STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA080000254	A. BUILDING ______ B. WING ______	12/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD ASSN OF SAN DIEGO CO	**7526 CLAIREMONT MESA BLVD SAN DIEGO, CA 92111**

(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
D 000	Initial Comments The following reflects the findings of the California Department of Public Health following an investigation of a self-reported breach of a patient's medical information. Complaint number: CA00419617 The investigation was limited to the specific event reported and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Health Facilities Evaluator Nurse State ID: 2794.	D 000	a. The deficiency occurred when one clinician inadvertently selected the wrong printer which resulted in incorrect prescription labels being printed to the wrong exam room. The clinician in that exam room then failed to follow the normal process for reviewing prescription labels prior to placing them on medications and handing them to the patient. RECEIVED CA DEPT OF PUBLIC HEALTH JAN - 8 2015 LICENSING & CERTIFICATION SAN DIEGO NORTH DISTRICT OFFICE The plan is to ensure that clinicians (a) always select and print to the correct printer and (b) double check that the patient information on the printed label matches the electronic medical record prior to placing the label on the medication and handing it to the patient. A breach notification letter was sent to Patient A.	11-6-14
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	The medications labeled with Patient A's information on them, were returned to the health center by Patient B. b. The procedure will include reviewing with all licensed staff our established process which includes (a) the need to print to the correct printer and (b) mandatory double checking of prescription labels prior to placing labels on medications and handing them to the patient. c. Monitoring procedures will include follow up training at center staff meetings regarding the importance of checking every prescription label prior to placing it on the medication and handing it over to the patient. The Health Center Manager and Lead Clinician are responsible for continuously monitoring compliance to all HIPAA privacy policies and procedures in their health centers including protection of patient privacy through mandatory double checking of all prescription labels prior to placing them on medications and handing them to the patient.	11-12-14
D 177	T22 DIV5 CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records	D 177		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane R. DeSille   TITLE: HIPAA Privacy Officer   (X6) DATE: 1-7-2015

Mathiesen 1-13-15. OK   1-16-15

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SAN DIEGO NORTH DISTRICT OFFICE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA080000254	A. BUILDING ______ B. WING ______	12/22/2014

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PLANNED PARENTHOOD ASSN OF SAN DIEGO CO	**7526 CLAIREMONT MESA BLVD SAN DIEGO, CA 92111**

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D 177	Continued From Page 1 shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws. This RULE: is not met as evidenced by: Based on interview and record review, the facility failed to protect the medical record information for one sampled patient (Patient A) as required per Health and Safety Code Regulation 1280.15. As a result, the patient's private health information (PHI) was compromised. Findings: The facility was made aware of a breach on 10/31/14. The facility notified the Department of the incident on 11/6/14. The facility reported that the breach included the following PHI related to Patient A: Name, weight, body mass index (weight to height ratio, medications, instructions for use, name of provider (a provider of medical or health services), and the name of the health center and telephone number. The Administrative staff confirmed the incident during a telephone interview on 12/22/14 at 9:45 A.M. The Administrative staff stated, Patient B was given patient documents and medications labeled with Patient A's PHI. The Administrative staff also said, the error was believed to have occurred, when an employee failed to double check the name on labels that were placed on medications and documents and given to Patient B in error.	D 177	In addition, the HIPAA Privacy Officer conducts HIPAA training for all new health center staff as part of the agency's orientation and training program as well as an annual HIPAA Compliance Training review. HIPAA compliance audits are also conducted annually at a minimum of six health centers. HIPAA privacy breaches are also reviewed and discussed with health center leadership at bi-annual meetings. The monitoring process will also include a review of all patient privacy root cause analysis reports by the HIPAA Privacy Officer, Sr. Director of Quality and the Sr. Director of Center Operations. We will identify any similar errors and address them immediately. d. The Health Center Manager and Lead Clinician are responsible for implementing the plan of correction. e. The Lead Clinician immediately reviewed what contributing factors led to the error by conducting a root cause analysis and determined that a clinician had not followed our mandatory internal process for reviewing prescription labels prior to placing them on medications and handing them over to the patient. The Lead Clinician reviewed and discussed the incident with all licensed staff at the next staff meeting and reminded them of the importance of ensuring that correct prescription labels are placed on medications prior to dispensing them to patients. All corrective actions were completed by 11-26-14.	11-26-14