California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA060001620	A. BUILDING: _____ B. WING _____	C 09/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD/ORANGE & SAN BEI	700 S TUSTIN STREET ORANGE, CA 92863

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A 000	Initial Comments AMENDED The following reflects the findings of the California Department of Public Health during the investigation of COMPLAINT NUMBER: CA00378267. Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 1835, HFEN. Findings for Complaint Number: CA00378267. The complaint allegation(s) were substantiated and regulatory violations written at A001 and A017.	A 000	**PPOSBC Response to Amended CMS 2567 for COMPLAINT NUMBER CA00378267 :** *** PPOSBC former Compliance Officer during the interval in question is no longer with PPOSBC. However, senior management at PPOSBC including the PPOSBC CEO, and COO are aware of the standard processes engaged in by said former Compliance Officer including but not limited to said Compliance Officer's adherence to PPOSBC policies regarding reporting applicable incidents such as that described herein, and direct communication(s) with applicable affected PPOSBC patients. Therefore, the following said PPOSBC response is in good faith with respect to said former Compliance Officer's tenure at PPOSBC.* ***Amended CMS 2567 form CA00378267 Findings :*** a) Patient at issue was contacted by PPOSBC's compliance officer or his/her designee, informing said patient of the respective incident, of PPOSBC policies on the same and that PPOSBC would thoroughly investigate said incident and remedy as applicable. Said patient was provided full contact information at PPOSBC for any additional questions or follow up at patient's discretion. PPOSBC staff involved in each said incident was counseled and placed on administrative suspension as of said 11/7/2013 report by PPOSBC to CDPH. Subsequently, said staff was separated from employment with PPOSBC, so as to ensure optimal and maximum protection of patient medical information and data privacy and security.	9.22.14
A 001	Informed Medical Breach Health and Safety Code Section 1280.15 (b)(2), " A clinic, health facility, agency, or hospice shall also report any unlawful or unauthorized access to, or use or disclosure of, a patient's medical information to the affected patient or the patient's representative at the last known address, no later than five business days after the unlawful or unauthorized access, use, or disclosure has been detected by the clinic, health facility, agency, or hospice." The CDPH verified that the facility informed the affected patient(s) or the patient's representative(s) of the unlawful or unauthorized access, use or disclosure of the patient's medical information.	A 001	*b) PPOSBC staff involved in said incident was counseled and placed on administrative suspension as of said 11/7/2013 report by PPOSBC to CDPH. Subsequently, said staff was separated from employment with PPOSBC, so as to ensure optimal and maximum protection of patient medical information and data privacy.*	

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Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE President/CEO (X6) DATE 10/15/14

STATE FORM 10/20/14 Acceptable POC - HFEN 1835. 6899 DTSM11 If continuation sheet 1

PL

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A 001	Continued From page 1	A 001	Additionally, PPOSBC has a robust series of policies that all staff must adhere to regarding the optimum security and privacy of patient protected health information. Staff are also regularly trained and educated on said policies.	9.22.14
A 017	1280.15(a) Health & Safety Code 1280 (a) A clinic, health facility, home health agency, or hospice licensed pursuant to Section 1204, 1250, 1725, or 1745 shall prevent unlawful or unauthorized access to, and use or disclosure of, patients' medical information, as defined in subdivision (g) of Section 56.05 of the Civil Code and consistent with Section 130203. The department, after investigation, may assess an administrative penalty for a violation of this section of up to twenty-five thousand dollars ($25,000) per patient whose medical information was unlawfully or without authorization accessed, used, or disclosed, and up to seventeen thousand five hundred dollars ($17,500) per subsequent occurrence of unlawful or unauthorized access, use, or disclosure of that patients' medical information. For purposes of the investigation, the department shall consider the clinic's, health facility's, agency's, or hospice's history of compliance with this section and other related state and federal statutes and regulations, the extent to which the facility detected violations and took preventative action to immediately correct and prevent past violations from recurring, and factors outside its control that restricted the facility's ability to comply with this section. The department shall have full discretion to consider all factors when determining the amount of an administrative penalty pursuant to this section. This Statute is not met as evidenced by: Based on interview and clinic document review, the clinic failed to prevent a disclosure of Patient	A 017	I. Pertinent said policies include: • PPOSBC Compliance Policy CO-600 Corporate Compliance Program • PPOSBC Compliance Policy CO-1104 Patient Right to File Complaints About Use and Disclo sure of their Protected Health Information • PPOSBC Compliance Policy CO-1105 HIPAA Privacy and Information Security Training • PPOSBC Compliance Policy CO-1108 Minimum Necessary Rule for Protected Health Information • PPOSBC Compliance Policy CO-111 Protected Health Information Breach Notification • PPOSBC Compliance Policy CO-112 Sanctions for Unauthorized Uses and Disclosures of a Patient's Protected Health Information II. In addition to said above-referenced incident-specific retraining and counseling, as well as the promulgation of said above-referenced policies at PPOSBC, PPOSBC also regularly trains and educates staff on said agency policies; both at inception of staff's tenure at PPOSBC as well as throughout the agency calendar; this includes: • Protected Health Information/HIPAA in-person training at staff orientation day/hire • An additional Protected Health Information/HIPAA Online module new staff training for new staff to be completed with a set period of time immediately post orientation/hire • Proactive calendared clinic/health center Licensed Clinician trainings that also include training on Protected Health Information/HIPAA	2014 OCT 17 AM 9:54

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A 017	Continued From page 2 1's protected health information (PHI) from an unauthorized staff member. Findings: Review of the clinic's documents showed Patient 1 was at the clinic on 11/7/13. Before concluding the visit, the patient reported unauthorized access of her medical record by a current staff of the clinic (Staff 1). Patient 1 stated Staff 1 was a paternal family member to her child. Additionally, Patient 1 claimed Staff 1 shared the information after inappropriately accessing the patient's health information. Review of the clinic's investigation showed an analysis of Patient 1's electronic medical record (EMR) was done. The analysis confirmed Staff 1 accessed the patient's EMR four different times, without a need to know. During the times Staff 1 inappropriately accessed Patient 1's EMR, the progress notes of four different clinic visits were viewed. Continued review of the clinic's investigation showed an interview with Staff 1 occurred on 11/8/13. When asked, Staff 1 confirmed a familial relationship to Patient 1's child and stated it was possible the access to the patient's EMR was out of curiosity. When asked, Staff 1 confessed to having accessed the patient's EMR without a need to know. On 9/9/14 at 1020 hours, a telephone conference with the Privacy Officer occurred regarding the breach as documented.	A 017	• Proactive calendared non-licensed clinic/health center staff (e.g., Medical Assistants, reception staff) trainings that also include training on Protected Health Information • Health Center Managers proactively calendared trainings that focus on managing health center staff with respect to several matters, including Protected Health Information/HIPAA • Proactively calendared Annual All-Staff agency Training on Compliance Policies and Procedures • PPOSBC implemented automated audit software that provides information on potential unauthorized access by/disclosure to any level of agency staff, with respect to the agency Electronic Health Records system as well as related patient information systems such as those relevant to patient scheduling and administrative records. This audit software is breach detection technology that is fully integrated with our electronic health record system. On a daily basis, the breach detection technology/software analyzes access into the agency systems, thereby automatically monitoring potential unauthorized access and/or disclosures on numerous levels of the patient record such as lab results, progress notes, appointment information, and related facets • A culture that invites reporting any suspected compliance and/or privacy matters to supervisors in any department, including but not limited to PPOSBC Human Resources Department, Patient Services Department, Administration and the Compliance Department • Dedicated and consistent agency Quality Management/Quality Assurance meetings through the Patient Services Department to review and as applicable, improve the quality of agency processes • Dedicated and consistent (quarterly) agency Compliance and Enterprise Risk Management Committee to review and as applicable, improve the quality of agency processes	9.22.14

