STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235041	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mackinac Straits Long Term Care Unit	1140 North State Street Saint Ignace, MI 49781

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on observation, interview, and record review, the facility failed to ensure that the Minimal Data Set (MDS) assessment was accurate for two residents (Resident #6 and Resident #22) of 12 sampled residents reviewed for comprehensive assessments. Findings include: Resident #6 (R6) Review of the facility's resident matrix revealed R6 had a facility acquired stage III pressure ulcer. On 6/24/24 at 11:15 AM, an interview was conducted with the Director of Nursing (DON) and asked if R6 had any pressure ulcers or wounds and replied, R6 has a right ankle stage III pressure injury that he was admitted with. The DON was asked if he required any type of dressing changes and replied, No. He is observation only and open to air. Review of R6's medical record revealed he was admitted to the facility on [DATE] with diagnoses including multiple sclerosis, chronic obstructive pulmonary disease (COPD), and pressure ulcer of right ankle (stage 3). Review of R6's admission and body assessment, date 4/19/24, revealed under the skin section a stage II right lower extremity pressure ulcer. Review of R6's MDS assessment, dated 7/26/23 revealed he scored a 10/15 on the Brief Interview for Mental Status (BIMS) assessment indicating moderate cognitive impairment. This MDS also revealed he had one pressure ulcer stage III that was facility acquired and none that were present on admission. Review of R6's MDS assessment, dated 10/24/23 revealed he had one pressure ulcer stage III that was facility acquired and none that were present on admission. Review of R6's MDS assessment, dated 1/23/24 revealed he had one pressure ulcer stage III that was facility acquired and none that were present on admission. Review of R6's MDS assessment, dated 4/15/24 revealed he had one pressure ulcer stage III that was facility acquired and none that were present on admission. (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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R6's wound progress notes, dated between 4/19/22 through 6/26/24 revealed that the original pressure ulcer stage III on his right ankle had not healed and remained open. On 6/25/24 at 10:00 AM, an observation was made of R6 in his room sitting in his wheelchair and playing solitaire. R6 was asked about his right ankle pressure ulcer and replied, You can look at it if you want to. I have had that sore since 1987. I hit my ankle on a rock when I was walking down a sidewalk and ever since then it has not healed. R6's right ankle was observed to have a pressure ulcer to the right malleolus with an area the size of a nickel that lacked a dressing and was open to air. On 6/25/24 at 11:05 AM, an interview was conducted with the DON and asked if R6 had a facility acquired pressure ulcer stage III and replied, No. He was admitted to the facility with that pressure ulcer, and it has not healed yet. The DON was asked why R6's MDS was coded to reflect a facility acquired pressure ulcer stage III and replied, The MDS is coded incorrectly. R6's MDS assessment should be coded as being present on admission. Resident #22 (R22) On 6/26/24 at 11:00 AM, an observation was made of R22 sitting in his wheelchair in the North Hall. R22 had a urinary catheter bag hanging from the bottom of his wheelchair. Review of R22's medical record revealed he was admitted to the facility on [DATE] with diagnoses including Lewy bodies, neuromuscular dysfunction of bladder, and retention of urine. Review of R22's physician order, dated 4/18/24 revealed an order that read, insert a 16F (French) Coude (rigid tip for narrow difficult catheter insertions) catheter for urinary retention. Review of R22's progress note, dated 5/23/24 read in part, .Foley patent to DD (dependent drainage) urine concentrated with sediment. Review of R22's quarterly MDS, dated ,d+[DATE] revealed under section H, bowel and bladder no indication of having an indwelling catheter. Review of R22's progress note, dated 5/26/24 read in part, .Urinary catheter has not being (sic) leaking since supervisor made adjustments. Review of R22's care plan, dated 4/24/24 read in part, .Problem: I require