

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/20/2025
NAME OF PROVIDER OR SUPPLIER  McLean Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  75 Great Pond Rd Simsbury, CT 06070	

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 - Actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (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 0689  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of clinical records, interviews, and review of facility documentation and policy for one (1) of three (3) residents (Resident #1) reviewed for accidents, the facility failed to ensure a resident was safely transferred using a mechanical lift. The findings included: Resident #1 was admitted to the facility March 2021 with diagnoses of hemiplegia and hemiparesis, major depressive disorder, and anxiety disorder. Review of the Comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) score of fifteen (15) and indicated Resident #1 was cognitively intact. The MDS further identified Resident #1 was dependent with toilet hygiene, personal hygiene, and transfers. Review of Resident #1's Care Plan dated 6/20/25 identified an activity of daily living, self-care performance deficit related to confusion and hemiplegia. Interventions directed to utilize the maxi lift (Hoyer lift) with an assist of two (2) and use of an extra-large blue sling. Review of Resident #1's Care Card dated 6/30/25 (utilized by nursing staff which listed Resident #1's specific care needs) identified transfer instructions directing staff to utilize the Maxi Lift (Hoyer) with an assist of two (2) staff and use of the extra-large blue sling (pad used to safely and securely transfer the resident) into the custom tilt in space wheelchair. Review of the Department of Public Health Facility Licensing and Investigation Section Reportable Event form dated 7/28/25 at 5:50 PM identified Resident #1 had slid out of her sling while being transferred in his/her room, had pain to the back of his/her head and left side heaviness, and that the incident was witnessed by NA#1 and NA#2. Review of Resident #1's hospitalization summary dated 7/28/25 identified both the C6 and C7 spinous processes were fractured with some edema surrounding them. Interview with NA #2 on 8/19/25 at 10:58 AM identified he/she participated in transferring Resident #1 from his/her wheelchair back to bed with the assistance of NA #1 on 7/28/25. NA #2 indicated he/she and NA #1 were only able to secure three (3) of the four (4) sling straps to the Maxi-Lift as each time they attempted to secure the fourth strap, Resident #1 would indicate he/she was in pain. NA #2 identified it was then that he/she thought the sling may have been the wrong size for the resident. NA #1 and NA #2 transferred Resident #1 with only three (3) straps secured to the Maxi-Lift, with one of them manually supporting the unstrapped/unsupported lower extremity during the transfer. While Resident #1 was suspended partially over his/her bed, NA #2 was unable to progress the lift forward as the wheel came into contact with a cord that was underneath Resident #1's bed. NA #2 indicated he/she chose to push the Maxi-Lift wheel over the cord, and after doing so, Resident #1 slid out of the sling and fell onto the floor. Interview with the Director of Nursing Services (DNS) on 8/20/25 at 12:00 PM identified the facility's standard of practice for a safe transfer utilizing a Maxi-Lift was to employ two (2) staff members to perform the task, assess the sling color (for integrity and to ensure the color matches the care card instruction), proper positioning of the sling under the resident, ensure the area was clear for the transfer, and to ensure that all four straps (via clips) were securely attached to the Maxi-Lift prior to initiating the transfer. The DNS further indicated any issues, concerns or questions regarding the transfer should be brought to the attention of the floor nurse prior to the transfer taking place. Review of the Transfers/Safe Resident Handling/Mechanical Lifting and Transfer Devices policy directed staff members were expected to maintain compliance with safe handling/transfer practices, and resident lifting and transferring would be performed according to the resident's individual plan of care. [JA1] The facility identified the deficient practice and developed an immediate plan of correction for past noncompliance as of July 30, 2025. Staff education: to ensure the safety of residents who require mechanical transfers. Staff members must look at the care card before performing the transfer, ensure the proper sling size is used, and ensure correction positioning. The facility completed lift orientation / competencies for all staff. Weekly Care audits were conducted to ensure proper lift and transfer of residents.