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A 017	Continued From page 3	A 017	• A dedicated Compliance agency Hotline 24 hours a day 7 days a week, 365 days a year • Suspension, Separation of Employment and/or other processes for sanctioning any staff that fails to follow said processes and trainings as described above Accordingly, as with any healthcare agency, such as hospitals, the CDPH, DHCS and other entities, PPOSBC is subject to common human errors or independent acts against established and reinforced agency policies. However, PPOSBC sets forth robust, consistent and good faith efforts to prevent and/or as applicable remediate towards optimum protection of health information for all patients. PPOSBC also makes every effort to communicate with any applicable patients at issue to assist them with any questions or concerns, including providing contact information for relevant staff such as patient services department or compliance department staff, and providing said patients with a toll-free phone number to utilize at any time. c) As noted in section (b): PPOSBC has a robust series of policies that all staff must adhere to regarding the optimum security and privacy of patient protected health information. Staff are also regularly trained and educated on said policies. I. Pertinent said policies include: • PPOSBC Compliance Policy CO-600 Corporate Compliance Program • PPOSBC Compliance Policy CO-1104 Patient Right to File Complaints About Use and Disclosure of their Protected Health Information • PPOSBC Compliance Policy CO-1105 HIPAA Privacy and Information Security Training • PPOSBC Compliance Policy CO-1108 Minimum Necessary Rule for Protected Health Information	9.22.14

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A 017	Continued From page 4	A 017	• PPOSBC Compliance Policy CO-111 Protected Health Information Breach Notification • PPOSBC Compliance Policy CO-112 Sanctions for Unauthorized Uses and Disclosures of a Patient's Protected Health Information II. In addition to the promulgation of said policies at PPOSBC, PPOSBC also regularly trains and educates on said agency policies, both at inception of staff's tenure at PPOSBC as well as throughout the agency calendar; this includes: • Protected Health Information/HIPAA in-person training at staff orientation day/hire • An additional Protected Health information/ HIPAA Online module new staff training for new staff to be completed with a set period of time immediately post-orientation/hire • Proactive calendared clinic/health center Licensed Clinician trainings that also include training on Protected Health Information/HIPAA • Proactive calendared non-licensed clinic/health center staff (e.g., Medical Assistants, reception staff) trainings that also include training on Protected Health Information • Health Center Managers proactively calendared trainings that focus on managing health center staff with respect to several matters, including Protected Health Information/HIPAA • Proactively calendared Annual All-Staff agency Training on Compliance Policies and Procedures • PPOSBC implemented automated audit software that provides information on potential unauthorized access by/disclosure to any level of agency staff, with respect to the agency Electronic Health Records system as well as related patient information systems such as those relevant to patient scheduling and administrative records. This audit software is breach detection technology that is fully integrated	9.22.14

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A 017	Continued From page 5	A 017	with our electronic health record system. On a daily basis, the breach detection technology/software analyzes access into the agency systems, thereby automatically monitoring potential unauthorized access and/or disclosures on numerous levels of the patient record such as lab results, progress notes, appointment information, and related facets • A culture that invites reporting any suspected compliance and/or privacy matters to supervisors in any department, including but not limited to PPOSBC Human Resources Department, Patient Services Department, Administration and the Compliance Department • Dedicated and consistent agency Quality Management/Quality Assurance meetings through the Patient Services Department to review and as applicable, improve the quality of agency processes • Dedicated and consistent (quarterly) agency Compliance and Enterprise Risk Management Committee to review and as applicable, improve the quality of agency processes • A dedicated Compliance agency Hotline 24 hours a day 7 days a week, 365 days a year • Suspension, Separation of Employment and/or other processes for sanctioning any staff that fails to follow said processes and trainings as described above Accordingly, as with any healthcare agency, such as hospitals, the CDPH, DHCS and other entities, PPOSBC is subject to common human errors or independent acts against established and reinforced agency policies. However, PPOSBC sets forth robust, consistent and good faith efforts to prevent and/or as applicable remediate towards optimum protection of health information for all patients. PPOSBC also makes every effort to communicate with any applicable patients at issue to assist them with any questions or concerns, including providing contact information for relevant staff such as patient services	9.22.14

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A 017	Continued From page 6	A 017	department or compliance department staff, and providing said patients with a toll-free phone number to utilize at any time. Thereby, PPOSBC submits in good faith that it is taking all measures feasible to prevent and as applicable in this matter, mitigate, reduce risk, raise quality and address any deficiencies that CPDH may nevertheless perceive. As additional measures: • PPOSBC has hired a chief Compliance Officer, chief Privacy Officer, and chief Security Officer to review PPOSBC systems for additional quality improvement as applicable. (i) One immediate result herein is the updating of the agency process to include the above-referenced robust Compliance & Enterprise Risk Management Committee. (ii) A second immediate result is an updated agency All-Staff annual training for Compliance policies and procedures that includes robust Protected Health Information/HIPAA training. (iii) Agency HIPAA Security measures have consistently also been reviewed for quality assurance; however, with said new hires' recent presence at PPOSBC, agency Security measures will also be re-reviewed for even further optimum compliance. • PPOSBC has also installed a Chief Operating Officer who regularly collaborates with the Compliance Officer, Privacy Officer and Security Officer, as well as the VP of HR, the agency Medical Director, and the Office of the CEO, to directly manage and oversee ongoing training of all agency health center staff, both licensed and non-licensed. • With said new hires, PPOSBC is also embarking on a long-term plan to continue to review all said applicable agency policies for optimum quality and compliance. • With said new hires, PPOSBC also plans for long term subject matter expertise for matters relevant to optimum protection of patient privacy and security, and compliance with regulatory and agency standards.	9.22.14

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A 017	Continued From page 7	A 017	**d) and e)** : As noted in section (c) in significant detail: PPOSBC has a robust series of policies that all staff must adhere to regarding the optimum security and privacy of patient protected health information. Staff are also regularly trained and educated on said policies. I. Pertinent said policies include: • PPOSBC Compliance Policy CO-600 Corporate Compliance Program • PPOSBC Compliance Policy CO-1104 Patient Right to File Complaints About Use and Disclosure of their Protected Health Information • PPOSBC Compliance Policy CO-1105 HIPAA Privacy and Information Security Training • PPOSBC Compliance Policy CO-1108 Minimum Necessary Rule for Protected Health Information • PPOSBC Compliance Policy CO-111 Protected Health Information Breach Notification • PPOSBC Compliance Policy CO-112 Sanctions for Unauthorized Uses and Disclosures of a Patient's Protected Health Information II. In addition to the promulgation of said policies at PPOSBC, PPOSBC also regularly trains and educates on said agency policies, both at inception of staff's tenure at PPOSBC as well as throughout the agency calendar; this includes: • Protected Health Information/HIPAA in-person training at staff orientation day/hire • An additional Protected Health Information/ HIPAA Online module new staff training for new staff to be completed with a set period of time immediately post-orientation/hire • Proactive calendared clinic/health center Licensed Clinician trainings that also include training on Protected Health Information/HIPAA	9.22.14