an indwelling catheter for obstructive uropathy . On 6/25/24 at 11:05 AM, an interview was conducted with the DON and was asked if R22's MDS was coded correctly to reflect he had an indwelling urinary catheter and replied, I would have to check. The DON reviewed R22's quarterly MDS, dated [DATE] and stated, No. His MDS is not coded correctly. I will call the MDS nurse to have her correct the coding. The DON was asked if the MDS nurse was involved in morning meetings and how frequently these occurred and replied, Every morning during the week we have them Monday through Friday and the MDS nurse is on the calls as she works remotely. The DON was asked if there was any reason why the MDS for R6 and R22 were coded incorrectly and replied, No. I will call her and have her correct them.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49397 Based on observation, interview, and record review the facility failed to ensure timely interventions to prevent facility acquired pressure injuries for one resident (#16) and failed to ensure comprehensive wound documentation for two residents (#16 and #6), per professional standards of practice. This deficient practice resulted in harm when resident #16 developed two Stage 2 pressure injuries and the potential for worsening and delayed healing of Stage 3 pressure injury for resident #6. Resident #16 (R16) A review of the Electronic Medical Record (EMR) for R16 revealed admission to the facility on [DATE] with diagnoses of Alzheimer's disease (progressive memory disorder), Down Syndrome (intellectual and developmental delay condition), and seizures. R16's face sheet had a note which read, R16 is unable to answer questions appropriately. Hearing is adequate and does not require hearing aids. A review of the MDS (Minimum Data Set) Braden Scale for Prediction of a Pressure Sore Risk for R16 dated 10/17/23 was scored at a 13/18, indicating a moderate risk for a pressure sore. Factors included having very moist skin, being chair fast, and having very limited mobility. The MDS indicated R16 was totally dependent on helpers for all activities of daily living. On 11/10/23, the Weekly (head to toe) Skin Assessment indicated R16 had the following skin observations: neck area reddened and superficial open area on buttocks. In the section titled skin condition: reddened neck was indicated, but there was nothing about the open area on the buttocks, and the remainder of the assessment was not completed. On 12/15/23, the Weekly (head to toe) Skin Assessment indicated R16 read in part: skin to buttock with existing area, treatment in place. In the section titled skin condition: other- treatment in place to buttocks, with the remainder of the assessment incomplete. A progress note, from 12/31/24 indicated R16 had a 1.5cm (centimeters) x 0.2cm open area on her left buttock, near the coccyx area. Some bleeding noted when cleansed/assessed. (R16) also has existing areas of sheared (when forces moving in opposite directions are applied to tissues in the body) skin near the same area. There was not a part in R16's care plan which addressed shearing. Progress Notes reviewed revealed the following: 1/17/24: R16 had excoriated/skin sloughing to bilateral upper buttocks with a slit in the crevice of buttocks. 3/3/24: read in part, R16's wound measured R (right) buttocks: 2cm x 2cm of sheared skin, with a 0.5cm x 0. 5cm open area. L (left) buttocks: 2cm x 1.5cm of redness with a 1.5cm x 1cm open area. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	3/16/24: read in part, R16 had redness and excoriation observed to bilateral buttocks, blanchable. 3/23/24: read in part, R16 had redness and excoriation observed to bilateral buttocks, blanchable. 3/27/24: read in part, R16's Right buttock darker purplish area measuring 0.2cm x 4cm with intact skin. Left buttock had 4 areas of concern .The area at 3 o'clock on left buttocks measures 1cm x 0.5cm and is identified as skin shearing with the area superficial but center of area shiny red in appearance. The other 3 areas of concern are a darker purplish red in color on the left buttocks. The 12 o'clock area measures 0.7cm x 0.3cm. The two just below in on the left buttocks (6 o'clock) are very close to each other but not connected and each measure 0.6cm x0.3cm. 3/30/24: read in part, Area on left buttock open. Skin surface only. 3/31/24: read in part, right and left buttocks cheeks reddened with open areas noted calazime (skin protectant) applied. Areas do not seem to be improving, will suggest magic butt cream to speed up healing process to supervisor. 