

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  305074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/03/2025
NAME OF PROVIDER OR SUPPLIER  Holy Cross Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  357 Island Pond Road Manchester, NH 03109	

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)
<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>51399</p> <p>Based on interview and record review, it was determined that the facility failed to ensure that the required committee members attended Quality Assurance Performance Improvement (QAPI) meetings at least quarterly for 3 of the 4 quarterly meetings reviewed for 2024.</p> <p>Findings include:</p> <p>Review on 1/3/25 of the first quarter QAPI meeting attendance sheet, dated 1/26/24, revealed that the Medical Director or designee (required member) was not in attendance.</p> <p>Review on 1/3/25 of the second quarter QAPI meeting attendance sheet, dated 4/26/24, revealed that the Infection Preventionist (required member) was not in attendance.</p> <p>Review on 1/3/25 of the fourth quarter QAPI meeting attendance sheet, dated 10/25/24, revealed that the Infection Preventionist (required member) was not in attendance.</p> <p>Interview on 1/3/25 at approximately 2:00 p.m. with Staff A (Administrator) confirmed the above findings.</p> <p>Interview on 1/3/25 at approximately 11:00 a.m. with Staff B (Infection Preventionist) revealed that he/she did not attend the above mentioned QAPI meetings because they were working as a nurse on the unit during scheduled quarterly QAPI meetings.</p>

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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