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
	CA070000184	A. BUILDING _____ B. WING _____	C 05/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD	625 HILBY AVENUE SEASIDE, CA 93955

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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	The following is Planned Parenthood Mar Monte's (PPMM's) response to the Department's request for a Plan of Correction with respect to Entity Reported Incidents CA00306419 in CDPH letter dated June 11, 2012. **Deficiency # D071 [22 CCR 75030(a)(2) not met because of failure to ensure written policies and procedures were implemented for one patient; failure to provide supervision to ensure the policy was implemented]** **(a) Corrective actions to be accomplished for the affected patient:** As soon as the Seaside Center Manager learned about the possible breach of the patient's protected health information (PHI), a comprehensive investigation was begun. After it was determined that a breach had occurred, a PPMM representative called and spoke with Patient 1 informing her of the breach and apologizing. PPMM's Compliance Officer also sent Patient 1 a letter communicating similar information. There is no Statement of Deficiency concerning PPMM's communication with the patient.	(a) 4/10/12
D 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of an entity reported incident conducted on 5/29/12. Entity Reported Incident CA00306419 regarding a breach of patient health information by the primary care clinic was substantiated. A deficiency was identified (see California Code of Regulations, Title 22, Section 75030(a)(2)). The affected patient was notified by the clinic of the privacy on 4/9/12. Inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the clinic.	D 000	**(b) Identification of other patients potentially affected by the same deficient practice and corrective action to be taken:** This situation involved Staff B impermissibly gaining access to Patient 1's chart because Patient 1 was Staff B's relative and Staff B had no business reason to gain that access. The breach was reported to PPMM's Compliance Officer by another employee (Staff A). PPMM has repeatedly emphasized the importance of employees reporting possible PHI breaches to their supervisor, as Staff A did. None of the people to whom employees are directed to report this conduct (Compliance Officer, CEO, General Counsel, Seaside Center Manager) has received such reports or reports from any other sources about such PHI breaches. PPMM is also not aware of Staff B having any other relatives receiving care at PPMM nor of Staff B impermissibly gaining access to any other patient charts. When Staff B was approached following the breach, she said that she had never accessed a friend's or another relative's chart, except her mother's chart.	(b) 4/9/12

POC accepted 6/25/12 by S. Nolan

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D 000	Continued From page 1 Representing the California Department of Public Health: 11442, Health Facilities Evaluator Nurse.	D 000	**(c) Immediate measures and systemic changes that will be put in place to ensure that deficient practice does not recur.** PPMM took appropriate corrective disciplinary action for Staff B on April 6 and April 20, 2012 to ensure she would not commit similar breaches. On April 19, 2012, the Seaside Center Manager conducted a staff meeting explicitly addressing intentional breaches and the Relatives policies. The Center Manager also gave staff quizzes on intentional breaches three times in 2012: April 24, May 4, and May 9. On April 27, 2012, PPMM revised its Privacy Manual and posted it on PPMM's intranet. A copy of the Privacy Manual was also included in the Health Center Administrative Manual. Included in the Privacy Manual is a policy addressing provision of services to relatives (Policy 5) and a policy on sanctions for privacy breaches (Policy 19).	(c) 5/9/12
D 071	T22 DIV5 CH7 ART4-75030(a)(2) Basic Services--Policies and Procedures (2) Policies relating to patient care. This Statute is not met as evidenced by: Based on interview and record review, the clinic failed to ensure written policies and procedures were implemented for confidentiality of patient health information for one of one sampled patient (1). Findings: On 5/29/12, the electronic medical record (EMR) indicated Patient 1 checked in at the clinic on 4/4/12 at 3:05 p.m. for an appointment. In an interview on 5/29/12, the clinic's patient flow manager (Staff A) stated in the afternoon on 4/4/12, she saw the check-in processor's (Staff B) computer screen opened in areas that were not appropriate. The clinic's computer program has time stamps when someone accesses a patient's record. Patient 1 was a family member of Staff B. Staff B had opened the patient's record 17 times from 9:49 a.m. to 4:18 p.m. On 4/4/12, at approximately 5 p.m. Staff A called the clinic's manager and reported what she discovered. Review of the employee file indicated, on 12/6/11, Staff B signed a form which confirmed she received a copy of the clinic's policy Regarding Provision of Services to Relatives and Others Known to Staff. The policy indicated."...Personnel shall not provide medical-related services to their relatives,...services shall include...access to	D 071	**(d) Monitoring Process/Quality Assurance** This breach was discovered by a Seaside supervisor observing that front office Staff B had her screen open to a part of the electronic medical record (EMR) that front office staff typically do not need for business purposes. Additional monitoring and supervision of Seaside front office staff will occur. Specifically, starting on June 25, 2012, the Seaside Center Manager and Patient Flow Manager (or their designees if neither is available) will circulate in the front office space on a more frequent basis to identify, if possible, whether any front office staff are accessing any of the EMR templates that are not necessary for them to view in the performance of their job. From June 25 until July 31, 2012, there will be daily visual supervision/monitoring. If any staff members are found to be on EMR templates outside those required for their job duties, the immediate follow-up will occur to determine whether PHI was impermissibly accessed. If such access is identified, the Seaside Center Manager, working with the PPMM Compliance Officer, will take appropriate steps to address the situation.	(d) 6/25/12

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D 071	Continued From page 2 medical files/records..." The clinic failed to provide supervision to ensure the policy was implemented to protect patient health information.	D 071	After July 31, 2012, the Seaside Center Manager, in consultation with the PPMM Compliance Officer and other appropriate PPMM staff, will review the results of this supervision/monitoring. If there are no instances of EMR access, they will re-evaluate the need for daily visual supervisions. The Compliance Officer tracks each confirmed incident of an intentional privacy breach within the affiliate as well as any violations of the PPMM's policy concerning provision of services to relatives. Certain incidents will be reviewed by PPMM's Risk and Quality Management Committee to identify issues involving these intentional breaches. When appropriate, additional corrective actions will be implemented at those sites where the intentional breaches occurred. These issues will be reinforced at periodic health center privacy training and staff will be required to attend and sign an attendance sheet and acknowledgement that they understand the contents. **(e) Date corrective action will be completed:** See column x5 on CMS 2567.	