4/1/24: read in part, BL (bilateral) buttocks assessed and no yeast present. Magic Butt Cream is not appropriate at this time. 4/3/24: read in part, superficial opening/stage 2 PI (pressure injury) measuring 0.4.cm x 0.5cm the wound bed is red with crusted dry skin edges and bloody drainage. The left buttocks stage 2 PI measures 2.7cm x 1. 3cm and has bright red wound bed with dry crusted skin surrounding and bloody drainage. The areas are dried out and in need of moisture to aid healing. At this time wound order are changed back to Mepilex dressings. 4/9/24: read in part, Left buttocks stage 2 pressure injury measures 5cm x 5cm, right buttocks stage 2 pressure injury measures 1.7cm x 4cm. The pressure injuries are beefy red in appearance and raised. 4/10/24: read in part, wounds have improved significantly overnight with use of A&D ointment and calazime mixture. 4/16/24: read in part Right PI measures 6.7cm x4.5cm. Left PI measures 6cm x 4.3cm. Also recommend continuing to offload pressure to buttocks frequent repositioning . 4/21/24: a late entry progress note, read in part, Pressure injuries remain the same, superficial, no change in size or appearance of dull reddish-purple color, slowly blanchable Wound measurements to continue weekly on Tuesday. No measurements to substantiate the documentation of no change in size or appearance noted in progress note. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	4/23/24: a late entry progress note, read in part, Right pressure injuries measure 6.5cm x 5cm and has evidence of excoriation with superficial deep red purplish wound bed. The left pressure injury measures 7. 0cm x 5cm and is superficial deep red purplish wound bed .the pressure injuries are slow to blanch. Wound order is to cleanse entire buttocks with warm water and no foam soap, and pat dry. Cleanse with NS (normal saline) and pat dry with 4x4 (4 inch x 4 inch) gauze. Apply thin layer of mixture of 1 packet A&D with 6 grams of calazime to pressure injuries. Skin prep surrounding pressure injuries. Mepilex dressing to secure. Change every 3 days and PRN (as needed) >50% saturation. Strongly encourage frequent repositioning to offload pressure from areas. CN (Charge Nurse) and CNAs (Certified Nursing Assistant) aware. 5/3/24: read in part, The left PI measures 6cm x 4.5cm with excoriation in the wound bed, surrounding tissue normal. The right PI measures 6cm x5.3cm with normal tissue surrounding. The wound care order has been changed to cleanse bilateral buttocks with warm water and mild soap, pat dry. Apply skin prep surrounding pressure injuries and let dry, apply new duoderm to each PI and change q (each, every) 5 days and prn >50% saturated. 5/16/24: read in part, Stage 2 PI left buttock measures 8cm x 3.5cm. Stage 2 PI right buttock measures 7cm x 3cm with lower part having excoriation within the wound bed. The wound beds are dark red and blanchable. 5/20/24: read in part, R (right) buttocks PI measures 6.8cm x 6cm with scant amount of excoriation within wound bed and surrounding. Left buttocks PI measures 8cm x 5cm with small amount of excoriation on edges .There is evidence of the duoderm dressing causing more excoriation from the adhesive as the pressure injuries are becoming wider in nature with excoriation. Therefore, the wound order is discontinued at this time and a new order is entered: cleanse entire buttocks with warm water and soap, pat dry. Cleanse pressure injury areas with NS and gauze 4 x 4, pat dry. Mix 1 packet A&D ointment with 6 grams of calazime, skin protectant and apply thin layer to bilateral buttocks pressure injuries. Skin prep surrounding pressure injuries where adhesive will be. Secure 2 separate small Mepilex dressings or sacral Mepilex dressing. 5/26/24: read in part, Stage 2 PI left buttocks measures 8cm x 5 cm purplish-red with 1.2cm x 1cm area of superficial red excoriation within. Right buttocks Stage 2 PI measures 8cm x 5cm and is light purplish in color . Order is updated .secure left buttocks with Mepilex dressing change q 3 days or PRN 50% saturated. Utilize body pillow to reposition and offload pressure from buttocks and bony prominences. 