PRINTED: 08/13/2014
FORM APPROVED

RECEIVED CA DEPT OF PUBLIC HEALTH SEP - 5 2014 LICENSING & CERTIFICATION 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
	CA080000255	A. BUILDING ______ B. WING ______	08/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD-ESCONDIDO CENTER	347 W MISSION AVENUE ESCONDIDO, CA 92025

(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: CA00407428 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: 15932.	D 000	a) The deficiency occurred when a medical records staff person failed to follow the normal process for ensuring correct patient identity prior to releasing medical records via email. That process involves comparing the patient's email address listed on their medical records release form against the email address on the computer, prior to sending medical records via email. Performance issues related to quality of work had also been identified with the staff person involved in the error. She had difficulty operating systematically and in a timely fashion. The staff person was acting with a sense of urgency to meet the patient's request and inappropriately ignored all procedures that were outlined.	
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	Prior to this error, the staff person had received re-training and a detailed process for responding to medical records requests which had been developed for her to ensure timeliness and accuracy. She received this policy on 7-2-14 and was being actively monitored on a bi-weekly basis by her supervisor. As of 8-8-14, the staff person is no longer employed by the agency. b) New written procedures have been created and provided to the current medical records staff. In addition, we are developing a new onboarding process for all new medical records staff. The new onboarding process will focus on a standardized step by step procedure for fulfilling medical records requests, including responding to requests by email.	
D 177	T22 DIV5 CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records	D 177	c) This procedure will be used as the guideline for training and evaluating medical records staff on a regular basis. In addition, this procedure will be used at the four month	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane R. DiLille, HIPAA Privacy Officer — TITLE — (X6) DATE: 9/3/14

9/8/14

Accepted 9/8/14 15932

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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 7/23/14. The facility notified the Department of the incident on 7/28/14. The facility reported that the breach included the following PHI related to Patient A: Name, laboratory results, medical history, diagnosis, medications, and provider name.. The Administrative staff confirmed the incident during a telephone interview on 8/13/14. The Administrative staff stated a medical records employee failed to ensure an email address was correct prior to emailing PHI. As a result, PHI that belonged to Patient A, was emailed to Patient B.	D 177	performance evaluation to ensure that this person is meeting the requirements of the job. The Sr. Director of Quality is responsible for conducting performance evaluations for medical records staff which includes ensuring policies and procedures are followed regarding the appropriate release of patient records by email. The performance review process is part of our quality assurance program. d) The Sr. Director of Quality is also responsible for continuously monitoring compliance to all HIPAA privacy policies and procedures in the Medical Records Department. e) The Sr. Director of Quality oversees the Medical Records Department and is responsible for implementing the plan of correction. The Sr. Director of Quality immediately reviewed what contributing factors led to the error and determined that a medical records staff person had not followed the policy and procedure for responding to a patient's request to receive records by email. A written procedure was created and all medical records staff have been trained on this. The Sr. Director of Quality also met with the staff person involved to discuss the error and corrective actions. In addition, the HIPAA Privacy Officer conducts training for all new staff (including medical records staff) as part of the agency's orientation and training program. An annual HIPAA Compliance Training is also required of all staff. HIPAA compliance audits are also conducted on an annual basis by the HIPAA Privacy Officer All corrective actions were completed by 8-8-14.	