STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115700	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Bethany	466 South Gray Street Millen, GA 30442

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41165 Based on record review, staff interviews, and review of the facility policy titled Abuse Prevention and Reporting, the facility failed to protect the resident's right to be free from neglect by staff for one of five sampled residents (R) (R1) during Activities of Daily Living (ADL) care. Specifically, the Certified Nursing Assistant (CNA) CC was providing ADL care to R1 unassisted when R1 rolled away from CNA CC, falling from the bed, landing face down on the floor with blood noted on the head with a large open area, 14 cenimeter (cm) head laceration, and the scalp was pulled away from the head, exposing the skull. R1 expired at the hospital 50 minutes post fall. On [DATE], it was determined that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Senior Nurse Consultant (SNC) was informed of the Immediate Jeopardy on [DATE] at 4:06 pm. The noncompliance related to the Immediate Jeopardy was determined to have existed on [DATE]. Findings include: Review of the facility's policy titled Freedom from Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property Mission Statement, effective date [DATE], revised date [DATE], defined Abuse as Any intentional or grossly negligent act or series of acts or intentional grossly negligent omission to act which causes injury to a resident, including but not limited to, assault or battery, failure to provide treatment or care, or sexual harassment of the resident. The policy defined Neglect as The failure to provide goods and services necessary to avoid harm, mental anguish, or mental illness. The policy statement indicated the center will not tolerate abuse, neglect, or exploitation of its residents by anyone. Record review of the Electronic Medical Record (EMR) for R1 revealed diagnoses included infection and inflammatory reaction due to internal right knee prosthesis, sequela, peripheral vascular disease, and presence of left artificial knee joint. (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

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the most recent quarterly Minimum Data Set (MDS) for R1 dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03, indicating severe cognitive impairment. Section GG (Functional Abilities and Goals) documented that R1 was dependent on staff for self-care and mobility requires two persons assistance for ADL care. The helper does all of the effort. The resident does none of the effort to complete the activity. A review of the Resident Progress Note for R1 dated [DATE] at 3:59 pm revealed at approximately 10:50 am, nursing was alerted to the room by CNA (CNA CC). The resident was face down on the floor on the right side of the bed. The CNA stated she was giving care to the patient (changing brief), and when she rolled over, the CNA was unable to catch her, and she rolled off the bed onto the floor. Blood was noted on the head. She had a large open contusion to the head, and the scalp was open to expose the skull. Emergency Medical Services (EMS) was called, and dressings were applied. Wound to top of head covered with ABD pad (Army Battle Dressing [a gauze pad used to absorb heavy drainage]) and roll gauze. Hospice notified. The resident's family was notified. A report was given to the local hospital. EMS left with R1 at 11:15 am. Interview on [DATE] at 10:08 am with Licensed Practical Nurse (LPN) BB revealed she worked on Sunday, [DATE], and R1 was on her hall. She stated around 10:00 am, she was finished with her medication pass, and she stuck her head in R1's room. She stated both R1 and her roommate were in the room with their eyes closed. LPN BB stated CNA CC alerted her around 10:50 am to 11:00 am that the resident was on the floor. LPN BB stated that CNA CC and Registered Nurse (RN) AA/Weekend Supervisor were in R1's room. LPN BB further revealed when she entered the room, R1 was on the floor to the right of the bed, face down, with a lot of blood around the resident's head. LPN BB stated RN EE came from the other hall and they assessed R1 to see where the blood was coming from. She stated they saw that the blood was coming from her head, and she told CNA CC to call 911. LPN BB stated that 911 was asking questions over the phone that CNA CC could not answer, and RN AA went to talk to 911. LPN BB stated she and RN EE turned R1 onto her back, put a sheet under her, and held her head straight. LPN BB further stated RN AA assessed the wound and applied ABD pads, placing a pressure dressing on R1's head. LPN BB confirmed that the scalp was pulled up at the top of her head, exposing the bone, and the scalp was detached from that area of the head. LPN BB further revealed that R1 was moaning and was unresponsive. LPN BB confirmed that CNA CC had always changed R1 without any assistance. LPN BB stated that when she changed R1 alone, the resident would roll over and hold on to the side of the mattress. However, this did depend on the day and if you were liked by R1. She stated she did not know when R1 was last assessed for side rails. LPN BB revealed that she called the doctor, hospice nurse, and the family and called the hospital to give a report. She stated the resident left the facility via EMS around 11:20 am. LPN BB confirmed that the doctor called her between 12:00 pm and 12:30 pm, stating that R1 had expired at the hospital. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 10:25 am with RN EE revealed that on [DATE], when walking to the nurse's station, CNA CC told him they needed assistance in R1's room. RN EE stated when he entered the room, the resident was lying diagonally on the right side of the bed on the floor. He stated LPN BB and RN AA were in the room. RN EE further revealed that he lifted R1's right leg and was sure that the leg was broken because there was no alignment. He further stated he picked up the leg and felt what he thought was bone. RN EE confirmed that he told CNA CC to call 911. He stated he assessed the scalp wound and stated it was very bad. RN EE described the head wound as a horseshoe shape attached to the front of the head but detached from the sides and the back of the head. RN EE stated he went to get some ABD pads. RN EE stated that CNA CC could not answer the question from 911, so RN AA went to talk with 911. He stated he asked for a sheet to put under R1 because she was lying face down. RN EE revealed when EMS came, they lifted the sheet and put her on the gurney, and at that time, he saw her eyes roll backward in her head. RN EE further revealed he is not sure if R1 died en route to or at the hospital. He further described R1's bed as being up high and stated it was at least a three-foot drop. RN EE stated CNA CC had the bed up high because she was a tall lady. He further stated he had not worked with R1 and was unaware of her baseline status. A follow-up interview on [DATE] at 10:57 am with RN EE revealed at the time of the incident, staff got a sheet, rolled R1 on it, and put her in the bed because he could not get an accurate assessment to see if she was breathing. RN EE revealed that R1 was a large woman, and he could not see a visual rise in her chest. RN EE further revealed that he could not make out the left side of her face because of how she was positioned on the floor, and he did not know if there were more lacerations, so they put her back in bed. Interview on [DATE] at 2:15 pm with RN AA/Weekend Supervisor revealed at the time of the incident, CNA CC was yelling out for help. RN AA stated that R1 was in her room lying on the floor face down on the right side of the bed, but she did not realize that R1 was that hurt. RN AA further revealed that she went to her head and noticed her breathing was agonal (gasping for air), not what it should be, and was very limited breathing. RN AA stated at that time, she realized R1 was bleeding, and she raised R1's head to facilitate breathing. She stated she noticed blood was matted in her hair, but it wasn't dry at that time. RN AA stated she yelled for somebody to call 911 and left R1's side to speak with 911 while other nursing staff assisted R1. RN AA stated nursing staff put a pressure dressing on the resident before EMS arrived at the facility. She stated she noticed the resident was not responding as they put the dressing on her head, and after applying the dressing, R1 had a blank stare and a bluish color around her mouth. RN AA stated that she did not work directly at the bedside with R1, but she did not feel the resident could hold on to anything because she did not think the resident had the gripping capability. RN AA confirmed that R1 required maximum assistance, and one person provided care to her all the time. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview on [DATE] at 8:43 am with CNA CC revealed on [DATE] at around 10:53 am she went in to change R1 and raised the bed to her waist because she was tall. CNA CC stated she asked R1 to turn over, and R1 turned over so fast that her feeding pump rolled on top of the bed. She stated when she ran around to the other side of the bed, she saw R1 on the floor. CNA CC further revealed she and the feeding pump were both on the left side of the bed, and the feeding pump with the pole fell on to the bed, still connected to R1. CNA CC stated the RN AA/Weekend Supervisor went to the front desk and called 911, and EMS arrived quickly. CNA AA stated that for the past two years, she cared for R1. She further stated that sometimes R1 needed assistance with ADLs, but sometimes CNA CC could complete her ADLs without assistance. CNA CC confirmed that she did not need help with R1 that day ([DATE]) because they (CNA CC and R1) were conversing, and she went off of that conversation to provide ADLs. CNA CC stated she thought she could do R1's ADL care alone. CNA CC further revealed that R1 rolled over for her, and if she had thought that R1 could not roll over that day, she would have asked for help from her nurse. A telephone interview on [DATE] at 9:50 am with CNA DD revealed she had worked with hospice since 2019 and came to the facility twice a week to provide care to R1. CNA DD stated she bathed, washed her hair, and changed bed linens for R1. CNA DD further revealed that R1 required two person assistance. She stated at one time she had a rail on her bed to assist with turning. CNA DD stated the hospice social worker helped her with R1 during ADL care by holding her over while she changed R1. She stated that R1's bed did not have bed rails, which helped out a lot, and it was unsafe to roll R1 because her bed was not against the wall. CNA DD revealed that R1 would roll towards her to change her, but R1 could not help with care. CNA DD confirmed that R1 could not roll over by herself. An interview on [DATE] at 3:00 pm with Administrator HH revealed CNA CC was suspended pending the outcome of the investigation to determine what happened with the R1 incident. The Administrator stated that R1 was able to assist with turning and repositioning. The Administrator further revealed that some people could provide ADL care for R1 alone. The Administrator further revealed that they initiated a self-imposed Immediate Jeopardy and immediately began education with the staff.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41165 Based on record review, staff interviews, and review of the facility policy titled Care Plans, the facility failed to develop an accurate person-centered comprehensive care plan for one of five sampled residents (R) (R1) that specified the need for two-person assistance with Activities of Daily Living (ADL) care. On 7/9/2024, it was determined that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Senior Nurse Consultant (SNC) was informed of the Immediate Jeopardy on 7/9/2024 at 4:06 pm. The noncompliance related to the Immediate Jeopardy was determined to have existed on 6/30/2024. Findings include: A review of the facility policy titled Care Plans, revised 7/27/2023, revealed it is the policy of the health care center for each patient/resident to have a person-centered baseline care plan followed by a comprehensive care plan developed following completion of the Minimum Data Set (MDS) and Care Area Assessment (CAA) portions of the comprehensive assessment according to the Resident Assessment Instrument (RAI) Manual and the patient/resident choice. Admission Comprehensive Care Plan: Number 3. The comprehensive care plan should describe the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Number 4. The care plan will contain 4 main components: Problem, Goal, Approaches, and Role or Accountability. The care plan approach serves as instructions for the patient/resident's care and provides continuity of care by all partners. When approaches that involve the CNA have been added to the care plan, those approaches should also be included on the CNA Care Record or Resident Profile/Care Plan. Record review of the most recent quarterly Minimum Data Set (MDS) for R1, dated 5/26/2024, revealed section GG (Functional Abilities and Goals) documented for roll left and right and toileting hygiene; the resident is dependent, the helper does all of the effort. The resident does none of the effort to complete the activity. Or, the assistance of two or more helpers is required for the resident to complete the activity. A review of the care plan for R1 revised 7/1/2024, revealed that R1 requires staff assistance for ADLs due to physical deficits and the disease process of multiple diagnoses. Requires maximum to total assistance with ADL care, including but not limited to bed mobility, transfers, locomotion, and toileting. Approaches to one - two persons assistance for ADL care. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Resident Progress Note for R1 dated 6/30/2024 at 3:59 pm revealed at approximately 10:50 am, nursing was alerted to the room by CNA CC. The resident was face down on the floor on the right side of the bed. The CNA stated she was giving care to the patient (changing brief), and when she rolled R1 over, the CNA was unable to catch her, and she rolled off the bed onto the floor. Blood was noted on the head. She had a large open contusion to the head and scalp open exposed the skull. Emergency Medical Services (EMS) was called, and dressings were applied. Wound to top of head covered with ABD pad (abdominal gauze pad used to absorb heavy drainage) and roll gauze. Hospice notified. The resident's family was notified. A report was given to the local hospital. EMS left with R1 at 11:15 am. Interview on 7/3/2024 at 10:08 am with Licensed Practical Nurse (LPN) BB revealed R1 could roll over and hold on to the mattress, but it depended on what day it was and if she liked you. She stated she had changed R1 by herself, and CNA CC has always changed her by herself. She stated that the resident could wash her hands and drink a soda. She stated that R1 held on to the side of the mattress when she changed her by herself. A telephone interview on 7/9/2024 at 8:43 am with CNA CC revealed she had cared for R1 for two years. She stated some days she needed help with ADL care for R1, but some days she didn't need help. She stated that she did not need help with her the day of the fall because they were conversing, and she went off of the conversation. CNA CC stated she thought she could do R1's ADLs by herself. She further stated that R1 rolled over for her, and if she thought that R1 could not roll over that day, she would have also gotten her nurse to help. A telephone interview on 7/9/2024 at 9:50 am with Hospice CNA DD revealed she came to the facility twice a week. She stated that R1 was a two-person assist. CNA DD further revealed that sometimes the hospice nurse or the social worker is in the facility, and they would help her with R1. She stated a few of the aides at the facility would assist her with care, but R1 could not roll over by herself. She stated that R1's bed was not to the wall, and it was unsafe to roll her because it was not up against the wall. An interview on 7/3/2024 at 12:16 pm with LPN FF/Case Mix Director revealed that R1 was dependent on staff for ADLs. She stated that it depended on how R1 felt each day to determine if she needed one or two staff assistance. LPN FF further revealed that some staff can do ADLS for R1 alone. LPN FF confirmed that the MDS section GG stated that R1 was dependent on staff for ADLS, but it did not specify if she required one or two-person assistance. She stated that she puts in the care plans for CNAs to observe to see if residents need increased assistance and to notify the nurse for increased assistance. LPN FF stated that she put on the care plan that R1 required one to two people to assist with ADLs.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41165 Based on staff interviews and record review, the facility failed to provide adequate assistance for bed mobility for one of five residents (R) (R1) reviewed for falls. Specifically, R1 fell from the bed during Activities of Daily Living (ADL) care on [DATE], resulting in death within 50 minutes post-fall. On [DATE], it was determined that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Senior Nurse Consultant (SNC) was informed of the Immediate Jeopardy on [DATE] at 4:06 pm. The noncompliance related to the Immediate Jeopardy was determined to have existed on [DATE]. Findings include: A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed section GG (Functional Abilities and Goals) documented that R1 was dependent on staff for self-care and mobility. The helper does all of the effort. The resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity. A review of a document titled Fall Form dated [DATE] at 8:33 pm, completed by Licensed Practical Nurse (LPN) BB, indicated R1 was in bed receiving ADL care. Fall with a head injury from witnessed fall. A review of the emergency room Summary Report dated [DATE] at 11:27 am revealed R1 arrived with a large, approximately 14 centimeter (cm) laceration to the top of her head, exposing bone, no spontaneous respirations, pulseless, after a fall from her bed. R1 had a witnessed fall out of bed and must have hit her head on the side table. Additionally, R1 had a loss of scalp integrity, bruises noted to arms, 6cm x 2.5 cm left knee skin tear, 1 cm diameter skin tear to right hand, and 3.5 cm x 2.5 right shoulder skin tear. R1 expired at the hospital on [DATE] at 11:40 am. A review of a document titled SBAR (situation, background, appearance, review) dated [DATE] revealed the [Situation] The change in condition, symptoms, or signs observed and evaluated is/are R1 rolled out of bed, head injury. [Background] Unresponsiveness, Contusion, Skin tear, Wound, S/t (secondary to) to L (left) knee and RUA (right upper arm). Contusion/wound to top of head, moaning and flinching, altered level of consciousness (hyperalert), drowsy but easily aroused, difficult to arouse, unarousable. R1 was a Do Not Resuscitate. [Appearance] Resident rolled from bed causing head injury. Nurses Note revealed Nursing was alerted to room by Certified Nursing Assist (CNA). R1 was face down on the floor at right side of bed. CNA stated she was giving care to patient (changing brief) and when she rolled over the CNA was unable to catch her and she rolled off the bed onto the floor. Blood was noted to head. She had a large open contusion to the head and scalp open to expose skull. Emergency Medical Services (EMS) was called, and dressings applied. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 10:08 am with LPN BB revealed CNA CC alerted her between 10:50 am to 11:00 am that the R1 was on the floor. LPN BB stated when she entered the room, R1 was on the floor to the right of the bed face down with a lot of blood around the head. LPN BB further revealed Registered Nurse (RN) EE came from the other hall, and they assessed R1 and saw blood coming from her head. She stated that the scalp was pulled up at the top of her head, you could see the bone, and the scalp was detached in that area of the head. Interview on [DATE] at 10:25 am with RN EE revealed that when walking to the nurse's station, CNA CC told him they needed assistance in R1's room. RN EE stated when he entered the room, the resident was lying diagonally on the left side of the bed on the floor. RN EE further revealed that he lifted R1's right leg, thought he felt bone, felt no alignment, and was sure the leg was broken. He stated the scalp wound was horseshoe-shaped attached to the front but detached from the and the back of the head. RN EE stated that R1's bed was raised up high and at least a three-foot drop. RN EE stated CNA CC had the bed up high because she was tall. A telephone interview on [DATE] at 8:43 am with CNA CC revealed at around 10:53 am on [DATE], she went to change R1 and raised the bed to her waist because she was tall. CNA CC stated she asked R1 to turn over, and R1 turned over so fast that her feeding pump rolled on top of the bed. She stated when she ran around to the other side of the bed, she saw the resident on the floor. CNA CC further revealed that she and the feeding pump were both on the left side of the bed, and the feeding pump with the pole fell on the bed, still connected to R1. CNA AA stated she had cared for R1for two years. She further stated at times, she needed assistance with providing R1's ADL care, but at other times, CNA CC could provide R1's ADL care without assistance. CNA CC confirmed that she did not need help with R1 that day ([DATE]) because they (CNA CC and R1) were conversing, and she went off of that conversation to provide ADLs. CNA CC stated she thought she could provide R1's ADL care alone. CNA CC further revealed that R1 rolled over for her, and if she thought that R1 could not roll over that day, she would have asked for help from her nurse.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 41165 Based on record review, staff interviews, and review of the facility's Administrator and Director of Health Services (DHS) job descriptions, the facility Administration failed to ensure one of five sampled residents (R) (R1) was free from neglect during Activities of Daily Living (ADL) care. This failure resulted in R1 falling from the bed and expiring at the hospital 50 minutes post-fall. On 7/9/2024, it was determined that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Senior Nurse Consultant (SNC) was informed of the Immediate Jeopardy IJ on 7/9/2024 at 4:06 pm. The noncompliance related to the Immediate Jeopardy was determined to have existed on 6/30/2024. Findings include: Review of the facility-provided document titled Position Description-Administrator dated 12/27/2016, revealed the job purpose is to direct the day-to-day functions of the nursing center in accordance with federal, state, and local regulations that govern long-term care centers, and as may be directed by the Area [NAME] President, to provide appropriate care for our patients/residents. Review of the facility-provided document titled Position Description-Director of Health Services dated 12/27/2016, revealed the job purpose is plans, organizes, develops, and directs the overall operation of our 'Nursing Services Department' in accordance with current federal, state, and local regulations governing our nursing center, and as may be directed by the Administrator and the Medical Director, to provide appropriate care. Facility Administration, specifically the Administrator and the DHS, failed to protect residents and effectively oversee areas of the facility that were included in their job descriptions. 1. The facility failed to ensure R1 was free from neglect by facility staff during the provision of ADL care. Cross refer F600 2. The facility failed to develop a comprehensive person-centered care plan that specified the need for two-person assistance with ADL care. Cross refer F656 3. The facility failed to protect R1 from a fall during ADL care, resulting in her death at the hospital. Cross refer F689 (continued on next page)

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on 7/2/2024 at 3:00 pm with Administrator HH revealed she was not at the facility at the time of the incident but was informed of the incident by the weekend supervisor, Registered Nurse (RN) AA. Administrator HH further revealed Certified Nursing Assistant (CNA) CC was sent home and suspended pending the outcome of the investigation to determine what happened with R1. Administrator HH stated that some staff could do R1's ADL care by themselves. She stated that the facility had initiated a self-imposed Immediate Jeopardy and immediately began educating the staff. An interview on 7/2/2024 at 4:09 pm with the DHS revealed the weekend supervisor RN AA met with CNA CC and obtained a statement. She stated CNA CC was sent home on Sunday, 6/30/2024. She further stated CNA CC was off Monday but was called in and spoke with Administrator HH and the DHS. She stated CNA CC was suspended pending the investigation. The DHS stated that R1 could assist with turning, and she held on to the mattress while turning.