6/5/24: read in part, Right buttocks have 2 areas of shearing within red quickly blanchable area. Right superior area of shearing measures 1.2cm x 1.3cm, inferior area of shearing measures 0.6cm x 0.6cm. The left buttocks have 1 area of shearing measuring 0.4cm x 0.4cm. The left buttocks PI is observed to have too much moisture r/t (related to) Mepilex dressing and there is an attempt at healing with some loose scabbing. At this time, treatment is changed to cleanse buttocks with mild soap and water, pat dry. Apply thin layer of calazime to bilateral buttocks pressure injuries. Treatment BID (two times a day) and PRN brief changes. 6/11/24: read in part, Right buttocks Stage 2 PI has red sheared area measuring 1.2cm x 1cm. Left buttocks Stage 2 PI measures 1.2cm x 1cm and is scabbed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	6/19/24: read in part, Evidence of increased pressure to buttocks as right buttocks has deep red discoloration measuring 6.7cm x 3.5cm with area of dark purple shiny sheared skin measuring 0.7cm x 3cm. Left buttocks Stage 2 PI has red discoloration measuring 5cm x 3cm with excoriation within and superior area of excoriation measuring 2.2cm x 0.7cm. R16's care plan last updated 5/11/24 stated: Pressure Ulcer/Injury I am at risk for skin breakdown and developing a pressure ulcer related to incontinence, impaired mobility, decreased sensory perception and a history of multiple cysts and infections. Please apply my blue pressure relieving boots to both feet when I am in bed to avoid pressure on my bony prominences and prevent skin break down (initiated 5/11/24). I have a Stage II pressure ulcer on my right and left buttock, please complete treatments as ordered (initiated 4/6/24). Please provide me with an air mattress for pressure injury care and prevention (initiated 4/5/24). On 6/25/24 at 10:17 AM, during observation of morning care, resident has Stage 2 pressure ulcer to left and right buttocks, that was red, with uneven boarders, elongated in shape. On 6/25/24 at 4:15 PM, during an interview with the Director of Nursing (DON), who reviewed R16's chart and agreed nursing needed to put measurements when they assessed the wounds on R16's buttocks. The DON stated nurses were expected to fill out the weekly skin assessment completely. The DON acknowledged while looking through progress notes, the wound started in March and the resident was not given an air mattress until 4/5/24. The DON acknowledged the air mattress took too long to implement based on R16's wound assessments and when they began. A review of the EMR revealed an order for the air mattress dated 4/5/24. On 6/26/24 at 9:30 AM, during observation of Registered Nurse (RN) C who performed wound measurements, indicated the wound was looking ruddier. RN C noted a small new wound on sacral area. RN C then applied a sacral Mepilex dressing due to this added area of concern. The new area was located on the sacrum, was small, oblong, and had uneven wound edges. On 6/26/24 at 9:48 AM, a follow up interview was conducted with the DON, to discuss what might have caused the wounds on R16. The DON stated she did not see it when it first started but did thought it looked like the wounds were caused by shearing (mechanism of action in which uneven forces upon the skin increases the chance for skin tears, pressure injuries, and other wounds). 45123 Resident #6 (R6) Review of the facility's resident matrix revealed R6 had a facility acquired stage III pressure ulcer. On 6/24/24 at 11:15 AM, an interview was conducted with the Director of Nursing (DON) and asked if R6 had any pressure ulcers or wounds and replied, R6 has a right ankle stage III pressure injury that he was admitted with. The DON was asked if he required any type of dressing changes and replied, No. He is observation only and open to air. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R6's medical record revealed he was admitted to the facility on [DATE] with diagnoses including multiple sclerosis, chronic obstructive pulmonary disease (COPD), and pressure ulcer of right ankle (stage 3). Review of R6's admission and body assessment, date 4/19/24, revealed under the skin section a stage II right lower extremity pressure ulcer. Review of R6's MDS assessment, dated 7/26/23 revealed he scored a 10/15 on the Brief Interview for Mental Status (BIMS) assessment indicating moderate cognitive impairment. This MDS also revealed he had one pressure ulcer stage III that was facility acquired and none that were present on admission. Review of R6's care plan, dated 4/19/22, read in part .Problem: I am at risk for developing pressure ulcers, I have had pressure ulcers in the past .Approach .Please complete dressing order per MD (medical doctor) to my right malleolus (outer ankle area) .Please assess my skin . Review of R6's physician order, dated 4/21/24 read in part, Pressure sore: Measure and Document progress weekly . Review of R6's wound progress notes, dated between 4/19/22 through 6/26/24, revealed that the original pressure ulcer stage III on his right ankle had not healed and remained open. Review of R6's wound progress notes, dated between 8/1/23 through 6/26/24, revealed the lack of weekly wound measurements as follows: a.) between 8/20/23 through 9/9/23, b.) between 9/25/23 through 10/21/23, c.) between 10/23/23 through 11/25/23, d.) between 11/27/23 through 12/23/23, e.) between 1/15/24 through 3/2/24 and, f.) between 3/4/24 through 3/22/24. On 6/25/24 at 10:00 AM, an observation was made of R6 in his room sitting in his wheelchair and playing solitaire. R6 was asked about his right ankle pressure ulcer and replied, You can look at it if you want to. I have had that sore since 1987. I hit my ankle on a rock when I was walking down a sidewalk and ever since then it has not healed. R6's right ankle was observed to have a pressure ulcer to the right malleolus with an area the size of a nickel. No dressing was present, and the wound was open to air. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/25/24 at 3:10 PM, an interview was conducted with the DON and asked if R6 had a facility acquired pressure ulcer stage III and replied, No. He was admitted to the facility with that pressure ulcer, and it has not healed yet. The DON was asked how often R6 has his wound measurements and replied, They are completed weekly by the nurse managers or me. The DON was asked if R6 should have any weekly wound measurements incomplete and replied, No. The DON was asked where the documentation was kept and if there were any other place wound measurements were charted in the electronic medical record and replied, The wound measurements are documented under the wound progress notes and that is the only place they are documented. Review of policy titled, Decub/Skin Protocol, dated 3/31/17, read in part, .3. The program will be overseen by assigned Nursing Supervisor. All resident skin issues will be followed weekly by Nursing Supervisor .5 .a weekly skin assessment will be made out .6 .The care plan will be updated according to the resident's condition .

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 49397 Based on interview and record review the facility failed to identify, evaluate, and implement interventions to prevent an avoidable accident when bath aides failed to transport one Resident #3 (R3) of two residents reviewed for safety, safely to the bath via the bath lift in the tub room. This deficient practice resulted in bath lift tipping over while R3 aboard, causing a laceration to his left shin which required sutures. Resident #3 (R3) Review of R3's medical record indicated R3 was admitted to facility on 2/27/24 with diagnoses of age-related osteoporosis (when mineral density and bone mass decreases), Type II diabetes, muscle weakness, and traumatic brain injury. A review of the Minimum Data Set (MDS) assessment dated [DATE] revealed R3 had a BIMS (Brief Interview for Mental Status) score of 15/15, indicating R3 was cognitively intact. Review of R3's orders indicated clopidogrel (blood thinner) 75 mg (milligrams) was prescribed to R3 once a day at 9:00 AM. Clopidogrel is an antiplatelet medication that can cause increased potential for bruising and bleeding. A review of R3's care plan initiated on 2/27/24 indicated at risk for falls related to impaired mobility, disease process, and possible side effects of medication. Please assist me (R3) with transferring and toileting as needed. I use a full mechanical lift. I use a blue sling. A review of R3's progress notes dated 3/6/24 at 3:30 PM revealed the following: approximately 1520 (3:20 PM) in to get this nursing supervisor and provider for resident fall. This nurse went into tub room between north and south hall where resident was observed on the floor near tub with head against the wall facing the tub in supine position with bath trolley (bath lift) on top of resident. The resident was alert and oriented at baseline, reporting no pain anywhere during assessment. Vitals BP (Blood Pressure) 156/72, HR (Heart Rate) 95, T (Temperature) 98.2, R (respirations) 20, SpO2 (Oxygen Saturation) 97% on RA (Room Air). The bath aides reported they were getting ready to lower the resident into the tub when the trolley quickly tipped over resulting in the resident falling to the floor. Initially the resident is observed to have a laceration to anterior left shin and scant amount of bleeding form an abrasion to the posterior head. The provider evaluated the resident and determined need to transfer to the ER (emergency room) for a head CT (Computed Tomography) due to the resident on anticoagulant Plavix (clopidogrel) as well as need to repair leg laceration. Administrator advised of occurrence and resident's emergency contact notified. A progress note from the Physician Assistant (PA) dated 3/6/24 at 3:30 PM, read in part fell from lift to hard floor during transfer to bath . just fell off lift during transfer to receive a bath. He struck his head and lacerated R (right) anterior leg (incorrectly identified by PA in note). Denies LOC . denies any pain, SOB (shortness of breath) or chest discomfort. Denies cervical, thoracic, or lumbar spine pain. Denies headache (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of nursing progress notes on 3/6/24 at 6:43 PM, read in part, (R3) returned from the ER with sutures to the lower left leg laceration, tetanus shot updated, CT of head/C-Spine (cervical spine)/chest/pelvis/left leg with no acute injury or abnormalities. Resident has generalized pain from fall. An interview with R3 on 6/26/24 at 7:48 AM, revealed the following: R3 stated that during the fall it all happened too quick for him to alert staff something was wrong but felt something was not quite right while on the bath lift. R3 felt there was too much weight at one end. During an interview conducted with the Director of Nursing (DON) on 6/26/24 at 9:02 AM, she stated that the R3's fall was investigated and the lift had been taken out of commission until it was evaluated by the external vendor, stating that they ' . fixed it'. She indicated the external vendor informed the facility the lift was nearing the end of its life and was being replaced. The DON stated the facility had determined that the resident was too heavy for the bath lift. Review of manufacturers bath lift instructions for use, from medical supplier, indicated the maximum safe operating weight was 352 pounds for the bath lift. R3's chart indicated his weight at 309.5 pounds, which is under the safe operating weight. A review of the medical supplier's Inspection Report indicated that an incident report was completed and sent to complaints. Lift inspection completed no fault found, all functions working properly. Pictures of lift attached. A review of the Event Report Safety Events - LTC (Long Term Care) Fall Occurrence Report explanation of incident read in part as R3 seat belt in with safety bar over legs of bath/gurney trolley. Trolley completely knocked over with R3 down on floor. R3's upper torso partially off end of trolley on floor, head propped up on stack of towels. Left shin up against safety bar with laceration noted. Bleeding noted from posterior head. Unbuckled from trolley and trolley pulled away per three staff. On 6/26/24 10:16 AM, an interview was conducted with shower aide (SA) E, who was present at time of fall on 3/6/24. SA E stated she had resident sitting up with the bar over his leg, per bath lift protocol, brought R3 into the shower room, had R3 next to the bath and the apparatus just tipped over. SA E then proceeded to lean on the end of bath lift to show how hard it was to get it to lean. SA E stated she knew that R3 was not over the weight limit but after thinking about it she feels that R3's body makeup made him heavier on one side than the other and that is why it tipped. A follow-up interview was conducted with the DON and the NHA (Nursing Home Administrator) in attendance on 6/26/24 at 10:30 AM, where they indicated they had reenacted the fall, and could not figure out why the bath lift had fallen over, calling it a freak accident.