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>(continued on next page)</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of clinical records, interviews, and review of facility documentation and policy for one (1) of three (3) residents (Resident #1) reviewed for accidents, the facility failed to ensure new staff were competent to properly and safely administer mechanical lift transfers. The findings included: Resident #1 was admitted to the facility March 2021 with diagnoses of hemiplegia and hemiparesis, major depressive disorder, and anxiety disorder. Review of the Comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) score of fifteen (15) and indicated Resident #1 was cognitively intact. The MDS further identified Resident #1 was dependent with toilet hygiene, personal hygiene, and transfers. Review of Resident #1's Care Plan dated 6/20/25 identified an activity of daily living, self-care performance deficit related to confusion and hemiplegia. Interventions directed to utilize the maxi lift (Hoyer lift) with an assist of two (2) and use of an extra-large blue sling. Review of Resident #1's Care Card dated 6/30/25 (utilized by nursing staff which listed Resident #1's specific care needs) identified transfer instructions directing staff to utilize the Maxi Lift (Hoyer) with an assist of two (2) staff and use of the extra-large blue sling (pad used to safely and securely transfer the resident) into the custom tilt in space wheelchair. Review of the Department of Public Health Facility Licensing and Investigation Section Reportable Event form dated 7/28/25 at 5:50 PM identified Resident #1 had slid out of her sling while being transferred in his/her room, had pain to the back of his/her head and left side heaviness, and that the incident was witnessed by NA#1 and NA#2. Interview with NA #2 on 8/19/25 at 10:58 AM identified he/she participated in transferring Resident #1 from his/her wheelchair back to bed with the assistance of NA #1 (an agency hire that was new to the facility) on 7/28/25. NA #2 indicated he/she and NA #1 were only able to secure three (3) of the four (4) sling straps to the Maxi-Lift and transferred Resident #1. The transfer was initiated; Resident #1 was suspended in air and partially over his/her bed when the lift wheel encountered a cord underneath Resident #1's bed. NA #2 indicated he/she chose to push the Maxi-Lift wheel over the cord, and after doing so, Resident #1 slid out of the sling and fell onto the floor, with the back of her head hitting the metal base of the lift. Review of Resident #1's hospitalization summary dated 7/28/25 identified both the C6 and C7 spinous processes were fractured with some edema surrounding them. Interview with NA #1 (an experienced agency nurse's aide of 12 years) on 8/19/25 at 9:45 AM identified 7/28/25 was his/her first day at the facility, that he/she was new to its practices, and that he/she had followed NA #2's instructions on how to transfer Resident #1 via mechanical lift that day. [JA1] Although requested, the facility was unable to provide documentation identifying NA #1 was skilled checked for mechanical transfers. Interview with the Director of Nursing Services (DNS) on 8/19/25 at 12:20 PM identified NA #1 was not educated or skill checked for mechanical transfers prior to performing Resident #1's mechanical transfer on 7/28/25. The DNS indicated the focus for agency staff (nurse's aides) on their first day of work was to familiarize them with the residents' care needs, diet orders, and transfer statuses as the expectation was that they were already educated and skilled on how to properly perform mechanical transfers. The DNS further indicated that as mechanical transfers were a two person assist, a competent mentor (NA #2, a non-agency nurse aide hired by the facility) would guide them and ensure the correct procedure was followed and did not mandate agency staff to be skill checked for mechanical transfers prior to participating/performing them. Since Resident #1's accident on 7/28/25, the facility has changed its practice and all new agency staff are now educated/skill checked prior to participating in or performing mechanical transfers. Interview with NA #2 on 8/19/25 at 2:21 PM identified that he/she was not assigned to mentor/oversee NA #1 and that he/she just participated in assisting NA #1 with Resident #1's transfer on 7/28/25. Review of the Transfers/Safe Resident Handling/Mechanical Lifting and Transfer Devices policy directed staff would be educated on the use of safe handling/transfer practices to include use of mechanical lift devices upon hire, annually, and as the need arises or changes in equipment occur. The facility identified the deficient practice and developed an immediate plan of correction for past noncompliance as of July 30, 2025. Staff education: to ensure the safety of residents who require mechanical transfers. Staff members must look at the care card before performing the transfer, ensure the proper sling size is used, and ensure correction positioning. The facility completed lift orientation / competencies for all staff.</p>		