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
	240001766	A. BUILDING: _____ B. WING _____	01/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD/ORANGE & SAN BEI	1873 COMMERCENTER WEST SAN BERNARDINO, CA 92408

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D 000	Initial Comments The following reflects the findings of the California Department of Public Health during an abbreviated standard survey to investigate an entity reported incident. Entity Reported Incident Number: CA00421439 Representing the California Department of Public Health: 34388-HFEN The inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for entity reported incident number: CA00421439	D 000	RE: CMS 2567 Entity Reported Incident Number CA00421439 PPOSBC submits that to PPOSBC's knowledge, no PHI may have been actually been breached in this matter, as the receiving entity was a covered and treating entity that recognized based on patient name that the document at issue was not the intended patient record; and furthermore, that covered/treating entity expeditiously contacted PPOSBC and expeditiously returned the PHI to PPOSBC via certified mail. However, as reported in PPOSBC's initial report to your facility, PPOSBC nevertheless reported this matter in good faith; thereby, PPOSBC respectfully submits that this form may be inapplicable to PPOSBC for this matter. However, PPOSBC respectfully submits its plan of correction to your form 2567 as follows. Your CMS 2567 correspondence dated January 14, 2015 states in pertinent part:	01.23.15
D 177	T22 DIV5 CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure the confidential treatment of protected health information (PHI) for Patient B, when a medical assistant (MA 1) inadvertently scanned a release form into the medical record of Patient B instead of Patient A. A medical records clerk (MRC 1) then processed the release of records and mailed the medical records for Patient B to an outside entity. This failure resulted in an unauthorized release of PHI for Patient B.	D 177	The Plan of Correction for each deficiency must contain the following: a) What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice. b) How other patients having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken. c) What immediate measures and systemic changes will be put into place to ensure that the deficient practice does not recur. d) A description of the monitoring process and positions of persons responsible for monitoring (i.e., Administrator, Director of Nursing, or other responsible supervisory personnel). How the facility plans to monitor its performance to ensure corrections are achieved and sustained. The plan of correction must be implemented, corrective action evaluated for its effectiveness, and it must be integrated into the quality assurance system. e) Dates when corrective action will be completed. The corrective action completion date must be acceptable to the Department. The deficient practice should be corrected immediately. This date shall be no more than 30 calendar days from the date the facility was notified of the non-compliance. Per your request, please find the following pertinent Plan of Correction.	

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE President/CEO (X6) DATE 1/27/15

1-29-15 PW

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D 177	Continued From page 1 Finding: On December 30, 2014 at 11:50 AM, a phone interview was conducted with the Privacy and Compliance Officer (PCO) regarding an entity reported incident of a breach of PHI for Patient B, detected by the facility on November 5, 2014. The PCO stated it was an "unfortunate human error". She stated staff are trained to check the name and medical record number to make sure it is the right patient. She further stated there are policies and procedures in place to prevent this from happening, but they were not followed. During a record review it was determined Patient B, was notified via mail of the breach on November 10, 2014 of their individual PHI. During a review of the documentation mailed to the outside entity in error, the documentation contained Patient B's name, address, phone number, date of birth, age, account number, provider name and aspects of their health history. A review of the facility policy and procedure titled, "Medical Records Release," dated August, 2013, indicated, "All information contained within a patient's EMR...will be maintained in a confidential manner to protect the patient's right to confidentiality..." The failure to verify the correct patient and their medical records prior to mailing resulted in the unauthorized release and breach of PHI for Patient B.	D 177	a) PPOSBC contacted the patient at issue by phone as well as mailed a written correspondence Notice to the patient at issue; said correspondence included identifying the incident at issue, identifying PPOSBC commitment to patient privacy and security as well as PPOSBC"s commitment to retraining and counseling of staff at issue; as well as contact information for three credit reporting agencies, and contact information for PPOSBC's Privacy Officer in the event patient wished to further communicate regarding this matter. Said correspondence to patient was previously provided to your facility and is again attached. (b), (c), (d), and (e): PPOSBC takes this matter very seriously both for the matter at issue and regarding other patients. Thereby, PPOSBC continues with quality assurance measures to train and re-train all staff on management and protection of protected health information (PHI). PPOSBC conducts on-going quality assurance focused PHI trainings, with both patient services staff, and PPOSBC other staff. PHI training includes in-depth training at onset of hire with PPOSBC, as well as annual PHI trainings; as well as one-to-one re-trainings with specific staff involved in this specific matter. PPOSBC also completes pro-active ongoing PHI compliance and risk management trainings, including the annual all-staff training completed during October 2014; and further trainings during July 29, 2014, and July 30, 2014 for patient services staff. Please find previously-submitted enclosed copies of agendas for ongoing patient services, and all-staff PPOSBC compliance, privacy and PHI training. PPOSBC has a proactive program whereby clinical, and non-clinical staff are proactively trained/retrained on security and privacy of PHI, and PHI process(es). Specific trainings to specific staff are also conducted regarding any pertinent matters such as this matter. Thus, PPOSBC conducts both proactive	01.23.15

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D 177	Continued From page 2		on-going training as well as any applicable re-training as warranted. Also attached are relevant and previously submitted policies regarding compliance, privacy, PHI, and records release processing. In reviewing the matter at issue, PPOSBC submits in good faith that applicable robust trainings on pertinent policies were implemented proactively and consistently irrespective of this matter; and the matter at issue was an inadvertent, human-error matter requiring retraining and counseling of specific staff at issue as described. Nevertheless, as stated, PPOSBC has further retrained and counseled staff on the import of the privacy and security of PHI and related processes (please kindly again note by the several training agendas and programs copies attached hereto). Both the PPOSBC medical records clerk and the PPOSBC MA at issue have also received specific retraining and counseling on agency processes and policies required for release of records including verifying correct patient data and identification at each stage of said process Also as part of PPOSBC's commitment to quality assurance processes, PPOSBC will continue to focus on on-going robust trainings at all applicable levels. This includes not only a full compliance and PHI training at inception of employment, and at applicable departmental levels, but also, ongoing "Annual," all-staff trainings as exemplified by the newly implemented annual PPOSBC Compliance & Risk Management All-Staff training program commencing with the 2014 annual program (a paper copy of which program is also attached hereto). Applicable supervisory staff for ongoing trainings and monitoring of compliance include PPOSBC compliance management staff, PPOSBC Administrative management staff, PPOSBC Information Technology management staff, and PPOSBC Patient Services management staff;	01.23.15

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D 177	Continued From page 3		all staff work together on training applicable staff and issue, maintaining parallel policies on protected Health information privacy and security and monitoring compliance regarding the same. Additionally, through the supervision of PPOSBC Information Technology staff, PPOSBC has implemented new electronic security measures/processes through a third-party software program designed to automatically detect, and report to PPOSBC unauthorized access to protected health information and related systems. PPOSBC has also hired a Compliance Officer and Privacy Officer in addition to other additional compliance staff. PPOSBC Health Center Managers have also received additional training regarding on-site training, monitoring, reporting and management of protected health information privacy and security. PPOSBC therefore, respectfully and in good faith submits it has an efficient and good faith patient and protected health information plan of correction program for this matter currently implemented. Thank you for your attention to this matter.	01.23.15