 said that the ER was unable to unclog the PICC line and replaced it with a midline catheter for IV administration.During an interview on 10/21/25 at 4:18 PM, Assistant Director of Nursing (ADON)1 indicated that there should be orders on R1's MAR/TAR to flush before and after medicine/antibiotic was administered via a PICC line. ADON1 said that there were batch orders to select when entering orders for a resident with a central line that instructed nurses to flush with normal saline before and after medication administration, to monitor the site for redness, dislodgement, signs, and symptoms of infection, and to change the dressing every seven days. Record review of the facility's policy titled, Intravenous Administration of Fluids and Electrolytes, revised April 2009 indicated: The purpose of this procedure is to provide guidelines for the safe and aseptic administration of intravenous fluids. Inspect intravenous catheter and insertion site for signs and symptoms of complications at scheduled intervals [Per facility policy], during routine site care and when changing administration sets. Preparation 1. A physician's order is necessary to give intravenous fluids and electrolytes .

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and policy review, the facility failed to administer medications as scheduled for two of five residents (Resident (R)2 and R5) reviewed for pharmacy services out of a total sample of 11 residents. Failure to administer medications at the prescribed intervals between doses had the potential for increased side effects for residents who were administered the same medication several times a day.Findings include:1. Review of R2's undated admission Record located under the Profile tab in the electronic medical record (EMR) revealed R2 was admitted to the facility on [DATE] with diagnoses of generalized anxiety disorder, adjustment disorder with mixed anxiety and depressed mood, other frontotemporal neurocognitive disorder, and unspecified urinary incontinence.Review of R2's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/23/25, located under the MDS tab in the EMR revealed R2 had a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated R2 was severely cognitively impaired.Record review of R2's 10/20/25 - 10/21/25 Medication Admin Audit Report provided on paper, reflected an order for clonazepam oral tablet 0.5 [milligrams] mg [used to reduce anxiety]. Give 0.125 mg by mouth four times a day related to generalized anxiety disorder. The medication was scheduled every day at 6:00 AM, 11:00 AM, 3:00 PM, and 7:00 PM. The Medication Admin Audit Report reflected clonazepam 0.125 mg was administered by mouth as follows:10/20/25 6:00 AM dose was administered at 10:38 AM, four hours and 38 minutes after the scheduled time10/20/25 11:00 AM dose was administered at 11:36 AM, 58 minutes after the previous dose10/21/25 6:00 AM dose was administered at 8:34 AM, two hours and 34 minutes after the scheduled timeRecord review of R2's 10/20/25 - 10/21/25 Medication Admin Audit Report provided on paper, reflected an order for baclofen 10 mg by mouth in the morning [scheduled at 6:30 AM] related to cramp and spasm, baclofen 10 mg by mouth in the afternoon [scheduled at 12:00 PM] for tremors, and baclofen 10 mg by mouth at bedtime [scheduled at 7:00 PM] for tremors. The Medication Admin Audit Report reflected that baclofen 10 mg was administered by mouth as follows:10/20/25 6:30 AM dose was administered at 10:42 AM, four hours and 12 minutes after the scheduled time10/20/25 12:00 PM dose was administered at 11:36 AM, 54 minutes after the previous dose10/21/25 6:30 AM dose was administered at 8:34 AM, two hours and four minutes after the scheduled timeDuring an observation on 10/21/25 at 11:02 AM, Certified Medication Aide (CMA)1 administered medications to R2 to include:clonazepam 0.125 mg (11:00 AM) dosebaclofen 10 mg (12:00 PM) doseBoth medications were administered two hours and 28 minutes after the previous doses were documented as administered.2. Review of R5's undated admission Record located under the Profile tab in the EMR revealed R5 was admitted to the facility on [DATE] with diagnoses of unspecified mood (affective) disorder (a severe disturbance in mood [depression, anxiety, elation, and excitement]) and major depressive disorder, recurrent, moderate.Review of R5's admission MDS with an ARD of 09/23/25, located under the MDS tab in the EMR revealed R5 had a BIMS score of 15 out of 15, which indicated R5 was cognitively intact.Record review of R5's 10/01/25 - 10/22/25 Medication Admin Audit Report provided on paper, reflected an order for buspirone 5 mg tablet [used to treat anxiety disorders]. Give 1 tablet by mouth three times a day related to major depressive disorder, recurrent, moderate and gabapentin oral tablet 600 mg. Give 1 tablet by mouth three times a day for pain. The medications were scheduled every day at 6:00 AM, 11:00 AM, and 6:00 PM. The Medication Admin Audit Report reflected both the buspirone 5 mg tablet and gabapentin 600 mg tablet were administered as follows:10/01/25 6:00 AM doses were