STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	150044	A. BUILDING 00 B. WING	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BAPTIST HEALTH FLOYD	1850 STATE ST NEW ALBANY, IN 47150

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A 0000 Bldg. 00	This visit was for investigation of a federal hospital complaint. Complaint Number: IN00351592 Substantiated: Deficiencies unrelated to the allegations are cited. Survey Dates: 5/17/21 to 5/19/21 Facility Number: 005040 QA: 6/10/21	A 0000		
A 0168 Bldg. 00	482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION §§482.13(e)(5) - The use of restraint or seclusion must be in accordance with the order of a physician or other licensed practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law. Based on document review and interview, the hospital failed to ensure the use of restraint was in accordance with the order of a physician for 1 of 1 patients (P3) who was ordered restraints. Findings include: 1. Review of the policy titled Restraints, Revised & Effective 6/2019, indicated the following: Restraint Devices: The following list includes the restraining devices which have been approved for use in the hospital: Mittens. Soft wrist or ankle restraints. Vest restraint. Velcro.	A 0168	**Corrective Action Plan:** Baptist Health Floyd's goal is to provide guidance on the use of restraints and educate on the appropriate documentation for restraints. Remove Lap Belt as an order option for providers in EMR. This was completed June 22, 2021. Remove Lap Belt as a charting option for nursing in EMR. This was completed June 22, 2021. Accountability statement to be completed and signed by all	08/15/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	The use of restraints must be in accordance with the order of a physician or other practitioner... 2. Review of the medical record (MR) of patient P3 indicated that Physician D10 ordered restraints beginning 12/25/20 at 1309 hours as follows: Restraint reason: Pull lines/tubes. Type: Soft Restraint. Lap Belt. Side Rails Up x 4. Restraint orders on 12/26/20 by D10 and on 12/27/20 by D10 indicated restraints were continued/ordered for Lap Belt and Side Rails Up x 4. Restraint flowsheet documentation indicated the following: On 12/25/20 at 1300 hours and 1500 hours the MR lacked documentation of any "Restraint Type". Restraint type documented beginning 12/25/20 at 1900 hours indicated soft wrist restraints (right and left) "Continued". The MR lacked documentation of Lap Belt restraint and/or Side Rails Up x 4 having been implemented as restraint types and lacked documentation of the orders having been changed/clarified for use of bilateral wrist restraints and/or no use of the Side Rails Up x 4. 3. On 5/19/21, beginning at approximately 1:45 PM, A6, Application Support Analyst, verified MR documentation of P3.		current hospitalists acknowledging lap belts have been removed as restraint option, and a reminder to order least restrictive restraint option. Completion Date: August 2, 2021 Educate direct care inpatient nurses, excluding Women's Services nurses, on restraints to include: documentation, order clarification, types of restraints, and start / stop times. This will be completed by 100% direct care inpatient nurses, excluding Women's Services nurses by August 15, 2021 (excluding those on FMLA). Department leader or designee of inpatient units, excluding Women's Services, to complete concurrent daily audit on restraints, including all documentation for the shift and review of orders for appropriateness with verbal feedback given to nurse. These will be ongoing until 100% compliance is reached for 3 consecutive months. Counsel nurse involved with P3 documentation regarding restraints and order clarification in accordance with Just Culture policy. **Responsible Party:** Chief Nursing Officer, Chief Medical Officer Deadline: August 15, 2021	