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A 017	Continued From page 8	A 017	• Proactively calendared Annual All-Staff agency Training on Compliance Policies and Procedures • PPOSBC implemented automated audit software that provides information on potential unauthorized access by/disclosure to any level of agency staff, with respect to the agency Electronic Health Records system as well as related patient information systems such as those relevant to patient scheduling and administrative records. This audit software is breach detection technology that is fully integrated with our electronic health record system. On a daily basis, the breach detection technology/software analyzes access into the agency systems, thereby automatically monitoring potential unauthorized access and/or disclosures on numerous levels of the patient record such as lab results, progress notes, appointment information, and related facets • A culture that invites reporting any suspected compliance and/or privacy matters to supervisors in any department, including but not limited to PPOSBC Human Resources Department, Patient Services Department, Administration and the Compliance Department • Dedicated and consistent agency Quality Management/Quality Assurance meetings through the Patient Services Department to review and as applicable, improve the quality of agency processes • Dedicated and consistent (quarterly) agency Compliance and Enterprise Risk Management Committee to review and as applicable, improve the quality of agency processes • A dedicated Compliance agency Hotline 24 hours a day 7 days a week, 365 days a year • Suspension, Separation of Employment and/or other processes for sanctioning any staff that fails to follow said processes and trainings as described above	9.22.14

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A 017	Continued From page 9	A 017	Accordingly, as with any healthcare agency, such as hospitals, the CDPH, DHCS and other entities, PPOSBC is subject to common human errors or independent acts against established and reinforced agency policies. However, PPOSBC sets forth robust, consistent and good faith efforts to prevent and/or as applicable remediate towards optimum protection of health information for all patients. PPOSBC also makes every effort to communicate with any applicable patients at issue to assist them with any questions or concerns, including providing contact information for relevant staff such as patient services department or compliance department staff, and providing said patients with a toll-free phone number to utilize at any time. Thereby, PPOSBC submits in good faith that it is taking all measures feasible to prevent and as applicable in this matter, mitigate, reduce risk, raise quality and address any deficiencies that CPDH may nevertheless perceive. As additional measures: • PPOSBC has hired a chief Compliance Officer, chief Privacy Officer, and chief Security Officer to review PPOSBC systems for additional quality improvement as applicable. (i) One immediate result herein is the updating of the agency process to include the above-referenced robust Compliance & Enterprise Risk Management Committee. (ii) A second immediate result is an updated agency All-Staff annual training for Compliance policies and procedures that includes robust Protected Health Information/HIPAA training. (iii) Agency HIPAA Security measures have consistently also been reviewed for quality assurance; however, with said new hires' recent presence at PPOSBC, agency Security measures will also be re-reviewed for even further optimum compliance • With said new hires, PPOSBC is also embarking on a long-term plan to continue to review all said applicable	9.22.14

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A 017	Continued From page 10	A 017	agency policies for optimum quality and compliance. • With said new hires, PPOSBC also plans for long term subject matter expertise for matters relevant to optimum protection of patient privacy and security, and compliance with regulatory and agency standards. **Accordingly, and since the incident at issue is dated during calendar year 2013, PPOSBC submits in good faith that as of said current date of September 2014, it has already implemented and integrated a variety of applicable corrective actions to address the incident at issue. Any additional measures further outlined herein serve to also illustrate PPOSBC's commitment to overall continued long-term optimum management of relevant processes, and the privacy and security of protected health information for its valued patient population.** **PPOSBC takes the optimal customer service, and privacy and security of its patients very seriously and will continue to do so through all efforts listed herein; and any additional quality improvement measures that its quality assurance, risk management and compliance processes illuminate.** 2014 OCT 17 AM 9 55	9.22.14

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A 000	Initial Comments AMENDED The following reflects the findings of the California Department of Public Health during the investigation of COMPLAINT NUMBER: CA00397908. Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 1835, HFEN. Findings for Complaint Number: CA00397908. The complaint allegation(s) were substantiated and regulatory violations written at A001 and A017.	A 000	**PPOSBC Response to Amended CMS 2567 for COMPLAINT NUMBER CA00397908 :** *.* PPOSBC former Compliance Officer during the interval in question is no longer with PPOSBC. However, senior management at PPOSBC including the PPOSBC CEO, and COO are aware of the standard processes engaged in by said former Compliance Officer including but not limited to said Compliance Officer's adherence to PPOSBC policies regarding reporting applicable incidents such as that described herein, and direct communication(s) with applicable affected PPOSBC patients. Therefore, the following said PPOSBC response is in good faith with respect to said former Compliance Officer's tenure at PPOSBC.* ***Amended CMS 2567 form CA00397908 Findings #1- #8 (inadvertent incidents):*** a) Patients at issue were contacted by PPOSBC's compliance officer or his/her designee, informing each said patient of the respective incident, of PPOSBC policies on the same and that PPOSBC would thoroughly investigate said incident and remedy as applicable. Each said patient was provided full contact information at PPOSBC for any additional questions or follow up at patient's discretion. Given each said incident was varying in nature, each PPOSBC staff involved in each said incident was counseled and retrained relevant to the incident at issue; this counseling and retraining included retraining on the privacy and security of protected health information and ensuring agency policies are conformed to, so as to ensure optimal and maximum protection of patient medical information and data privacy and security. b) Given each said incident was varying in nature, each PPOSBC staff involved in each said incident was counseled and retrained relevant to the incident at issue;	9.22.14
A 001	Informed Medical Breach Health and Safety Code Section 1280.15 (b)(2), " A clinic, health facility, agency, or hospice shall also report any unlawful or unauthorized access to, or use or disclosure of, a patient's medical information to the affected patient or the patient's representative at the last known address, no later than five business days after the unlawful or unauthorized access, use, or disclosure has been detected by the clinic, health facility, agency, or hospice." The CDPH verified that the facility informed the affected patient(s) or the patient's representative(s) of the unlawful or unauthorized access, use or disclosure of the patient's medical information.	A 001		

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Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE President/CEO — (X6) DATE 10/15/14

STATE FORM 10/20/14 Acceptable POC - HFEN1835. 6899 CV0D11 If continuation sheet 1

PL

California Department of Public Health

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	CA060001620	A. BUILDING: _____ B. WING _____	C 09/09/2014