administered at 8:50 AM, two hours and 50 minutes after the scheduled time10/01/25 11:00 AM doses were administered at 10:29 AM, one hour and 39 minutes after the previous doses10/02/25 6:00 AM doses were administered at 8:03 AM, two hours and three minutes after the scheduled time10/02/25 11:00 AM doses were administered at 10:51 AM, two hours and 28 minutes after the previous doses10/03/25 6:00 AM doses were administered at 8:15 AM, two hours and 15 minutes after the scheduled time10/03/25 11:00 AM doses were administered at 11:01 AM, two hours and 46 minutes after the previous doses10/21/25 6:00 AM doses were administered at 8:37 AM, two hours and 37 minutes after the scheduled time10/21/25 11:00 AM doses were administered at 11:23 AM, two hours and 46 minutes after the previous doses10/22/25 6:00 AM doses were administered at 8:39 AM, two hours and 39 minutes after the scheduled time10/22/25 11:00 AM doses were administered at 10:55 AM, two hours and 16 minutes after the previous dosesDuring an observation on 10/21/25 at 11:20 AM, CMA1 administered medications to R5 to include:Buspirone 5 mg (11:00 AM) doseGabapentin 600 mg (11:00 AM) doseBoth

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and policy reviews, the facility failed to ensure Vancomycin (antibiotic used to treat serious bacterial infections) was administered as ordered resulting in two missed doses for one of five residents (Resident (R)1) reviewed for significant medication errors out of a total sample of 11 residents. This failure had the potential to increase the risk of serious complications from untreated sepsis such as organ damage and/or death, especially in critically ill patients.Findings include:Review of R1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/02/25 located under the MDS tab in the electronic medical record (EMR) revealed R1 was admitted to the facility on [DATE] with a diagnosis of gram-positive bacteremia (bacteria in the bloodstream). R1 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated moderately impaired cognition. The MDS reflected that R1 had an intravenous (IV) access placed and IV antibiotics administered within the last 14 days while R1 was a resident at the facility.Review of R1's undated hospital Discharge Summary located in the EMR under the Misc tab, revealed R1 discharged from an acute care hospital. The discharge summary revealed R1 received IV antibiotics during the hospital course (06/11/25 - 06/29/25). The discharge orders reflected vancomycin 750 milligrams (mg) IV daily over 30 minutes until July 15. The discharge orders did not include the last date and time that Vancomycin was administered in the hospital prior to R1's discharge to the facility.Record review of R1's undated Clinical Physician Orders located in the EMR under the Orders tab, reflected an order entered on 06/29/25 for Vancomycin intravenous solution 750 mg/150 milliliter [ML]. Give 750 mg intravenously one time a day [Start date: 06/30/25 at 5:00 PM] related to bacteremia was digitally transmitted to the pharmacy. Review of R1's Progress Notes located in the EMR under the Prog Note tab included electronic Medication Administration Record (eMAR) progress notes entered on 06/30/25 and 07/01/25 that indicated the Vancomycin was not available in the facility for administration to R1. Additional documentation, dated 06/30/25, reflected communication with the pharmacy and the orders were refaxed on 06/30/25 and the pharmacy indicated that the medication would be delivered that night.Review of R1's June and July Medication Administration Record (MAR) located in the EMR under the Orders tab revealed vancomycin was not administered on 06/30/25 or 07/01/25. The first dose of vancomycin was administered on 07/02/25. Review of R1's July Medication Admin Audit Report provided on paper by the facility reflected vancomycin intravenous solution 750 mg/150 ML was administered by Registered Nurse (RN)2 at 07/02/25 at 4:24 PM and on 07/03/25 at 4:57 PM via the PICC line to the right upper arm.During a phone interview on 10/20/25 at 2:45 PM, RN2 verified that she administered the medication on 07/02/25 and again on 07/03/25.During an interview on 10/22/25 at 10:52 AM, nurse practitioner (NP)1 stated he was unaware of the missed doses of vancomycin. NP1 said that he entered an order on 07/01/25 for the pharmacy to schedule a vancomycin trough for dose monitoring. The NP said that he expected to be informed about a late/missed dose so that he could make changes as needed. The NP said that if he had been aware, he would have inquired as to why the delay, written a prescription for a local pharmacy if the facility pharmacy did not have the medication available or could not deliver it, and he would have added more days onto the length of treatment.Record review of the facility's policy titled, Administering Medications, revised December 2009 indicated: Medications shall be administered in a safe and timely manner, and as prescribed. 3. Medications must be administered in accordance with the orders, including any required time frame. 