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A 0340 Bldg. 00	482.22(a)(1) MEDICAL STAFF PERIODIC APPRAISALS The medical staff must periodically conduct appraisals of its members. Based on document review and interview, it could not be determined that the Medical Staff (MS) conducted appraisals for 8 of 8 MS members (D1, D2, D3, D4, D5, D6, D7 and D8). Findings include: 1. Review of the Medical Staff Bylaws, Approved 10/2019, indicated the following: The primary responsibility delegated to each department is to implement and conduct specific review and evaluating activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the Hospital. To carry out this responsibility, each department shall (not all inclusive): Monitor, on a continuing and concurrent basis, adherence to: Staff and Hospital policies and procedures; Sound principles of clinical practice; and Other regulations designed to promote patient safety. Credentialing criteria, minimum threshold criteria, high risk or high volume procedures. Submit written reports to the Medical Executive Committee... concerning: Findings of the Department's review and evaluation activities, actions taken theron, and the results of such action... Involve members of the Department in monitoring and evaluation of the quality care provided... 2. The credential files of physicians D1, D2, D3, D4, D5, D6, D7 and D8; lacked documentation periodic appraisals/performance evaluations and/or peer review of the members. 3. Review of incident reports indicated the	A 0340	As of the date of the survey, Baptist Health Floyd maintained documentation to demonstrate that it performed appraisals for all eight (8) of the eight (8) Baptist Health Floyd medical staff members reviewed by the surveyor. Baptist Health Floyd Medical Staff Organizational Manual plan states the each authorized and approved department shall be organized as a separate part of the Medical staff. The primary responsibility of each department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided by the hospital. Each department is to monitor on a continuing and concurrent basis, adherence to: staff and hospital policies, sound principles of clinical practice, other regulations designed to promote patient safety, and credentialing criteria, minimum threshold criteria, high risk or high volume procedures. In addition, each department shall involve members of the department in the monitoring and evaluation of the quality of care provided by the department.	05/17/2021

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	following regarding patient P3: Event Date: 1/13/21. Brief Factual Description: Patient became unstable in PACU (Post-Anesthesia Care Unit). Patient had to be brought back into the operating room to assess for post op (operative) bleeding. The report indicated the physician involved was D2. *Note: Follow-Up Actions had been redacted from the report. Unable to determine actions taken/recommended. Resolution and Outcome information had been redacted from the report. Unable to determine if actions were performed/completed and/or effective. 4. The following was indicated in interview on 5/18/21: Beginning at approximately 10:30 AM, A5, Regional Director of Risk and Patient Safety, an event on 1/13/21 involving physician D2, related to patient P3, was sent for PEER review. Beginning at approximately 11:30 AM, A2, Accreditation Coordinator, upon re-request for evidence of MS evaluations/PEER review, indicated they (the administrative staff) were waiting to hear from legal if they could provide that documentation. A2 indicated that at this point, the documentation could not be provided. No further documentation was provided prior to exit.		Baptist Health Floyd Medical Staff Bylaws state: *It is recognized and acknowledged that clinical departments, services, committees, boards, study groups and hearing panels, whether authorized or established pursuant to these Medical Staff Bylaws, the Organization Manual or pursuant to the Hospital's Bylaws, shall be required from time to time to perform designated peer review duties and functions including, without limitation: (1) the review of an applicant's or member's credentials: (2) determination of whether a Practitioner should have clinical privileges or be appointed to membership: (3) determination of the scope and conditions applicable to privileges or membership: (4) recommendations or actions on the modification, suspension or termination of clinical privileges or membership: (5) the review and evaluation of the competence or professional conduct of a Practitioner, including such things as clinical competence, character, mental or emotional stability, physical condition, and ethics, which affect, or could adversely affect, the health or welfare of patients or which otherwise may adversely affect the quality and appropriateness of patient care; (6) corrective actions, including summary suspension; (7) hearings and appellate reviews; (8) quality*	

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			improvement/assessment, including medical care evaluation; (9) utilization review; (10) other hospital, departmental, service or Baptist Health Floyd Medical Staff Bylaws. There are two major kinds of peer review processes followed by Baptist Health Floyd Medical Staff. The first is identified in the Credentialing Manual for Ongoing Professional Practice Evaluation (OPPE). As described in the Credentialing Manual OPPE is a continuous process for analyzing practitioner competency along with ongoing monitoring. This routine monitoring is designed to be comprehensive and objective, evaluating clinical outcomes, professionalism and hospital practice citizenship to include compliance with medical record completion guidelines. OPPE may identify opportunities for improvement which may lead to focused professional practice evaluation (FPPE) of a given provider. The clinical department chair is responsible for routine review of OPPE for providers in their department. The second type of peer review process is an incident based process. This process is to identify and, if indicated, address any concerns related to the	

