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
	CA230000367	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHASTA COMMUNITY HEALTH CENTER	1035 PLACER STREET REDDING, CA 96001

(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 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	**Repeat submission for further details.** **With regard to your letter dated February 14, 2012, please refer to the Plan of Correction below:** On 10/10/11, I was advised by our Chief Operations Officer that there had been an employee breach of PHI which had been reported by the patient. After investigation it became clear that the employee had gone into the patient's record and accessed it in such a way that it was apparent he had been able to obtain PHI. He also went to the patient, who was also his friend, and told her that her physician had been telling her the truth and treating her well. The patient felt violated and reported this incident to her clinician, who then reported it to the COO. **Investigation:** After an investigation by the patient's clinician, the Privacy Officer, as well as the COO, the patient was notified that her claim had been validated and action would be taken. The decision was made to terminate the offending employee effective 10/12/11. **Organizational Corrective Action Plan:** **Corrective Action:** When I initially replied to this corrective action request I stated that we were in the process of obtaining family members names and asking for voluntary cooperation to	
A 000	Initial Comment The following reflects the findings of the California Department of Public Health during the investigation of an entity reported incident. Entity reported incident: 286832 The inspection ws limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility. Representing the Department: 22705, HFEN A deficiency was written for entity reported incident 286832 at A017.	A 000		
A 017	1280.15(a) Health & Safety Code 1280	A 017		

Licensing and Certification Program

LABORATOR[redacted] H II, MH TIVE'S SIGNATURE Privacy/Security Officer TITLE 3/29/12 (X6) DATE

STATE FORM 6899 CIYE11 If continuation sheet 1 of 4

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A 017	Continued From page 1 (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 document review, the facility failed to prevent unlawful or unauthorized access/disclosure of medical information by failing to safeguard confidential health information for one patient when Licensed Nurse (LN) C, who was unauthorized to access the information, viewed a portion of her medical record. (Patient	A 017	block employees from their family and friends records. Since that time we have received over 100 block requests (some of them one employee with multiple family/friend members), and they continue to come in. **How other patients having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Multiple in-services have been held to reinforce the importance of the "minimum necessary" element of the HIPAA Privacy Law. Additionally, our organization has purchased add-on software called Fair Warning, which enables the building of Ad Hoc investigative reports. These report options are attached in a screen print. We also have the ability to build reports based on any aberrant behavior by an employee in addition to the automatic random reports. We have had no suspicious viewing since this incident. **What immediate measure and systemic changes will be put into place to ensure that the deficient practice does not recur:** The immediate changes were as noted above: 1. Quarterly training for every department. (Employee sign in records are available on request.) 2. E-mail reminders	

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A 017	Continued From page 2 1) Findings: 1. On 10/14/11, the California Department of Public Health (CDPH) was notified by fax, that on 10/10/11, the facility had discovered that an employee (LN C) had accessed Patient 1's medical record without authorization. During an interview on 10/20/11 at 8:10 am, Administrative Staff (Admin) A stated that Licensed Nurse (LN) C had been terminated after it was determined that he had inappropriately accessed Patient 1's record and violated the facility's policy. Admin A stated that Patient 1 complained that LN C had viewed her record. Admin A explained that they have a "tool" that shows who accessed a record and when. This "tool" showed that LN C did access Patient 1's record. She confirmed that LN C had no reason to access Patient 1's record because he had never cared for her as a patient and worked in a different department. On 10/20/11 at 9:15 am, the facility's access log was viewed by Health Information Staff B who confirmed that on 7/27/11, LN C had accessed Patient 1's demographic information which included name, address, social security number, phone number, insurance information as well as notes from all visits which included vital signs, nurses notes, and physician notes. She stated that the record showed that Patient 1 complained about LN C accessing her records, during her appointment on 10/11/11. During an interview on 10/27/11 at 9:40 am, LN C confirmed that on [redacted]11 or thereabouts, he had looked at Patient 1's lab results and last two chart	A 017	3. Fair Warning – Random and focused investigations. 4. Voluntary blocking on employee friends and family. **Description of monitoring process and positions of persons responsible for monitoring:** All department Clinical Directors are responsible for reporting any need for investigation, these reports are subsequently given to the Director of Nursing as well as the Chief Operations Officer (also the Compliance Officer) as well as the Chief Information Officer. Quality assurance efforts are reported to the Chief Operations Officer by the Privacy/Security Officer on a weekly basis. **Dates when corrective action will be completed.** Corrective Action was immediately implemented and has been ongoing since the event. Official implementation date: 02/21/12. Unofficial implementation date with development of initial plan began 10/14/11. This began with the intensified use of Fair Warning as well as ramping up department meeting in-services. Requests for voluntary blocks from family/friends went out via e-mail to the organization on 10/12/11; the date after the investigation. Respectfully submitted, Alexis Parsons	

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A 017	Continued From page 3 notes. LN C stated that he wanted to make sure that her physician was "doing right by her." LN C stated that he and Patient 1 knew each other and he told Patient 1 that he had viewed her record. The facility's policy, dated 8/24/11, Ethics, Compliance and Code of Conduct read as follows under the "Patient Relationships" section 2h on page 8, "To that end, all facility patients shall be accorded appropriate confidentiality and privacy during the provision of services and in the maintenance of medical and financial records." It read as follows under the "Patient Privacy" section on page 9, "Facility employees must never disclose confidential information that violates patients' rights to privacy. No staff member has a right to any patient information other than that necessary to perform his or her job. Patients can expect that their privacy will be protected and that patient specific information will be released only to persons authorized by law or by the patient's written consent. LN C had signed an acknowledgment of this policy on 8/17/10.	A 017		