9. Medications may not be prepared in advance and must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and policy review, the facility failed to identify and investigate an adverse event and develop a corrective plan to include staff education after one of one residents (Resident (R) 1) reviewed for an adverse event of an unwitnessed fall was found with a potential injury of unknown origin with her chin and neck against the bed frame and her lower body on the floor, unresponsive, and required Cardiopulmonary Resuscitation (CPR) per her code status out of a total sample of 11 residents. This failure had the potential to affect the health and well-being of residents susceptible to accidents, incidents, and injuries from unknown origins.Findings include:Review of R1's admission Record located under the Profile tab in the electronic medical record (EMR) revealed R1 was admitted to the facility on [DATE]. R1 was discharged from the facility on [DATE] to a funeral home. Review of R1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] and located under the MDS tab in the EMR, revealed a Brief Interview for Mental Status (BIMS) summary score of 10 out of 15 which indicated R1's cognition was moderately impaired. R1 had diagnoses of Parkinson's disease, seizure disorder or epilepsy, and difficulty in walking. During an interview on [DATE] at 2:09 PM, Certified Nursing Assistant (CNA)1 said that she was assigned to R1's hall on [DATE], 6:00 AM - 6:00 PM shift. CNA1 said she conducted rounds on R1's hall, around 4:00 PM, could not see R1 in bed from the hallway and stepped into the room. CNA1 said that she discovered R1 in a face-down back bending position (up-and-down direction), perpendicular to the bed, like the letter 'T'. R1's chin and neck was pressed against the metal bedframe on the side of the bed, with an excessive backwards bending of the head, neck, and shoulders towards the upper midline region of the back. R1's upper body was lifted off the floor, and her legs rested on the floor. During a phone interview on [DATE] at 5:19 PM, Licensed Practical Nurse (LPN)1 said that she worked on [DATE], 6:00 AM - 6:00 PM but was not assigned to R1. LPN1 said that she was asked by CNA1 to assess R1. LPN1 said she saw R1 in a face down position with her head and neck against the bed when she entered the room. LPN1 said that R1 was unresponsive, was not breathing, and she could not feel a pulse. Review of facility's Incident Reports log for the months of June and [DATE], provided on paper, revealed there were no incident reports created for R1. The facility did not provide evidence of a Quality Assurance and Performance Improvement (QAPI) review that reflected the Quality Assessment and Assurance (QAA) committee identified, investigated, developed, and monitored the unwitnessed fall resulting in a potential unknown injury leading to unresponsiveness and death. During an interview on [DATE] at 8:30 AM, the Regional Support Administrator said that incident reports were completed for falls, skin tears, or resident-to-resident altercations, that R1 did not fall, therefore an incident report was not required. The Regional Support Administrator agreed that a death in the facility from an injury of unknown origin was an adverse event (an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof) and should be reviewed by the QAA Committee. The Regional Support Administrator said that the QAA Committee did not identify R1's death as an adverse event, did not initiate an incident report, did not review the incident, and did not complete a facility internal investigation. Review of the facility's policy titled, Quality Assessment and Assurance Committee, revised [DATE], indicated: This facility shall establish and maintain a Quality Assessment and Assurance Committee that oversees the identification and handling of quality issues. The primary goals of the Quality Assessment and Assurance Committee are: 1. To monitor and evaluate the appropriateness and quality of care provided within the framework of the Quality Assessment and Assurance Plan; 2. To oversee facility systems and processes related to improving quality of care and services . 3. To promote consistent facility systems and processes and appropriate practices in resident care . 4. To help identify negative outcomes relative to resident care and resolve them appropriately. The Quality Assessment and Assurance Committee advises the Administrator and owner and/or governing board [body]. The committee has the full authority to oversee the implementation of the Quality Assessment and Assurance Program, including, but not limited to identifying negative and positive outcomes of care and services. Review of the facility's policy titled, Quality Assessment and Assurance Plan, revised [DATE], indicated: The primary purposes of the Quality Assessment and Assurance Plan are: 1. To provide a means to identify and resolve present and potential negative outcomes related to resident care and safety . 3. To provide a structure and process to correct identified quality deficiencies . 4. To establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome