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
	CA250001816	A. BUILDING: _____ B. WING _____	C 01/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD-COACHELLA VALLE	49-111 HIGHWAY 111, UNIT 6 COACHELLA, CA 92236

(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
A 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of one entity reported incident. Entity reported incident number: CA00365335 Representing the California Department of Public Health: 25937 / 2122 The inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility. This Department was able to substantiate a violation of the regulations.	A 000	We apologized to Patient B on the phone, reassured her that Planned Parenthood is committed to protecting patient privacy and asked that she return the letter intended for Patient A. Patient B returned the letter to us the same day. An apology letter was mailed to Patient A regarding the privacy breach and reassuring her that Planned Parenthood is committed to protecting patient privacy. Patient A was also informed that Patient B had returned the letter to us. The Case Management Supervisor reviewed the incident with staff at their staff meeting and they performed a root cause analysis to determine what contributing factors led to the error. The solution was determined to be the installation of personal desk printers for printing out patient lab result letters. This allows the Case Management Specialist to print the patient's lab result letter from the Electronic Medical Record at the same time that they print the patient's address label from their personal label printer. The letter and label are therefore printed in the same order and matched prior to mailing. See above regarding immediate measures that were put into place to ensure deficient practice does not recur. Printers installed shortly after solution determined.	07/30/13 07/31/13 07/31/13
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	APOC 2-24-14 KC	

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane R. DeRille | TITLE: HIPAA Privacy Officer | (X6) DATE: 2.19.14

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A 017	Continued From page 1	A 017	Continued from page 1	
A 017	1280.15(a) Health & Safety Code 1280 (a) A clinic, health facility, home health agency, or hospice licensed pursuant to Section 1204, 1250, 1725, or 1745 shall prevent unlawful or unauthorized access to, and use or disclosure of, patients' medical information, as defined in subdivision (g) of Section 56.05 of the Civil Code and consistent with Section 130203. The department, after investigation, may assess an administrative penalty for a violation of this section of up to twenty-five thousand dollars ($25,000) per patient whose medical information was unlawfully or without authorization accessed, used, or disclosed, and up to seventeen thousand five hundred dollars ($17,500) per subsequent occurrence of unlawful or unauthorized access, use, or disclosure of that patients' medical information. For purposes of the investigation, the department shall consider the clinic's, health facility's, agency's, or hospice's history of compliance with this section and other related state and federal statutes and regulations, the extent to which the facility detected violations and took preventative action to immediately correct and prevent past violations from recurring, and factors outside its control that restricted the facility's ability to comply with this section. The department shall have full discretion to consider all factors when determining the amount of an administrative penalty pursuant to this section. This Statute is not met as evidenced by: Based on interview and facility document review, the facility failed to prevent unauthorized access and/or disclosure of Patient 1's medical information, when Patient A's laboratory results	A 017	Monitoring of compliance to the new process has been incorporated into the initial assessment and training for new case management staff and the annual performance evaluation. The Case Management Supervisor is responsible for conducting the annual performance evaluation. The annual review process is part of our quality assurance program. The Case Management Supervisor is responsible for continuously monitoring compliance to all HIPAA privacy policies and procedures in Case Management including protection of patient privacy through use of a dedicated printer for patient lab results. In addition, the HIPAA Privacy Officer conducts HIPAA training for all new case management staff as part of the agency's orientation and training program as well as an annual HIPAA Compliance Training review. All corrective actions were completed by 8-20-13.	04/12/12 *(date assessment form implemented)*

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A 017	Continued From page 2 were sent to Patient B. This failure had the potential to result in misuse of private/protected information. Findings: On January 23, 2014, at 11:55 a.m., the Privacy officer (PO) was interviewed. The PO stated Patient B notified the facility on July 30, 2013, that she had received a letter in the mail that was intended for Patient A. The PO stated Patient B's name and address was on the outside envelope, but the letter inside was addressed to Patient A, and contained protected health information (PHI). The PO stated Patient B returned the letter to the facility. The letter sent to Patient B was reviewed. The letter contained Patient A's name, address, and positive test results for Chlamydia (a sexually transmitted disease). In addition, there was a one page information sheet describing the disease as a sexually transmitted disease. The information contained in the facility employee handbook, under Health Insurance Portability and Accountability Act (HIPAA) Privacy Statement. The information indicated the following: 1. Make sure all medical records are secure from unauthorized use. 2. Never allow an unauthorized person access to any medical records or PHI. 3. As a general matter, An individual's PHI may not be used or disclosed without proper permission.	A 017		