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 _____	09/21/2016

STATE DEPT OF HEALTH SERVICES
16 OCT 12 AM 9:10
LIC. & CERT. SAN BERNARDINO COUNTY

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

(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 during an investigation of a Community Clinic reported incident. Entity Reported Incident number: CA00488868 Representing the California Department of Public Health: 34959 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: CA00488868	D 000	a) What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice. PPOSBC respectfully submits it was not deficient in practice but rather, was required to mitigate, remediate and address behavior by then-staff that was fully noncompliant with established PPOSBC policies. PPOSBC previously had and continues to have established policies and training on protected health information security and privacy, effective both prior to the incident at issue and continuing after the incident at issue. Nevertheless, and in good faith, PPOSBC corrective action plans include (1) investigating and verifying the limited nature of the information at issue and establishing the patient information at issue was illegible and did not contain or set forth detailed medical or protected heatlh information, (2) notifying the patients at issues by individual phone calls by PPOSBC (3) notifying the patients by individual written notifications by PPOSBC, (4) by expeditiously separating the noncompliant staff at issue from employment with PPOSBC (5) by contacting Upland police department to request additional law enforcement measures against the noncompliant staff at issue (6) by completing additional training with staff for optimum mitigation of future noncompliance by any remaining staff. (b) How other patients having the potential to be affected by the same deficient practice by identified, and what corrective action will be taken. PPOSBC respectfully submits it was not deficient in practice but rather, was required to mitigate, remediate and address behavior by the	10/1/16
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 protect the confidential medical information (CMI) for 19 patients (Patients A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, and S), when the Medical Assistant (MA) (one who assists a qualified physician in an office or other clinical settings) sent a text message to her domestic partner through the phone that contained Patients A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, and S confidential medical information (CMI), resulting in a breach of	D 177		

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: President/CEO — (X6) DATE: 10/10/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 177	Continued From page 1 Patients A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, and S's CMI. During a phone interview on June 2, 2016 at 9:48 AM, with the Assistant Manager (AM), when asked if she knew MA's boyfriend since she said it came from an anonymous source, but the text had been sent to her phone number, she denied it. During a phone interview on June 2, 2016 at 11:00 AM, with the AM, she stated that she received an anonymous text screen shot to her cell phone that showed the scheduled appointments for the 19 patients that included: Patients first and last name, medical record number and the reason for the visit. The screen shot included the name and phone number of the MA as it appeared when the MA sent it to the person who reported it to the AM. During a phone interview on September 15, 2016 at 5:22 PM, with the General Counsel (GC), she stated that the MA sent a text to her boyfriend to show him what her schedule was for the day. The text was a snap shot of the white board sent from MA's cell phone which included: patients names, date, and the reason the patients had an appointment at the facility, for example: a headache. "When I interviewed MA she stated at first she lost her phone, then stated she left her phone behind with her partner." A review of the copies of the letters provided by the facility that were sent to patients to notify them that their medical information was breached was conducted. The letter were individually addressed to Patients A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, and S, and informed each of them that their personal information to include	D 177	staff at issue who was fully noncompliant with established PPOSBC policies. PPOSBC previously had and continues to have established policies and training on protected health information security and privacy, effective both prior to the incident at issue and continuing after the incident at issue. Additionally, the information at issue was limited, illegible and did not contain detailed medical or protected health information. Moreover, this was a limited set of patients at issue. Therefore, there is no current potential for any other patients to be identified as potentially affected by the practice at issue. However, and nevertheless, as described in subsection (a), PPOSBC corrective action plans included (1) investigating and verifying the limited nature of the information at issue (2) notifying the patients at issues by individual phone calls by PPOSBC (3) notifying the patients by individual written notifications by PPOSBC, (4) by expeditiously separating the noncompliant staff at issue from employment with PPOSBC (5) by contacting Upland police department to request additional law enforcement measures against the noncompliant staff at issue (6) by completing additional training with staff at the center site at issue for optimum mitigation of future noncompliance by any remaining staff at the PPOSBC center at issue. C) What immediate measures and systemic changes will be put into place ensure that the deficient practice does not recur. PPOSBC respectfully submits it was not deficient in practice but rather, was required to mitigate, remediate and address behavior by the staff at issue who was fully noncompliant with established PPOSBC policies. PPOSBC previously had and continues to have established policies	10/1/16