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A 001	Continued From page 1	A 001	however, this counseling and retraining collectively included retraining on the privacy and security of protected health information and ensuring agency policies are conformed to, so as to ensure optimal and maximum protection of patient medical information and data privacy and security. Additionally, PPOSBC has a robust series of policies that all staff must adhere to regarding the optimum security and privacy of patient protected health information. Staff are also regularly trained and educated on said policies. I. Pertinent said policies include: • PPOSBC Compliance Policy CO-600 Corporate Compliance Program • PPOSBC Compliance Policy CO-1104 Patient Right to File Complaints About Use and Disclosure of their Protected Health Information • PPOSBC Compliance Policy CO-1105 HIPAA Privacy and Information Security Training • PPOSBC Compliance Policy CO-1108 Minimum Necessary Rule for Protected Health Information • PPOSBC Compliance Policy CO-111 Protected Health Information Breach Notification • PPOSBC Compliance Policy CO-112 Sanctions for Unauthorized Uses and Disclosures of a Patient's Protected Health Information II. In addition to said above-referenced incident-specific retraining and counseling, as well as the promulgation of said above-referenced policies at PPOSBC, PPOSBC also regularly trains and educates staff on said agency policies; both at inception of staff's tenure at PPOSBC as well as throughout the agency calendar; this includes: • Protected Health Information/HIPAA in-person training at staff orientation day/hire	9.22.14
A 017	1280.15(a) Health & Safety Code 1280 (a) A clinic, health facility, home health agency, or hospice licensed pursuant to Section 1204, 1250, 1725, or 1745 shall prevent unlawful or unauthorized access to, and use or disclosure of, patients' medical information, as defined in subdivision (g) of Section 56.05 of the Civil Code and consistent with Section 130203. The department, after investigation, may assess an administrative penalty for a violation of this section of up to twenty-five thousand dollars ($25,000) per patient whose medical information was unlawfully or without authorization accessed, used, or disclosed, and up to seventeen thousand five hundred dollars ($17,500) per subsequent occurrence of unlawful or unauthorized access, use, or disclosure of that patients' medical information. For purposes of the investigation, the department shall consider the clinic's, health facility's, agency's, or hospice's history of compliance with this section and other related state and federal statutes and regulations, the extent to which the facility detected violations and took preventative action to immediately correct and prevent past violations from recurring, and factors outside its control that restricted the facility's ability to comply with this section. The department shall have full discretion to consider all factors when determining the amount of an administrative penalty pursuant to this section. This Statute is not met as evidenced by: Based on interview and facility document review, the facility failed to prevent the disclosure of eight	A 017		

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A 017	Continued From page 2 patients (Patients A, B, C, D, E, F, G and H) protected health information (PHI) to unauthorized individuals. Findings: 1. Review of the clinic documentation shows a breach of Patient A's PHI occurred at the Anaheim Health Center on 12/5/12. The clinic staff were made aware the incorrect patient was handed a urine cup labeled with Patient A's PHI on it. Patient A's disclosed PHI included initial of first name, last name and date of birth (DOB). 2. On 1/2/13, the Department was notified a breach of Patient B's PHI occurred at the Mission Viejo Health Center on 12/31/12. A clinic Physician's Assistant inadvertently handed a prescription intended for Patient B to another patient. Patient B's disclosed PHI included first and last name, DOB, address and phone number. 3. Review of the clinic's report showed a breach of Patient C's PHI occurred on 1/11/13, at the Westminster Health Center. The investigation showed a patient checked in and stated her first name. An Administrative staff asked if the patient's last name began with a certain letter in the alphabet to which the patient agreed. The Administrative staff typed and printed labels which were affixed to the paperwork and handed the paperwork to the patient to fill out. The patient took the paperwork to complete and went back to the administrative staff and stated the last name on the labels were incorrect.	A 017	• An **additional** Protected Health Information/HIPAA Online module new staff training for **new staff** to be completed with a set period of time immediately post-orientation/hire • Proactive calendared clinic/health center Licensed Clinician trainings that also include training on Protected Health Information/HIPAA • Proactive calendared non-licensed clinic/health center staff (e.g., Medical Assistants, reception staff) trainings that also include training on Protected Health Information • Health Center Managers proactively calendared trainings that focus on managing health center staff with respect to several matters, including Protected Health Information/HIPAA • Proactively calendared Annual **All-Staff** agency Training on Compliance Policies and Procedures • PPOSBC implemented automated audit software that provides information on potential unauthorized access by/disclosure to any level of agency staff, with respect to the agency Electronic Health Records system as well as related patient information systems such as those relevant to patient scheduling and administrative records. This audit software is breach detection technology that is fully integrated with our electronic health record system. On a daily basis, the breach detection technology/software analyzes access into the agency systems, thereby automatically monitoring potential unauthorized access and/or disclosures on numerous levels of the patient record such as lab results, progress notes, appointment information, and related facets • A culture that invites reporting any suspected compliance and/or privacy matters to supervisors in any department, including but not limited to PPOSBC Human Resources Department, Patient Services Department, Administration and the Compliance Department • Dedicated and consistent agency Quality Management/Quality Assurance meetings through	9.22.14

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A 017	Continued From page 3 Patient C's disclosed PHI included first and last name, DOB and medical record number. 4. Review of the clinic's documentation showed, on 3/5/13, clinic staff became aware a breach of Patient D's PHI occurred at the Santa Ana Health Center on 2/21/13. On 2/21/13, a new patient (Patient D) checked in and staff made a Family Pact Identification Card for Patient D. Just after Patient D checked in, an established patient checked in and handed their Family Pact Card to the staff. When finished checking in, staff handed the established patient the newly made Family Pact Identification Card for Patient D. Patient D's disclosed PHI included name, DOB and Family Pact Identification Card number. 5. Review of the clinic's reported incident showed a breach of Patient E's PHI occurred at the Anaheim Health Center on 3/21/13. Patient E had already checked in at the clinic when a new walk-in patient checked in shortly afterwards. The new patient completed all the paperwork and a Family PACT Identification Card was made for this patient. However, after about 15 minutes of waiting, the new patient could not wait any longer. A staff member handed the new patient what was thought to be the Family PACT Identification Card made for the new patient. Later, the staff member realized Patient E's Family PACT Identification Card was inadvertently given to the new patient. Patient E's disclosed PHI included name, DOB and the Family PACT Identification Card number. 6. Review of the Anaheim Health Center's documentation showed on 4/30/13, they discovered a breach involving Patient F occurred	A 017	the Patient Services Department to review and as applicable, improve the quality of agency processes • Dedicated and consistent (quarterly) agency Compliance and Enterprise Risk Management Committee to review and as applicable, improve the quality of agency processes • A dedicated Compliance agency Hotline 24 hours a day 7 days a week, 365 days a year • Suspension, Separation of Employment and/or other processes for sanctioning any staff that fails to follow said processes and trainings as described above Accordingly, as with any healthcare agency, such as hospitals, the CDPH, DHCS and other entities, PPOSBC is subject to common human errors or independent acts against established and reinforced agency policies. However, PPOSBC sets forth robust, consistent and good faith efforts to prevent and/or as applicable remediate towards optimum protection of health information for all patients. PPOSBC also makes every effort to communicate with any applicable patients at issue to assist them with any questions or concerns, including providing contact information for relevant staff such as patient services department or compliance department staff, and providing said patients with a toll-free phone number to utilize at any time. c) As noted in section (b): PPOSBC has a robust series of policies that all staff must adhere to regarding the optimum security and privacy of patient protected health information. Staff are also regularly trained and educated on said policies. I. Pertinent said policies include: • PPOSBC Compliance Policy CO-600 Corporate Compliance Program	9.22.14