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			delivery of clinical care relative to a specific patient or group of patients. These issues are typically brought to light primarily through incident reports. This process is designed to identify opportunities specific to providers to improve provider quality of care as stated in the Organizational manual. Baptist Health Floyd follows its internal process for peer review. Due to the incident based nature of this second process, not all providers will be subject to this kind of peer review process. The Executive Director of Quality of Baptist Health Floyd showed the surveyor the requirements set forth in the medical staff Credentialing Manual and the Organizational Manuals for OPPE/FPPE and incident based peer review during the survey. Baptist Health Floyd's medical staff conducted ongoing professional practice evaluations for the following physicians D1-D8. During the survey, Baptist Health Floyd provided the following specific documents requested by the surveyors from the eight provider credentialing files to include: licensure, appointment / reappointment, delineation of privileges, experience and /or credentialing to work in specialized area, and any peer review / counseling incidents	

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			related to performance or concerns from December 2020 to May 17, 2021. When the Risk Manager was reviewing redacted incident reports with surveyor, she verbally stated that one of the four incident reports regarding a post-surgical complication was sent for peer review. The peer review process for this incident was verbally discussed during the survey by the Executive Director of Quality and the Chief Medical Officer. The Executive Director of Quality and the Chief Medical Officer reviewed meeting minutes and other documents described below with the surveyor to demonstrate how the Baptist Health Floyd peer review process was followed as it relates to patient P3. In this case, the documentation reviewed with the surveyor demonstrates that the Baptist Health Floyd medical staff and quality team followed its standard process for peer review. The documentation that was reviewed with the surveyor included the following: · The Executive Director of Quality provided a flow diagram document of the clinical care peer review process to the surveyor. · The clinical care review case summary document signed by the Chair of the Surgery Department on February 17, 2021 and the agenda for the Department of Surgery meeting occurring on	

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			April 20, 2021 were provided by the Executive Director of Quality to the surveyor as evidence of the completion of the clinical care peer review process. These documents included the same patient identifiers to show the process of clinical care quality adjudication by the Department of Surgery chair prior to the Department of Surgery meeting. · The surveyor requested incident reports involving a specific list of patients for a select group of medical staff members. Of the medical staff credentialing files requested and provided to the surveyor, only one member of the medical staff (D2) was identified as having any potential concerns. Baptist Health Floyd also provided evidence of ongoing professional practice evaluations as part of the credentialing and re-credentialing process. · As reflected in the April 20, 2021 Department of Surgery meeting minutes that were reviewed with the surveyor, 12 cases of separate patients cared for by different providers, were reviewed by the Department chair, including the care of patient P3. These cases were summarized and presented for review to the committee. The peer review for the patient encounter in question was determined to be a Level 2 event (unanticipated event with appropriate care). The care that	

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			the patient received from physician (D2) was deemed appropriate thus the care provided did not warrant any further investigation or provider specific remediation. Although we note this case summary was not yet in the credentialing file of physician D2 at the time of the survey, documents demonstrating the clinical care peer review process by the Department of Surgery chair and the Department of Surgery Committee were reviewed with the surveyor. The case summary is now in the credentialing file of physician D2. As evidenced by the documentation above, Baptist Health Floyd was in compliance with the appraisal process related to the 8 members of the medical staff reviewed by the surveyor. **Action:** At the time of the survey, Baptist Health Floyd followed it medical staff process for the performance of periodic appraisal/performance evaluations, as further discussed above. Baptist Health Floyd Medical Staff will continue to follow the Medical Staff Bylaws and Operations Manual for periodic appraisal / performance evaluations. The Medical staff files of D1-D8 contain peer evaluations / reappointment that support the Bylaws and Organizational Manual plan for	

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			Baptist Health Floyd. Completion Date: Baptist Health Floyd believes it was compliant as of the date of the survey May 17, 2021 and will continue to follow all processes to perform peer review and ongoing professional practice evaluations. **Responsible Party:** Chief Medical Officer	
S 0000 Bldg. 00	This visit was for investigation of a state licesure hospital complaint. Complaint Number: IN00351592 Substantiated: Deficiencies unrelated to the allegations are cited. Survey Dates: 5/17/21 to 5/19/21 Facility Number: 005040 QA: 6/10/21	S 0000		
S 0256 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(2)(A)(B) (a) The Governing Board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:			

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	(2) Ensure that the hospital: (A) meets all rules and regulations for licensure and certification, if applicable; and (B) makes available to the commissioner upon request all reports, records, minutes, documentation, information, and files required for licensure. Based on document review and interview, it could not be determined that appropriate investigation and action was taken and/or that a peer review was conducted in 1 instance (patient P3) Findings include: 1. Review of the Medical Staff Bylaws, Approved 10/2019, indicated the following: The primary responsibility delegated to each department is to implement and conduct specific review and evaluating activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the Hospital. To carry out this responsibility, each department shall (not all inclusive): Monitor, on a continuing and concurrent basis, adherence to: Staff and Hospital policies and procedures; Sound principles of clinical practice; and Other regulations designed to promote patient safety. Credentialing criteria, minimum threshold criteria, high risk or high volume procedures. Submit written reports to the Medical Executive Committee... concerning: Findings of the Department's review and evaluation activities, actions taken theron, and the results of such action... Involve members of the Department in monitoring and evaluation of the quality care	S 0256	As of the date of the survey, Baptist Health Floyd maintained evidence that an appropriate investigation and peer review process was performed related to patient P3 as follows: Baptist Health Floyd Organizational Manual states that each department shall be organized as a separate part of the Medical staff. The primary responsibility of each department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided by the hospital. Each department is to monitor, on a continuing and concurrent basis, adherence to the following: staff and hospital policies, sound principles of clinical practice, other regulations designed to promote patient safety, and credentialing criteria, minimum threshold criteria, high risk or high volume procedures. In addition, each	06/02/2021

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	provided... PEER REVIEW DUTIES AND FUNCTIONS: It is recognized and acknowledged that clinical departments...shall be required from time to time to perform designated peer review duties and functions including, without limitation: 1) the review of an applicant's or member's credentials: 2) determination of whether a Practitioner should have clinical privileges or be appointed to membership: 3) determination of the scope and conditions... 4) recommendations or actions on the modification, suspension or termination... 5) the review and evaluation of the competence or professional conduct of a Practitioner... 6) corrective actions... 7) hearings... 8) quality improvement/assessment, including medical care evaluation; 9) utilization review; 10) other hospital, departmental, service or committee activities related to appropriate patient care... and 11) requests for information from, and reports to... and any other state or federal agency from whom information may be sought... 2. Review of incident reports indicated the following regarding patient P3: Event Date: 1/13/21. Brief Factual Description: Patient became unstable in PACU (Post-Anesthesia Care Unit). Patient had to be brought back into the operating room to assess for post op (operative) bleeding. The report indicated the physician involved was D2. *Note: Follow-Up Actions had been redacted from the report. Unable to determine actions taken/recommended. Resolution and Outcome information had been redacted from the report. Unable to determine if actions were performed/completed and/or effective. 3. The following was indicated in interview on 5/18/21: Beginning at approximately 10:30 AM, A5,		department shall involve members of the department in the monitoring and evaluation of the quality of care provided by the department. Baptist Health Floyd Medical Staff By-laws state the following: *It is recognized and acknowledged that clinical departments, services, committees, boards, study groups and hearing panels, whether authorized or established pursuant to these Medical Staff Bylaws, the Organization Manual or pursuant to the Hospital's Bylaws, shall be required from time to time to perform designated peer review duties and functions including, without limitation: (1) the review of an applicant's or member's credentials: (2) determination of whether a Practitioner should have clinical privileges or be appointed to membership: (3) determination of the scope and conditions applicable to privileges or membership: (4) recommendations or actions on the modification, suspension or termination of clinical privileges or membership: (5) the review and evaluation of the competence or professional conduct of a Practitioner, including such things as clinical competence, character, mental or emotional stability, physical condition, and ethics, which affect, or could adversely affect, the health or welfare of patients or which otherwise may*	

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	Regional Director of Risk and Patient Safety, an event on 1/13/21 involving physician D2, related to patient P3, was sent for PEER review. Beginning at approximately 11:30 AM, A2, Accreditation Coordinator, upon re-request for evidence of MS evaluations and/or PEER review, indicated they (the administrative staff) were waiting to hear from legal if they could provide that documentation. A2 indicated that at this point, the documentation could not be provided. No further documentation was provided prior to exit.		*adversely affect the quality and appropriateness of patient care; (6) corrective actions, including summary suspension; (7) hearings and appellate reviews; (8) quality improvement/assessment, including medical care evaluation; (9) utilization review; (10) other hospital, departmental, service or Baptist Health Floyd Medical Staff Bylaws.* During the survey, the Baptist Health Floyd Risk Manager reviewed with the surveyor four redacted incident reports that were requested by the surveyor. The Risk Manager verbally stated to the surveyor that one of four redacted incident reports indicated that the clinical care involved in the report was sent for clinical care peer review. The peer review process for this incident was verbally discussed during the survey by the Executive Director of Quality and the Chief Medical Officer. The Executive Director of Quality and the Chief Medical Officer reviewed meeting minutes and other documents described below with the surveyor to demonstrate how the Baptist Health Floyd peer review process was followed as it relates to patient P3. In this case, the documentation that was reviewed with the surveyor demonstrates that the Baptist Health Floyd Medical Staff and quality team followed its standard process for	

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			clinical care peer review. The documentation reviewed with the surveyor included the following: · The Executive Director of Quality provided a flow diagram document of the clinical care peer review process to the surveyor. · The clinical care review case summary document signed by the Chair of the Surgery Department on February 17, 2021 and the agenda for the Department of Surgery meeting occurring on April 20, 2021 were provided by the Executive Director of Quality to the surveyor as evidence of the completion of the clinical care peer review process. These documents included the same patient identifiers to show the process of clinical care quality adjudication by the Department of Surgery chair prior to the Department of Surgery meeting. · The surveyor requested incident reports involving a specific list of patients for a select group of medical staff members. Of the medical staff credentialing files requested and provided to the surveyor, only one member of the medical staff (D2) was identified as having any potential concerns. Baptist Health Floyd also provided evidence of ongoing professional practice evaluations as part of the credentialing and re-credentialing process. · As reflected in the April 20,	

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			2021 Department of Surgery meeting minutes that were reviewed with the surveyor, 12 cases of separate patients cared for by different providers, were reviewed by the Department chair, including the care of patient P3. These cases were summarized and presented for review to the committee. The peer review for the patient encounter in question was determined to be a Level 2 event (unanticipated event with appropriate care). The care that the patient received was deemed appropriate thus the care provided did not warrant any further investigation or provider remediation. Although we note this case summary was not yet in the credentialing file of physician D2 at the time of the survey, documents demonstrating the clinical care peer review process by the Department of Surgery chair and the Department of Surgery Committee were reviewed with the surveyor. The case summary is now in the credentialing file of physician D2. **Action:** At the time of the survey, Baptist Health Floyd maintained a peer review process for evaluating performance of its medical staff members and Baptist Health Floyd was in compliance with the existing medical staff process for periodic appraisal/performance evaluations including the peer	

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			review duties, as outlined above. The Baptist Health Floyd Medical Staff will continue to comply with the Medical Staff Bylaws and Operations Manual for periodic appraisal/ performance evaluations and perform peer review on referred cases. Since the time of the survey, physician D2 has been successfully reappointed to the Medical Staff in a manner compliant with the Baptist Health Floyd Medical Staff bylaws. The updated credentialing file of physician D2, uploaded into the Baptist Health Floyd Medical Staff credentialing software on June 2, 2021, reflects documentation to support compliance with this process. **Responsible Party**: Chief Medical Officer Completion Date: June 2, 2021	
S 0842 Bldg. 00	410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5 (b)(3)(A)(B)(C)(D)(E)(F)(G)(H)(I)(J)(K) (b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following: (A) A description of medical staff organizational structure. If the organization calls for an executive committee, a majority of the members			

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	shall be physicians on the active medical staff. (B) Meeting requirements of the staff. (C) A provision for maintaining records of all meetings of the medical staff and its committees. (D) A procedure for designating an individual physician with current privileges as chief, president, or chairperson of the staff. (E) A statement of duties and privileges for each category of the medical staff. (F) A description of the medical staff applicant qualifications. (G) Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges. (H) A process for review of applications for staff membership, delineation of privileges in accordance with the competence of each practitioner, and recommendations on appointments to the governing board. (I) A process for appeals of decisions regarding medical staff membership and privileges. (J) A process for medical staff performance evaluations based on clinical performances indicated in part by the results of quality assessment and improvement activities. (K) A process for reporting practitioners who fail to comply with state professional licensing law requirements as found in IC 25-22.5, and for documenting appropriate enforcement actions against			

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	practitioners who fail to comply with the hospital and medical staff bylaws and rules. Based on document review and interview, it could not be determined that the Medical Staff (MS) conducted appraisals for 8 of 8 MS members (D1, D2, D3, D4, D5, D6, D7 and D8). Findings include: 1. Review of the Medical Staff Bylaws, Approved 10/2019, indicated the following: The primary responsibility delegated to each department is to implement and conduct specific review and evaluating activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the Hospital. To carry out this responsibility, each department shall (not all inclusive): Monitor, on a continuing and concurrent basis, adherence to: Staff and Hospital policies and procedures; Sound principles of clinical practice; and Other regulations designed to promote patient safety. Credentialing criteria, minimum threshold criteria, high risk or high volume procedures. Submit written reports to the Medical Executive Committee... concerning: Findings of the Department's review and evaluation activities, actions taken theron, and the results of such action... Involve members of the Department in monitoring and evaluation of the quality care provided... 2. The credential files of physicians D1, D2, D3, D4, D5, D6, D7 and D8; lacked documentation periodic appraisals/performance evaluations. 3. The following was indicated in interview on 5/18/21: Beginning at approximately 11:30 AM, A2,	S 0842	As of the date of the survey, Baptist Health Floyd maintained documentation to demonstrate that it performed appraisals for all eight (8) of the eight (8) Baptist Health Floyd medical staff members reviewed by the surveyor. Baptist Health Floyd Medical Staff Organizational Manual plan states the each authorized and approved department shall be organized as a separate part of the Medical staff. The primary responsibility of each department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided by the hospital. Each department is to monitor on a continuing and concurrent basis, adherence to: staff and hospital policies, sound principles of clinical practice, other regulations designed to promote patient safety, and credentialing criteria, minimum threshold criteria, high risk or high volume procedures. In addition, each department shall involve members of the department in the monitoring and evaluation of the quality of care provided by the department. Baptist Health Floyd Medical Staff	05/17/2021

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	upon re-request for evidence of MS evaluations/PEER review, indicated they (the administrative staff) were waiting hear from legal if they could provide that documentation. A2 indicated that at this point, the documentation could not be provided. No further documentation was provided prior to exit.		Bylaws state: *It is recognized and acknowledged that clinical departments, services, committees, boards, study groups and hearing panels, whether authorized or established pursuant to these Medical Staff Bylaws, the Organization Manual or pursuant to the Hospital's Bylaws, shall be required from time to time to perform designated peer review duties and functions including, without limitation: (1) the review of an applicant's or member's credentials: (2) determination of whether a Practitioner should have clinical privileges or be appointed to membership: (3) determination of the scope and conditions applicable to privileges or membership: (4) recommendations or actions on the modification, suspension or termination of clinical privileges or membership: (5) the review and evaluation of the competence or professional conduct of a Practitioner, including such things as clinical competence, character, mental or emotional stability, physical condition, and ethics, which affect, or could adversely affect, the health or welfare of patients or which otherwise may adversely affect the quality and appropriateness of patient care; (6) corrective actions, including summary suspension; (7) hearings and appellate reviews; (8) quality improvement/assessment,*	

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			including medical care evaluation; (9) utilization review; (10) other hospital, departmental, service or Baptist Health Floyd Medical Staff Bylaws. There are two major kinds of peer review processes followed by Baptist Health Floyd Medical Staff. The first is identified in the Credentialing Manual for Ongoing Professional Practice Evaluation (OPPE). As described in the Credentialing Manual OPPE is a continuous process for analyzing practitioner competency along with ongoing monitoring. This routine monitoring is designed to be comprehensive and objective, evaluating clinical outcomes, professionalism and hospital practice citizenship to include compliance with medical record completion guidelines. OPPE may identify opportunities for improvement which may lead to focused professional practice evaluation (FPPE) of a given provider. The clinical department chair is responsible for routine review of OPPE for providers in their department. The second type of peer review process is an incident based process. This process is to identify and, if indicated, address any concerns related to the delivery of clinical care relative to a	

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			specific patient or group of patients. These issues are typically brought to light primarily through incident reports. This process is designed to identify opportunities specific to providers to improve provider quality of care as stated in the Organizational manual. Baptist Health Floyd follows its internal process for peer review. Due to the incident based nature of this second process, not all providers will be subject to this kind of peer review process. The Executive Director of Quality of Baptist Health Floyd showed the surveyor the requirements set forth in the medical staff Credentialing Manual and the Organizational Manuals for OPPE/FPPE and incident based peer review during the survey. Baptist Health Floyd's medical staff conducted ongoing professional practice evaluations for the following physicians D1-D8. During the survey, Baptist Health Floyd provided the following specific documents requested by the surveyors from the eight provider credentialing files to include: licensure, appointment / reappointment, delineation of privileges, experience and /or credentialing to work in specialized area, and any peer review / counseling incidents related to performance or	

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			concerns from December 2020 to May 17, 2021. When the Risk Manager was reviewing redacted incident reports with surveyor, she verbally stated that one of the four incident reports regarding a post-surgical complication was sent for peer review. The peer review process for this incident was verbally discussed during the survey by the Executive Director of Quality and the Chief Medical Officer. The Executive Director of Quality and the Chief Medical Officer reviewed meeting minutes and other documents described below with the surveyor to demonstrate how the Baptist Health Floyd peer review process was followed as it relates to patient P3. In this case, the documentation reviewed with the surveyor demonstrates that the Baptist Health Floyd medical staff and quality team followed its standard process for peer review. The documentation that was reviewed with the surveyor included the following: · The Executive Director of Quality provided a flow diagram document of the clinical care peer review process to the surveyor. · The clinical care review case summary document signed by the Chair of the Surgery Department on February 17, 2021 and the agenda for the Department of Surgery meeting occurring on April 20, 2021 were provided by	

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			the Executive Director of Quality to the surveyor as evidence of the completion of the clinical care peer review process. These documents included the same patient identifiers to show the process of clinical care quality adjudication by the Department of Surgery chair prior to the Department of Surgery meeting. · The surveyor requested incident reports involving a specific list of patients for a select group of medical staff members. Of the medical staff credentialing files requested and provided to the surveyor, only one member of the medical staff (D2) was identified as having any potential concerns. Baptist Health Floyd also provided evidence of ongoing professional practice evaluations as part of the credentialing and re-credentialing process. · As reflected in the April 20, 2021 Department of Surgery meeting minutes that were reviewed with the surveyor, 12 cases of separate patients cared for by different providers, were reviewed by the Department chair, including the care of patient P3. These cases were summarized and presented for review to the committee. The peer review for the patient encounter in question was determined to be a Level 2 event (unanticipated event with appropriate care). The care that the patient received from physician	

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			(D2) was deemed appropriate thus the care provided did not warrant any further investigation or provider specific remediation. Although we note this case summary was not yet in the credentialing file of physician D2 at the time of the survey, documents demonstrating the clinical care peer review process by the Department of Surgery chair and the Department of Surgery Committee were reviewed with the surveyor. The case summary is now in the credentialing file of physician D2. As evidenced by the documentation above, Baptist Health Floyd was in compliance with the appraisal process related to the 8 members of the medical staff reviewed by the surveyor. **Action:** At the time of the survey, Baptist Health Floyd followed it medical staff process for the performance of periodic appraisal/performance evaluations, as further discussed above. Baptist Health Floyd Medical Staff will continue to follow the Medical Staff Bylaws and Operations Manual for periodic appraisal / performance evaluations. The Medical staff files of D1-D8 contain peer evaluations / reappointment that support the Bylaws and Organizational Manual plan for Baptist Health Floyd.	

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			Completion Date: Baptist Health Floyd believes it was compliant as of the date of the survey May 17, 2021 and will continue to follow all processes to perform peer review and ongoing professional practice evaluations. **Responsible Party:** Chief Medical Officer !--[if !supportAnnotations]-->	
S 0930 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3) (b) The nursing service shall have the following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. Based on document review and interview, the hospital failed to ensure evaluation of nursing care for use of restraint(s) in accordance with the order of a physician for 1 of 1 patients (P3). Findings include: 1. Review of the policy titled Restraints, Revised & Effective 6/2019, indicated the following: Restraint Devices: The following list includes the restraining devices which have been approved for use in the hospital: Mittens. Soft wrist or ankle restraints. Vest restraint. Velcro. The use of restraints must be in accordance with the order of a physician or other practitioner...	S 0930	**Corrective Action Plan:** Baptist Health Floyd's goal is to provide guidance on the use of restraints and educate on the appropriate documentation for restraints. Remove Lap Belt as an order option for providers in EMR. This was completed June 22, 2021. Remove Lap Belt as a charting option for nursing in EMR. This was completed June 22, 2021. Accountability statement to be completed and signed by all current hospitalists acknowledging lap belts have been removed as restraint option, and a reminder to order least restrictive restraint	08/15/2021

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	2. Review of the medical record (MR) of patient P3 indicated that Physician D10 ordered restraints beginning 12/25/20 at 1309 hours as follows: Restraint reason: Pull lines/tubes. Type: Soft Restraint. Lap Belt. Side Rails Up x 4. Restraint orders on 12/26/20 by D10 and on 12/27/20 by D10 indicated restraints were continued/ordered for Lap Belt and Side Rails Up x 4. Restraint flowsheet documentation indicated the following: On 12/25/20 at 1300 hours and 1500 hours the MR lacked documentation of any "Restraint Type". Restraint type documented beginning 12/25/20 at 1900 hours indicated soft wrist restraints (right and left) "Continued". The MR lacked documentation of Lap Belt restraint and/or Side Rails Up x 4 having been implemented as restraint types and lacked documentation of the orders having been changed/clarified for use of bilateral wrist restraints and/or no use of the Side Rails Up x 4. 3. On 5/19/21, beginning at approximately 1:45 PM, A6, Application Support Analyst, verified MR documentation of P3.		option. Completion Date: August 2, 2021 Educate direct care inpatient nurses, excluding Women's Services nurses, on restraints to include: documentation, order clarification, types of restraints, and start / stop times. This will be completed by 100% direct care inpatient nurses, excluding Women's Services nurses by August 15, 2021 (excluding those on FMLA). Department leader or designee of inpatient units, excluding Women's Services, to complete concurrent daily audit on restraints, including all documentation for the shift and review of orders for appropriateness with verbal feedback given to nurse. These will be ongoing until 100% compliance is reached for 3 consecutive months. Counsel nurse involved with P3 documentation regarding restraints and order clarification in accordance with Just Culture policy. **Responsible Party:** Chief Nursing Officer, Chief Medical Officer Deadline: August 15, 2021	