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D 177	Continued From page 2 their reason for their appointment at the facility, had been breached. During a review of the copy of the Separation Notice dated May 4, 2016, provided by the facility that was given to the MA indicated: "Termination notice pursuant to the provisions of 22 Code of Regulations Section 1089-1 of the California Unemployment of Insurance Code. This will notify you a change in you employment status due to discharge." During a review of the copy of the HIPAA/Privacy and Security Recap. Training dated March 23, 2016, provided by the facility indicated by the MA's signature that she was aware of maintaining confidentiality of patient information. The facility's policy and procedure entitled [Name of Facility] Sanctions for Unauthorized Access, Use and /or Disclosures of Protected Health Information, dated February 4, 2015, indicated, "Accessing a patient's medical record/Personal health information for any purpose outside of treatment, payment, health care operations, job/service duties and/or Health Insurance Portability and Accountability Act (HIPAA) (a 1996 Federal law that restricts access to individuals private medical information) (minimum necessary standards. Accessing, using and / or disclosing personal health information out of curiosity or for any purpose outside of treatment, payment, health care operations, job/service duties and / or Health Insurance Portability and Accountability Act minimum necessary standards."	D 177	and training on protected health information security and privacy, effective both prior to the incident at issue and continuing after the incident at issue. Additionally, the information at issue was limited, illegible and did not contain or set forth any level of detailed medical or protected health information. Moreover, this was a limited set of patients at issue. Therefore, there is no current potential for any recurrence. However, and nevertheless, as described in subsection (a), PPOSBC instituted quality assurance and quality improvement measures, and corrective action plans that included (1) investigating and verifying the limited nature of the information at issue (2) notifying the patients at issues by individual phone calls by PPOSBC (3) notifying the patients by individual written notifications by PPOSBC, (4) by expeditiously separating the noncompliant staff at issue from employement with PPOSBC (5) by contacting Upland police department to request additional law enforcement measures against the noncompliant staff at issue (6) by completing additional training with staff at the center site at issue for optimum mitigation of future noncompliance by any remaning staff at the PPOSBC center at issue. Moreover (7) PPOSBC has expanded its policies on cell phone/electronic device use to require non-clinician staff to secure any such personal devices in containers and lockers during work time periods. Additionally, (8) PPOSBC provided multiple trainings on its policies on protected health information privacy and security both pre and post the incident date of February 14, 2016, including on or about July 22, 2015, November 10, 2015, January 5, 2016, March 23, 2016, April 27, 2016, May 12, 2016, June 21, 2016 and currently again in October 2016. PPOSBC thereby respectfully submits it implemented	10/1/16

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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 177	Continued From page 3	D 177	both immediate and systemic changes towards ensuring no deficient practice shall occur. (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 integrated into the quality assurance system. The incident at issue was reported in May 2016. The date of this notice form 2567 is September 28, 2016. PPOSBC received said notice on or about October 5, 2016. Thereby, PPOSBC has completed quality assurance, quality improvement and corrective action plans during this extended time period, including continuing to monitor performance to ensure corrections are achieved and sustained and the plan is integrated into the quality assurance system. The plan is directly administered by Patient Services Department via Senior Director of Operations, and the Training Manager. The Patient Services Quality Management Director also monitors all trends associated with this type of incident and plan effectiveness, should any future trends appear. Additionally, the PPOSBC VP of HR as well as the PPOSBC VP of Compliance further administer and monitor this plan for any core compliance, added training and any required disciplinary process measures. As described above, the fully implemented plan includes (1) investigating and verifying the limited nature of the information at issue to better assess any root cause and better plan an appropriate corrective action plan (2) monitoring	10/1/16

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D 177	Continued From page 4	D 177	and ensuring notice to the patients at issue by individual phone calls by PPOSBC (3) monitoring and ensuring notice to the patients at issue by individual written notifications by PPOSBC, (4) by effectively expeditiously separating the noncompliant staff at issue from employment with PPOSBC (5) by coordinating with Upland police department to request additional law enforcement measures against the noncompliant staff at issue (6) by completing additional training with staff at the center site at issue for optimum mitigation of future noncompliance by any remaining staff at the PPOSBC center at issue. Moreover (7) PPOSBC has expanded its policies on cell phone/electronic device use to require non-clinician staff to secure any such personal devices in containers and lockers during work time periods. Additionally, (8) PPOSBC provides multiple trainings on its policies on protected health information privacy and security both pre and post the incident dated of February 14, 2016, including on or about July 22, 2015, November 10, 2015, January 5, 2016, March 23, 2016, April 27, 2016, May 12, 2016, and June 21, 2016. PPOSBC will continue to monitor, train on, and address compliance and quality assurance for agency guidelines on privacy and security of protected health information including agency training also in October 2016. Compliance trainings are also scheduled for all staff at hire, and again annually each October. By this plan and these processes, PPOSBC respectfully submits that is has and continues to monitor its performance to ensure corrections are achieved and sustained its plan of correction is implemented, and the corrective actions are evaluated for effectiveness, and integrated into the quality assurance and compliance systems.	10/1/16

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PLANNED PARENTHOOD/ORANGE & SAN BEI	1873 COMMERCENTER WEST SAN BERNARDINO, CA 92408

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D 177	Continued From page 5	D 177	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. The incident at issue was reported in May 2016. The date of this notice form 2567 is September 28, 2016. PPOSBC recieved said notice on or about October 5, 2016. 30 calendar days from the date listed on the written notice is on or about October 27, 2016. Since PPOSBC self-reported the incident to CDPH on or about May 16, 2016 and commenced its correction action plan at that time, PPOSBC has since completed that action plan completed October 1, 2016. Therefore, PPOSBC has timely and compliantly completed implementation of the corrective action plan described in this response. Thank you.	10/1/16

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
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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