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A 017	Continued From page 4 on 9/29/12. The investigation showed when a returning patient came into the center on 4/30/13, the patient's card with NexPlan on it had Patient F's name on it. It was discovered a Physician Assistant (PA) saw both the returning patient and Patient F on 9/29/12. On 9/29/12 while the PA was preparing NexPlan for the returning patient, Patient F's chart was open and the PA inadvertently documented Patient F's name on the incorrect card. Patient F's disclosed PHI included name only. 7. Review of a Costa Mesa Health Center report showed on 6/7/13 a breach of Patient G's PHI occurred. On 6/7/13, a patient came into the clinic requesting a copy of their medical record. A staff printed the medical record and gave it to the patient. Later the patient called to inform the staff the last page in the medical record packet belonged to another patient. Patient G's disclosed PHI included name, DOB, address, phone number, last four digits of the social security number and a laboratory requisition. 8. Review of a report regarding the Costa Mesa Health Center showed a patient who was at the clinic on 6/6/13, called on 6/7/13 to inform staff she received notification of being Web enabled to the Patient Portal online. However, when the patient logged on the information belonged to Patient H. Investigation showed this patient and Patient H were seen at the clinic at approximately the same time on 6/6/13 and a staff inadvertently put Patient H's information into this other patient's medical record. Patient H's disclosed PHI included name and	A 017	• PPOSBC Compliance Policy CO-1104 Patient Right to File Complaints About Use and Disclosure of their Protected Health Information • PPOSBC Compliance Policy CO-1105 HIPAA Privacy and Information Security Training • PPOSBC Compliance Policy CO-1108 Minimum Necessary Rule for Protected Health Information • PPOSBC Compliance Policy CO-111 Protected Health Information Breach Notification • PPOSBC Compliance Policy CO-112 Sanctions for Unauthorized Uses and Disclosures of a Patient's Protected Health Information II. In addition to the promulgation of said policies at PPOSBC, PPOSBC also regularly trains and educates on said agency policies, both at inception of staff's tenure at PPOSBC as well as throughout the agency calendar; this includes: • Protected Health Information/HIPAA in-person training at staff orientation day/hire • An **additional** Protected Health Information/HIPAA Online module **new staff** training for new staff to be completed with a set period of time immediately post-orientation/hire • Proactive calendared clinic/health center Licensed Clinician trainings that also include training on Protected Health Information/HIPAA • Proactive calendared non-licensed clinic/health center staff (e.g., Medical Assistants, reception staff) trainings that also include training on Protected Health Information • Health Center Managers proactively calendared trainings that focus on managing health center staff with respect to several matters, including Protected Health Information/HIPAA • Proactively calendared Annual **All-Staff** agency Training on Compliance Policies and Procedures • PPOSBC implemented automated audit software	9.22.14

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A 017	Continued From page 5 year of birth. On 9/9/14 at 1020 hours, a telephone conference with the Privacy Officer occurred regarding the breaches as documented.	A 017	that provides information on potential unauthorized access by/disclosure to any level of agency staff, with respect to the agency Electronic Health Records system as well as related patient information systems such as those relevant to patient scheduling and administrative records. This audit software is breach detection technology that is fully integrated with our electronic health record system. On a daily basis, the breach detection technology/software analyzes access into the agency systems, thereby automatically monitoring potential unauthorized access and/or disclosures on numerous levels of the patient record such as lab results, progress notes, appointment information, and related facets • A culture that invites reporting any suspected compliance and/or privacy matters to supervisors in any department, including but not limited to PPOSBC Human Resources Department, Patient Services Department, Administration and the Compliance Department • Dedicated and consistent agency Quality Management/Quality Assurance meetings through the Patient Services Department to review and as applicable, improve the quality of agency processes • Dedicated and consistent (quarterly) agency Compliance and Enterprise Risk Management Committee to review and as applicable, improve the quality of agency processes • A dedicated Compliance agency Hotline 24 hours a day 7 days a week, 365 days a year • Suspension, Separation of Employment and/or other processes for sanctioning any staff that fails to follow said processes and trainings as described above Accordingly, as with any healthcare agency, such as hospitals, the CDPH, DHCS and other entities, PPOSBC is subject to common human errors or independent acts against established and reinforced agency policies.However, PPOSBC sets forth robust	9.22.14

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A 017	Continued From page 6	A 017	consistent and good faith efforts to prevent and/or as applicable remediate towards optimum protection of health information for all patients. PPOSBC also makes every effort to communicate with any applicable patients at issue to assist them with any questions or concerns, including providing contact information for relevant staff such as patient services department or compliance department staff, and providing said patients with a toll-free phone number to utilize at any time. Thereby, PPOSBC submits in good faith that it is taking all measures feasible to prevent and as applicable in this matter, mitigate, reduce risk, raise quality and address any deficiencies that CPDH may nevertheless perceive. As additional measures: • PPOSBC has hired a chief Compliance Officer, chief Privacy Officer, and chief Security Officer to review PPOSBC systems for additional quality improvement as applicable. (i) One immediate result herein is the updating of the agency process to include the above-referenced robust Compliance & Enterprise Risk Management Committee. (ii) A second immediate result is an updated agency All-Staff annual training for Compliance policies and procedures that includes robust Protected Health Information/HIPAA training. (iii) Agency HIPAA Security measures have consistently also been reviewed for quality assurance; however, with said new hires' recent presence at PPOSBC, agency Security measures will also be re-reviewed for even further optimum compliance. • PPOSBC has also installed a Chief Operating Officer, who regularly collaborates with the Compliance Officer, Privacy Officer and Security Officer, as well as the VP of HR, the agency Medical Director, and the Office of the CEO, to directly manage and oversee ongoing training of all agency health center staff, both licensed and non-licensed.	9.22.14

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A 017	Continued From page 7	A 017	• With said new hires, PPOSBC is also embarking on a long-term plan to continue to review all said applicable agency policies for optimum quality and compliance. • With said new hires, PPOSBC also plans for long term subject matter expertise for matters relevant to optimum protection of patient privacy and security, and compliance with regulatory and agency standards. **d) and e)** : As noted in section (c) in significant detail: PPOSBC has a robust series of policies that all staff must adhere to regarding the optimum security and privacy of patient protected health information. Staff are also regularly trained and educated on said policies. I. Pertinent said policies include: • PPOSBC Compliance Policy CO-600 Corporate Compliance Program • PPOSBC Compliance Policy CO-1104 Patient Right to File Complaints About Use and Disclosure of their Protected Health Information • PPOSBC Compliance Policy CO-1105 HIPAA Privacy and Information Security Training • PPOSBC Compliance Policy CO-1108 Minimum Necessary Rule for Protected Health Information • PPOSBC Compliance Policy CO-111 Protected Health Information Breach Notification • PPOSBC Compliance Policy CO-112 Sanctions for Unauthorized Uses and Disclosures of a Patient's Protected Health Information II. In addition to the promulgation of said policies at PPOSBC, PPOSBC also regularly trains and educates on said agency policies, both at inception of staff's tenure at PPOSBC as well as throughout the agency calendar; this includes: • Protected Health Information/HIPAA in-person	9.22.14 9.22.14

