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 _____	C 10/21/2015

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 investigation of a Community Clinic reported incident. Entity Reported Incident number: CA00460847 Representing the California Department of Public Health: HFEN 35290 The inspection was limited to the specific incident reported, and does not represent the findings of a full inspection of the facility. One deficiency was issued as a result of entity reported event: CA00460847	D 000	**RE: CDPH Intake File Number: CA00460847** *"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."*** **a):** The patient at issue was contacted by PPOSBC informing patient of the incident, that PPOSBC would investigate said incident and remediate (please see copy of PPOSBC written correspondence to (patient at issue attached hereto and incorporated herein (Name and Address of patient redacted for privacy; a non-redacted copy of said letter was provided to at CDPH on or about October 12, 2015). Patient was provided full contact information at PPOSBC for any additional questions or concerns at patient's discretion. To concretely ensure ongoing safety and privacy of patient's protected health information, PPOSBC R.N. staff member at issue was also promptly counseled and retrained by the agency Compliance Officer and by the agency Director of Quality Management on or about September 28, 2015 and September 29, 2015. Said PPOSBC R.N. staff member at issue also re-completed the agency compliance annual training on or about October 2, 2015 (please see copy of proof of training of R.N. for both 2014, and 2015 PPOSBC annual Compliance Training on protected health information/HIPAA, attached hereto and incorporated herein). Moreover, on or about September 29, 2015, PPOSBC promptly	10/12/15
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 A, when a progress note for Patient A that contained PHI, was faxed to an incorrect FAX number. This resulted in the unauthorized release of Patient A's PHI to an unauthorized entity. Findings: During a phone interview with the Compliance	D 177		

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE President/CEO (X6) DATE 11/4/15

11-10-15 DW

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D 177	Continued From page 1 Officer (CO) on October 7, 2015 at 3:55 PM, the CO stated that the breach was discovered on September 21, 2015, when Registered Nurse (RN 1) noticed the fax confirmation sheet indicated the documents were faxed to two fax numbers instead of just the one for which it was intended. RN 1 contacted the agency where the fax was sent in error, and employees of the agency advised her that the faxed documents would be destroyed. The documentation contained Patient A's name, account number, date of birth, address, phone number, past medical history, past surgical history, vital signs (blood pressure, heart rate, height, weight, and temperature) current medication, medication/treatment prescribed, negative Human Immune Deficiency Virus Antibody (HIV) test results, recent sexual history, drug use history, and family medical history. A concurrent interview was conducted on October 09, 2015 at 9:45 AM with the CO and RN 1. When asked how the incident occurred, RN 1 stated, "We have numbers (fax numbers) that are already pre-populated (entered previously). I pick from the drop-down menu and press send ....The confirmation sheet noted it was sent to (agency name where it was intended to be faxed) and another fax number ... There was another fax number somewhere in fax machine history ...The other fax number did not appear anywhere when I sent the fax." The CO was asked about what facility or departmental measures have been established to prevent an occurrence like this in the future. The CO stated, "Information Technology (IT)	D 177	thoroughly evaluated said facsimile machine functions for performance improvement; PPOSBC was able to expeditiously devise bolstered quality assurance for said facsimile machine wherein the machine is now programmed to prompt a user to affirmatively approve any fax number(s) to which a user intends to submit authorized facsimile transmissions. Additionally, PPOSBC case management staff members were promptly counseled and retrained on or about September 29, 2015 regarding protected health information privacy and security, as well as use of said updated facsimile process (please see copy of September 29, 2015 PPOSBC Case Management Training Agenda, attached hereto and incorporated herein). ***"(b) How other patients having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken."*** **(b):** PPOSBC has a robust series of policies that staff must adhere to for optimum security and privacy of patient protected health information. Staff is also regularly trained on said policies. I. Pertinent said policies include: (1) Compliance Policy 200-301 PPOSBC Confidentiality of PHI, (2) Compliance Policy 200-307 PPOSBC PHI Minimum Necessary Rule, (3) Compliance Policy 200-308 PPOSBC Sanctions Unauthorized Access PHI, (4) Patient Services Policy HIV Testing and Results Management 6.24	10/12/15

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D 177	Continued From page 2 Department has changed the fax machine to force the sender to confirm the fax number before sending the fax ... The sender cannot fax without first confirming the number." A review of the facility policy titled, "Confidentiality of Protected Health Information," revised February, 2015, indicated, "Procedures: 1 ...Protected Health Information (PHI) may not be disclosed or released without a completed valid written authorization signed by the patient or legally authorized representative."	D 177	(Please see copies of said policies attached hereto and incorporated herein) II. In addition to the promulgation of said policies at PPOSBC, PPOSBC also regularly trains and educates staff for optimum privacy and security of protected health information. Ongoing training is accomplished for (i) any applicable re-training, (ii) for proactive training at inception of staff hire, and (iii) for proactive annual training, including as follows: • Protected Health Information (PHI)/HIPAA in-person training at staff orientation day/hire. • An **additional** Protected Health Information/HIPAA Online training for new staff to be additionally completed within 30 days of hire (please see copy of outline of LawRoom training module for new hires, attached hereto and incorporated herein). • Proactive Patient Services staff training on Protected Health Information(PHI)/HIPAA (please see copy of July 2015 protected health information/HIPAA training agenda for patient services staff, attached hereto and incorporated herein). • Proactively calendared Annual **All-Staff** Training on Compliance Policies and Procedures that include protected health information (PHI)/HIPAA (please see copies of excerpts of 2014 and 2015 Annual PPOSBC Compliance Trainings, attached hereto and incorporated herein). • Expeditious evaluation and remediation of the functionality of the facsimile machine at issue as described herein. Further expeditious retraining to case management staff on protected health information privacy and security, as well as updated training on facsimile use as described herein	10/12/15