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A 017	Continued From page 8	A 017	training at staff orientation day/hire • An **additional** Protected Health Information/HIPAA Online module **new staff** training for new staff to be completed with a set period of time immediately post-orientation/hire • Proactive calendared clinic/health center Licensed Clinician trainings that also include training on Protected Health Information/HIPAA • Proactive calendared non-licensed clinic/health center staff (e.g., Medical Assistants, reception staff) trainings that also include training on Protected Health Information • Health Center Managers proactively calendared trainings that focus on managing health center staff with respect to several matters, including Protected Health Information/HIPAA • Proactively calendared Annual **All-Staff** agency Training on Compliance Policies and Procedures • PPOSBC implemented automated audit software that provides information on potential unauthorized access by/disclosure to any level of agency staff, with respect to the agency Electronic Health Records system as well as related patient information systems such as those relevant to patient scheduling and administrative records. This audit software is breach detection technology that is fully integrated with our electronic health record system. On a daily basis, the breach detection technology/software analyzes access into the agency systems, thereby automatically monitoring potential unauthorized access and/or disclosures on numerous levels of the patient record such as lab results, progress notes, appointment information, and related facets • A culture that invites reporting any suspected compliance and/or privacy matters to supervisors in any department, including but not limited to PPOSBC Human Resources Department, Patient Services Department, Administration and the Compliance Department	9.22.14

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A 017	Continued From page 9	A 017	• Dedicated and consistent agency Quality Management/Quality Assurance meetings through the Patient Services Department to review and as applicable, improve the quality of agency processes • Dedicated and consistent (quarterly) agency Compliance and Enterprise Risk Management Committee to review and as applicable, improve the quality of agency processes • A dedicated Compliance agency Hotline 24 hours a day 7 days a week, 365 days a year • Suspension, Separation of Employment and/or other processes for sanctioning any staff that fails to follow said processes and trainings as described above Accordingly, as with any healthcare agency, such as hospitals, the CDPH, DHCS and other entities, PPOSBC is subject to common human errors or independent acts against established and reinforced agency policies. However, PPOSBC sets forth robust, consistent and good faith efforts to prevent and/or as applicable remediate towards optimum protection of health information for all patients. PPOSBC also makes every effort to communicate with any applicable patients at issue to assist them with any questions or concerns, including providing contact information for relevant staff such as patient services department or compliance department staff, and providing said patients with a toll-free phone number to utilize at any time. Thereby, PPOSBC submits in good faith that it is taking all measures feasible to prevent and as applicable in this matter, mitigate, reduce risk, raise quality and address any deficiencies that CPDH may nevertheless perceive. As additional measures: • PPOSBC has hired a chief Compliance Officer, chief Privacy Officer, and chief Security Office to review	9.22.14

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A 017	Continued From page 10	A 017	PPOSBC systems for additional quality improvement as applicable. (i) One immediate result herein is the updating of the agency process to include the above-referenced robust Compliance & Enterprise Risk Management Committee. (ii) A second immediate result is an updated agency All-Staff annual training for Compliance policies and procedures that includes robust Protected Health Information/HIPAA training. (iii) Agency HIPAA Security measures have consistently also been reviewed for quality assurance; however, with said new hires' recent presence at PPOSBC, agency Security measures will also be re-reviewed for even further optimum compliance • With said new hires, PPOSBC is also embarking on a long-term plan to continue to review all said applicable agency policies for optimum quality and compliance. • With said new hires, PPOSBC also plans for long term subject matter expertise for matters relevant to optimum protection of patient privacy and security, and compliance with regulatory and agency standards. **Accordingly, and since the incidents at issue span calendar years 2012 and 2013, PPOSBC submits in good faith that as of said current date of September 2014, it has already implemented and integrated a variety of applicable corrective actions to address the incidents at issue. Any additional measures further outlined herein serve to also illustrate PPOSBC's commitment to overall continued long-term optimum management of relevant processes, and the privacy and security of protected health information for its valued patient population.** **PPOSBC takes the optimal customer service, and privacy and security of its patients very seriously and will continue to do so through all efforts listed herein; and any additional quality improvement measures that its quality assurance, risk management and compliance processes illuminate.**	9.22.14

2014 OCT 17 AM 9 27

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA060001620	A. BUILDING: _____ B. WING _____	C 07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD/ORANGE & SAN BEI	700 S TUSTIN STREET ORANGE, CA 92863

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A 000	HSC Initial Comments The following reflects the findings of the California Department of Public Health during a complaint investigation for COMPLAINT NO: CA00352542. Inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 28950, HFEN. Deficencies were found and written at H&S 1293.2. GLOSSARY OF ABBREVIATION: CDPH - California Department of Public Health	A 000	**Response to A001 -** We will work to make every attempt to provide records within a timely manner. **Corrective action for identified patients -** We cannot change the charting or medical doctor assessment of EBL for the patients identified in this report or any additional past patients. We did intervene with these physicians and discussed clear documentation of EBL in the future. **Response to D183-1 -** Our recovery room nurses are trained to measure EBL on sanitary pads, and a pictorial of sanitary pad soaking is placed on the wall in the recovery room bathroom. As a result of these incidents, a direct intervention with the physician occurred in which he was advised to more closely monitor EBL and was limited in gestational age in which he may perform procedures. In addition, an in-service has been held with the staff and MDs on September 26, 2013 that reviewed modes of estimating EBL, including weighing chucks and measuring suction canister volume. Training components included reference to visual aids, review of PPOSBC protocols, and practice in calculating EBL to better support accurate EBL documentation	2013 SEP 26 PM 12 15
A 001	HSC 1293.2. H & S Code 1293.2.(a) 1293.2. It is a misdemeanor for any person to do any of the following: (a) Willfully prevent, interfere with, or attempt to impede in any way the work of any duly authorized representative of the state department in the lawful enforcement of this chapter. This Statute is not met as evidenced by: Based on interview, the facility failed to provide access to medical records, as required by law, for the CDPH representative. This has the potential to impede a medical investigation. Findings: On 4/29/13 at 1420 hours, a visit was made to the	A 001		

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Assistant 9/26/13

Accepted 10-3-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 001	Continued From page 1 facility to begin a complaint investigation. Upon arrival, the Facility Manager was informed a complaint investigation was being conducted, official state identification was provided and a request for a tour of the facility was made. The Facility Manager provided a tour after calling the CDPH office to verify the identity of the surveyor. At 1500 hours, the Facility Manager was interviewed and was asked for access to the medical records to continue the investigation. The manager left the room and returned a few minutes later. The manager stated the CEO had been called and would not permit access to the medical records. The manager stated a written request for patient records from the CDPH could be made and medical information would then be sent to the department. At 1530 hours, a copy of the Health and Safety Code 1293.2 was provided to the Facility Manager. The Facility Manager still refused access to the medical records.	A 001	During the past year, we have also initiated a more vigilant incident monitoring program through our Quality Management Department to identify areas for potential improvement in care and documentation. In addition to documenting quality improvement activities, detailed summaries of all adverse events occurring in the health centers are reported to Planned Parenthood Federation of America (PPFA). After this intervention, and routinely thereafter, the Director of Quality Management and Medical Director will complete a chart audit using PPFA-approved audit tools for evaluating surgical abortion procedures which includes the assessment of documented EBL estimations. In addition to a review of medical records, we will also utilize the PPFA-approved observation tool to assess adherence to PPOSBC protocols for surgical abortion procedures. The chart audit and observations will be performed by our Director of Quality Management and supervised by the Medical Director. Subsequent reviews will consist of an annual comprehensive program review of surgical abortion procedures. This review has been added to the Annual Quality Management calendar of activities and is scheduled for February, 2014. In addition, we are currently redesigning our surgical abortion progress note in our electronic medical record to make it easier to document EBL and track complications. This will be completed in September 2013.	2013 SEP 25 PM 12 15
D 183	T22 DIV5 CH7 ART6-75055(f) Unit Patient Health Records (f) Patients' health records shall be current and kept in detail consistent with good medical and professional practice and shall describe the services provided to each patient. All entries shall be dated and be authenticated with the name, professional title, and classification of the person making the entry. This Statute is not met as evidenced by: Based on health record review and interview, the	D 183		

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D 183	Continued From page 2 clinic failed to document accurate blood loss using professional practices for two of five sampled patients (Patients 1 and 2). The estimated blood loss (EBL) for Patient 1 was documented as a total of 215 ml (milliliters). The patient had a significant drop in her hemoglobin from 13.8 to 8.6, indicating a higher loss of blood. Patient 2 had a drop of her hemoglobin from 11.8 to 9.4; and was documented as having heavy bleeding. Physician 2 estimated Patient 2's blood loss as less than 15 ml. This has the potential for the patients' physical assessments to be incorrect which can lead to complications from blood loss. Findings: 1. Health record review for Patient 1 was initiated on 5/7/13. Review of the Progress Notes dated 2/22/13, showed at 1140 hours, Patient 1's hemoglobin level prior to her surgical procedure was 13.8 gm/dl (grams per deciliter) (normal 12-14 gm/dl). The procedure was initiated at 1331 hours. At the end of the procedure, the physician documented an EBL of 15 ml. Patient 1 was transferred to the recovery room at 1353 hours. The progress notes show an EBL of 200 ml and a hemoglobin of 11 gm/dl (a drop of 2.8) while in the recovery room. At 1417 hours, Patient 1 was transferred back to the procedure room for active bleeding. The documentation shows at 1743 hours, the indwelling catheter was removed and Patient 1 had "copious vaginal bleeding." The hemoglobin was re-measured at 8.6 gm/dl (a total drop of 5.2 gm/dl). Patient 1 was emergently transported to an acute facility for evaluation and treatment. An interview with the Medical Director was initiated on 7/11/13 at 1000 hours. The Medical	D 183	**Response to D183-2-** Our recovery room nurses are trained to measure EBL on sanitary pads, and a pictorial of sanitary pad soaking is placed on the wall in the recovery room bathroom. As a result of these incidents, a direct intervention with the physician occurred in which he was advised to more closely monitor EBL. This physician has now retired and is no longer working for PPOSBC. In addition, an in-service was held with the staff and MDs on September 26, 2013 that reviewed modes of estimating EBL, including weighing chucks and measuring suction canister volume. Recovery room staff will be empowered to quantify EBL in their notes based on their training. Of note, enhanced use of the electronic medical record system will better facilitate documentation of EBL in the patient's record. During the past year, we have also initiated a more vigilant incident monitoring program through our Quality Management Department to identify areas for potential improvement in care and documentation. After this intervention, we will complete a chart audit to assess EBL estimations going forward. The chart audit will be performed by our Director of Quality Management and supervised by the Medical Director. As noted in PPOSBC's Quality Management Plan, all audit results will be shared with the Quality Management Committee. Quality Improvement activities will be implemented as needed to address deficiencies and strengths identified during the review.	2013 SEP 26 PM 12 15

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D 183	Continued From page 3 Director stated a drop in the hemoglobin by one point usually means a loss of 300 ml of blood (a 5.2 point drop x 300 ml = 1560 ml blood loss). An interview with Physician 1 was initiated on 7/11/13 at 1130 hours. Physician 1 was asked about the EBL. He stated the EBL is usually done by a pad count and the documented estimate on the progress note was approximate. Documentation of a pad count was not found in the progress notes. 2. Health record review for Patient 2 was initiated on 5/7/13. Review of the Progress Notes dated 3/9/13, showed Patient 2's pre procedure hemoglobin level was 11.8 gm/dl on 3/8/13. The documentation shows the procedure was initiated on 3/9/13 at 1118 hours and completed at 1133 hours. Physician 2 documented the EBL was less than 15 ml. At 1210 hours, the documentation shows Patient 2 passed a large blood clot and is having active bleeding. Patient 2 was discharged from the facility at 1351 hours.	D 183	**Monitoring** - Per PPOSBC's Quality Management Plan, all quality activities and corrective action steps will be formally documented and managed by the Director of Quality Management. The Corrective Action Plan will be signed by the Medical Director and Chief Administrative Officer once completed.	
	At 1430 hours, Patient 2 returned to the clinic complaining of having heavy bleeding. The hemoglobin was 9.4 gm/dl (a 2.4 gm/dl drop). An interview with the Medical Director was initiated on 7/11/13 at 1000 hours. The Medical Director stated a drop in the hemoglobin by one point usually means a loss of 300 ml of blood (2.4 point drop x 300 ml = 720 ml blood loss).			

California Department of Public Health

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A 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of COMPLAINT NUMBER: CA00334630. Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 1835, HFEN. Findings for Complaint Number CA00334630: The complaint allegation(s) were substantiated and regulatory violations written at A001 and A017.	A 000	**Complaint Number CA00334630** a) Corrective Actions accomplished for the patients identified to have been affected are as follows: **1. Mission Viejo Health Center** Letters sent to Patients A, B and F notifying them of an unintentional breach of their personal information which included their name, date of last menstrual period, size of family, income and the internal medical record number. Letter sent to Patient C notifying her of an unintentional breach of her personal information which included her name.	3/19/12 3/19/12
A 001	Informed Medical Breach Health and Safety Code Section 1280.15 (b)(2), " A clinic, health facility, agency, or hospice shall also report any unlawful or unauthorized access to, or use or disclosure of, a patient's medical information to the affected patient or the patient's representative at the last known address, no later than five business days after the unlawful or unauthorized access, use, or disclosure has been detected by the clinic, health facility, agency, or hospice." The CDPH verified that the facility informed the affected patient(s) or the patient's representative(s) of the unlawful or unauthorized access, use or disclosure of the patient's medical information.	A 001	Letter sent to Patient D notifying her of an unintentional breach of her personal information which included her name, date of birth and date of last menstrual period. Letter sent to Patient E notifying her of an unintentional breach of her personal information which included her name, date of birth, phone number, social security number, name of her insurance company and the insurance identification number. Provided all patients resources on how to contact our office for additional assistance.	3/19/12 3/19/12