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D 177	Continued From page 3	D 177	(please see copy of September 29, 2015 PPOSBC Case Management Training Agenda, attached hereto and incorporated herein). • An agency culture that invites reporting any suspected compliance and/or privacy matter to supervisors in any department, including but not limited to PPOSBC Human Resources Department, Patient Services Department, Administration and the Compliance Department. III. Moreover, PPOSBC supports/implements: • A dedicated agency Compliance Hotline 24 hours a day 7 days a week, 365 days a year (please see a copy of said Hotline program communication to staff, attached hereto and incorporated herein). • Suspension of Employment, Separation of Employment, other disciplinary processes and/or retraining and counseling for any staff that fails to follow policies and processes described herein. Accordingly, PPOSBC submits in good faith, that it implements and continues to implement robust, consistent and good faith efforts towards optimum protection of protected health information for all patients including any other patients having any potential to be affected. ***"c) What immediate measures and systemic changes will be put into place to ensure that the deficient practice does not recur."*** **c):** As described herein, PPOSBC has a robust series of policies that staff must adhere to for optimum security and privacy of patient protected health information. Staff is also	10/12/15

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D 177	Continued From page 4	D 177	regularly trained on said policies. I. Pertinent said policies include: (1) Compliance Policy 200-301 PPOSBC Confidentiality of PHI, (2) Compliance Policy 200-307 PPOSBC PHI Minimum Necessary Rule, (3) Compliance Policy 200-308 PPOSBC Sanctions Unauthorized Access PHI, (4) Patient Services Policy HIV Testing and Results Management 6.24 (Please see copies of said policies attached hereto and incorporated herein) II. In addition to the promulgation of said policies at PPOSBC, PPOSBC also regularly trains and educates staff for optimum privacy and security of protected health information. Ongoing training is accomplished for (i) any applicable re-training, (ii) for proactive training at inception of staff hire, and (iii) for proactive annual training, including as follows: • Protected Health Information (PHI)/HIPAA in-person training at staff orientation day/hire. • An **additional** Protected Health Information/HIPAA Online training for new staff to be additionally completed within 30 days of hire (please see copy of outline of LawRoom training module for new hires, attached hereto and incorporated herein). • Proactive Patient Services staff training on Protected Health Information(PHI)/HIPAA (please see copy of July 2015 protected health information/HIPAA training agenda for patient services staff, attached hereto and incorporated herein).	10/12/15

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D 177	Continued From page 5	D 177	• Proactively calendared Annual **All-Staff** Training on Compliance Policies and Procedures that include protected health information (PHI)/HIPAA (please see copies of excerpts of 2014 and 2015 Annual PPOSBC Compliance Trainings, attached hereto and incorporated herein). • Expeditious evaluation and remediation of the functionality of the facsimile machine at issue as described herein. Further expeditious retraining to case management staff on protected health information privacy and security, as well as updated training on facsimile use as described herein (please see copy of September 29, 2015 PPOSBC Case Management Training Agenda, attached hereto and incorporated herein). • An agency culture that invites reporting any suspected compliance and/or privacy matter to supervisors in any department, including but not limited to PPOSBC Human Resources Department, Patient Services Department, Administration and the Compliance Department. III. Moreover, PPOSBC supports/implements: • A dedicated agency Compliance Hotline 24 hours a day 7 days a week, 365 days a year (please see a copy of said Hotline program communication to staff, attached hereto and incorporated herein). • Suspension of Employment, Separation of Employment, other disciplinary processes and/or retraining and counseling for any staff that fails to follow policies and processes described herein. IV. As further, additional measures: • PPOSBC employs a chief Compliance Officer, chief HIPAA Privacy Officer, and chief HIPAA	10/12/15

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D 177	Continued From page 6	D 177	Security Officer to review PPOSBC systems for additional compliance and quality improvement as applicable. (i) One immediate result herein is the updating of applicable agency process (es) to include an agency enterprise-wide Compliance, Quality & 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) Also resulting is bolstered agency HIPAA Security processes including software programs designed to detect potential systems intrusions and/or unauthorized attempted access. (iv) PPOSBC has also installed a Chief Operating Officer who regularly collaborates with the Compliance Officer, HIPAA Privacy Officer, HIPAA Security Officer, VP of HR, PPOSBC Medical Director, Patient Services Management Staff, and the Office of the CEO, to directly oversee ongoing training of agency health center staff, both licensed and non-licensed. • PPOSBC also commits to a long-term plan to continue to review applicable agency policies and training for optimum quality and compliance. • PPOSBC also commits to optimum protection of patient privacy and security, and compliance with regulatory and agency standards. Accordingly, PPOSBC submits in good faith, that it implements and continues to implement robust, consistent and good faith efforts towards optimum protection of protected health information for all patients including any other patients having any potential to be affected.	10/12/15

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D 177	Continued From page 7	D 177	Thereby, PPOSBC further submits in good faith that it is taking, and has taken notable measures to ensure that the CDPH described deficiencies that CPDH sets forth for Complaint Number CA00460847, do 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."*** **d) and e):** As noted in above-referenced section (c) in detail, PPOSBC has a robust series of policies that staff must adhere to for optimum security and privacy of patient protected health information. Staff is also regularly trained on said policies. I. Pertinent said policies include: (1) Compliance Policy 200-301 PPOSBC Confidentiality of PHI, (2) Compliance Policy 200-307 PPOSBC PHI Minimum Necessary Rule, (3) Compliance Policy 200-308 PPOSBC Sanctions	10/12/15