Licensing and Certification Division

Pat Velting Pat Velting — Operations Manager for CQRM — 1/25/13

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

1/29/13 - Accepted - LB 385 HFEN

California Department of Public Health

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A 017	Continued From page 1	A 017	a) Corrective Actions Continued	
A 017	1280.15(a) Health & Safety Code 1280 (a) A clinic, health facility, home health agency, or hospice licensed pursuant to Section 1204, 1250, 1725, or 1745 shall prevent unlawful or unauthorized access to, and use or disclosure of, patients' medical information, as defined in subdivision (g) of Section 56.05 of the Civil Code and consistent with Section 130203. The department, after investigation, may assess an administrative penalty for a violation of this section of up to twenty-five thousand dollars ($25,000) per patient whose medical information was unlawfully or without authorization accessed, used, or disclosed, and up to seventeen thousand five hundred dollars ($17,500) per subsequent occurrence of unlawful or unauthorized access, use, or disclosure of that patients' medical information. For purposes of the investigation, the department shall consider the clinic's, health facility's, agency's, or hospice's history of compliance with this section and other related state and federal statutes and regulations, the extent to which the facility detected violations and took preventative action to immediately correct and prevent past violations from recurring, and factors outside its control that restricted the facility's ability to comply with this section. The department shall have full discretion to consider all factors when determining the amount of an administrative penalty pursuant to this section. This Statute is not met as evidenced by: Based on interview and hospital document review, the facility failed to prevent the disclosure of 11 patients' protected health information (PHI) to unauthorized individuals (Patients A, B, C, D, E, F, G, H, I, J and K).	A 017	**2. Costa Mesa Health Center** Letter sent to Patient H notifying them of an unintentional breach of their name, date of birth, the health center's internal chart number and their Health Access Program number. Also provided patient resources on how to contact our office for additional assistance. **3. Anaheim Health Center** Letter sent to Patient J notifying her of an unintentional breach of her first initial, last name and date of birth. Also provided patient resources on how to contact our office for additional assistance. **4. Orange Administration Office** Letter sent to Patient G notifying her of an unintentional breach of her name, date of birth, the health center's internal medical record number, income and phone number. Also provided patient resources on how to contact our office for additional assistance. **5. Santa Ana Health Center** Letter sent to Patient I notifying her of an unintentional breach of her name, date of birth and her Family Pact card identification number. Also provided patient resources on how to contact our office for additional assistance. **6. Westminster Health Center** Letter sent to Patient K notifying her of an unintentional breach of her name and test results. Also provided patient resources on how to contact our office for additional assistance.	6/21/12 10/19/12 5/3/12 8/2/12 11/9/12

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A 017	Continued From page 2 Findings: 1. Review of Mission Viejo Health Center documentation showed a breach of PHI involving six patients. On 3/14/12, a back office Medical Assistant was handed four pieces of paper, folded in half, and dated 3/13/12, by a patient. The papers contained the hand written PHI of Patients A, B, C, D, E, and F. Further review of the health center's investigation showed on 3/13/12, a call center representative was taking the four pieces of paper with the six patient's PHI to the shredder. However, the call center representative had to go to the bathroom. The patient, who returned the papers stated they were found on top of the paper towel dispenser in the bathroom. The disclosed PHI belonging to Patients A, B, C, D, E and F are as follows: Patients A, B, and F's name, date of last menstrual period, size of family, income and the internal medical record number were disclosed. Patient C's name was disclosed. Patient D's name, date of birth and date of last menstrual period were disclosed. Patient E's name, date of birth, phone number, social security number and the name of their insurance company and the insurance identification number were disclosed. 2. Review of Costa Mesa Health Center's	A 017	b) How other patients having the potential to be affected by the same deficient practice can be identified and what corrective actions will be taken. In the above findings members of our staff neglected to follow our procedure for verifying the identity of a patient before giving them a urine cup, supply or prescription. We continue to education our staff on patient verification before distribution of supplies or paperwork. We also stress the importance of verifying FAX numbers before transmitting information. We remind staff to follow our FAX policy regarding PHI information. When a HIPAA violation occurs the health center manager investigates the situation, talks to our compliance office and we work on solutions so these types of errors will not happen in the future. When required, new policies are written and communicated with staff. Employees we were able to identify as violators of HIPAA incidents receive Corrective Action Warning Notices. 2013 JAN 25 AM 11 41	

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A 017	Continued From page 3 documentation showed on 6/19/12, it was discovered two urine cups with Patient H's PHI, had been given to another patient to take home on 12/20/11. The PHI disclosed belonging to Patient H included name, date of birth, the health center's internal chart number and the Health Access Program number. Further review of the Health Center's investigation showed staff neglected to follow the policy on verifying patient identity on labeled supplies and/or documents before distribution. 3. On 8/14/12, the Anaheim Health Center discovered staff inadvertently handed a patient a urine cup labeled with Patient J's PHI. The patient went to the bathroom and noticed the urine cup with Patient J's name and returned it to a staff member. The PHI disclosed included first initial, last name and date of birth of Patient J. 4. Review of documentation showed, on 4/26/12, the Orange Health Center discovered Patient G's PHI was faxed to a private citizen instead of the intended recipient on 4/25/12. Through investigation the health center discovered staff had inadvertently switched the last two numbers of the fax number. Patient G's PHI disclosed included name, date of birth, the health center's internal medical record number, income and phone number. 5. On 7/24/12, the Santa Ana Health Center inadvertently handed a patient a Family Pact	A 017	c) What immediate measures and systemic changes will be put in place to ensure that deficient practices do not recur? On the above listed findings we made the following changes: We placed a personal shredder next to the health center's call representative's desk so they could shred documents before they left their desk. Since this incident occurred we moved our call center representatives from each health center location to one location. They now have their own secure area with shred bins and no patients have access to the documents or the paperwork on their desks. We remind staff and include in our new hire training that staff should always confirm the patient's full name and date of birth before handing a patient anything that has patient information written on it. This includes urine cups, Family Pact cards, prescriptions, test results, supplies etc. We continue to remind staff to be familiar with our new FAX policy and to pre-program those FAX numbers that are used repeatedly. One must always verify the numbers they have entered before transmitting a FAX. 2013 JUN 25 AM 11:41	

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A 017	Continued From page 4 identification card belonging to Patient I. The health center discovered the inadvertent act on 7/29/2012. The PHI belonging to Patient I that was disclosed included name, date of birth, and the Family Pact card identification number. 6. On 11/5/12, the Westminster Health Center discovered staff had inadvertently given another patient a form belonging to Patient K on 11/1/12. The PHI disclosed on the form showed Patient K's name and a test result. The above breaches of PHI were confirmed during a telephone interview with the health centers' Operations Manager for Compliance, Quality and Risk Management and the Senior Vice President of Compliance and Privacy on 12/6/12 at 1400 hours.	A 017	d) Description of the monitoring process. Monitoring process includes Management overseeing the operations of our health centers including the distribution of supplies and prescriptions. Newly hired staff receive HIPAA training on their first day of work before going to their worksite. Health Center Medical Assistants receive additional HIPAA training during their weeklong orientation training within 30 days of new hire. We also have quarterly Medical Assistant trainings where we train and reinforce the importance of Privacy and following HIPAA requirements and regulations. This training is provided by the Compliance Department. Health Center staff are also reminded of the importance of following HIPAA guidelines at each of their Monthly Health Center staff meetings. At quarterly Quality & Risk Management Meetings, HIPAA breaches are discussed and monitored by management. We also have spot checking audits conducted by the Compliance Office throughout the year. The importance of this function has been communicated to staff and they understand the importance of following our policies. e) Date when corrective action will be completed.	Ongoing 1/6/13