

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/28/2014
NAME OF PROVIDER OR SUPPLIER NORTHERN INYO HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 150 Pioneer Ln, Bishop, CA 93514-2666 INYO COUNTY		
(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
	<p>1280.15(b)(2):</p> <p>(2) Subject to subdivision (c), a clinic, health facility, home health 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, or by an alternative means or at an alternative location as specified by the patient or the patient's representative in writing pursuant to Section 164.522(b) of Title 45 of the Code of Federal Regulations, no later than 15 business days after the unlawful or unauthorized access, use, or disclosure has been detected by the clinic, health facility, home health agency, or hospice. Notice may be provided by email only if the patient has previously agreed in writing to electronic notice by email.</p> <p>The CDPH verified that the affected patient or the patient's representative was notified of the unauthorized access within 15 business days.</p> <p>AND</p> <p>1280.15 (a):</p> <p>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. For purposes of this section, internal paper records, electronic mail, or facsimile transmissions inadvertently misdirected within the same facility or</p>		<p>A) continued</p> <ol style="list-style-type: none"> 1. This violating employee was terminated from Northern Inyo Hospital on August 6, 2013. 2. Patients A and Patient B were notified on September 27, 2013, via USPS Certified Mail, of the unauthorized access of their protected health information, as per regulatory requirements. 3. The Inyo County District Attorney was notified of the unauthorized access of Patient A and Patient B's protected health information by our former employee. An investigation concluded with misdemeanor charges of unlawful access to a computer were filed with a guilty verdict and sentencing occurring. 4. All staff have been re-educated on: <ol style="list-style-type: none"> a. Access & disclosure of protected health information/minimum necessary practices for work related purposes. b. Disciplinary measures as the result of intentional & purposeful access or disclosure of protected health information. 5. Revision of NIH policy "Sanctions for Breach of Patient Information" to include <ol style="list-style-type: none"> a. Minor/Moderate/Majore Breach Levels for disciplinary action guidance. b. Intentional policy violations with protected health information are a terminatable offense. 6. Development of NIH policy "Auditing of Employee Access to Patient Information" which addresses random, routine and specific cause audits of employee access to patient information and the description and practice 	

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	<p>health care system within the course of coordinating care or delivering services shall not constitute unauthorized access to, or use or disclosure of, a patient's medical information. 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.</p> <p>Based on interview and record review, the facility failed to safeguard the medical information of two patients, Patient A and Patient B, when Employee 1 accessed their electronic medical information without authorization, which resulted in a breach of medical information for Patients A and B.</p> <p>FINDINGS: On April 1, 2014 at 10:00 AM, a phone interview</p>		<p>A) 6. continued of each type of audit. 7. In addition to the "Sanctions for Breach of Patient Information" policy and the "Auditing of Employee Access to Patient Information" policy, the following additional policies and procedures are current and in practice: a. Minimum Necessary Access, Use and Disclosure of PHI b. Communicating Protected Health Information Via Electronic Mail (Email) c. Using and Disclosing Protected Health Information for Treatment, Payment and Health Care Operations d. Information Security and Integrity 8. All staff must complete mandatory MedCom training on the above policies and procedures including, passing a post-test to complete the training. 9. All new hire employees with access to hospital information systems containing protected health information are audited by the Chief Compliance Officer or designee prior to the completion of his/her 90-day Introductory Period. Individuals who are found in violation of hospital policy regarding accessing of patient information without authorization will be subject to disciplinary action as per hospital policy "Sanctions for Breach of Patient Information". 10. All new hire employees receive HIPAA training at the time of Orientation, which is now scheduled on the first day of employment and prior to his/her working in their designated department.</p>	

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	<p>was conducted with the facility privacy officer (FPO) to investigate an entity-reported incident of a breach of medical information for Patients A and B. The FPO advised that Patient A had previously been in a romantic relationship with Employee 1 prior to marrying Patient B. Patient A reported to the Facility Privacy Officer (FPO), who was also the Health Information Management Director (HIM Director), on September 23, 2013 that Employee 1 may have accessed Patient A's clinical record without authorization. At the time the report was made, Employee 1's employment with the facility had been terminated.</p> <p>The FPO/HIM Director further advised that an audit was conducted regarding Employee 1's access of Patient A's electronic medical records on September 24, 2013. The results of the audit confirmed that Employee 1 had accessed medical records for Patient A on two separate dates.</p> <p>A review of the facility's electronic audit for Patient A, dated September 24, 2013, submitted by the FPO/HIM Director, was conducted on April 4, 2014 at 2:15 PM. The document provided to the surveyor was a copy of the electronic audit and contained a computerized record of log-ins made by Employee 1 on August 5, 2010 at 2:47 PM, and which indicated Employee 1 accessed Patient A's medical information as set forth below:</p> <p>Outpatient PT (physical therapy) dated October 30, 2009;</p> <p>Correspondence dated September 24, 2009;</p>		<p>B) The Chief Compliance Officer has direct oversight of this plan of correction. C) Our plan for compliance and a monitoring process to prevent recurrence includes HIPAA training on the first day of employment and prior to the new hire employee working in their designated department, auditing of new employee record access history prior to the completion of their 90-day Introductory Period to ensure record access is only for work related purposes and to quickly identify areas of concern. HIPAA staff training on a mandatory annual basis and as needed throughout the year when concerns/new requirements arise. In addition, the Chief Compliance Officer will monitor and address compliance through reports of PHI breaches and investigations. The Chief Compliance Officer will report the number of PHI breaches to Performance Excellence and the Board of Directors on annual basis. D) Corrective Action was completed on July 31, 2014.</p>	<p>9/5/2015 1/1/2014 7/31/2014</p>

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	<p>Doctor's first report dated September 22, 2009;</p> <p>Emergency room visit dated September 21, 2009;</p> <p>Emergency Room x-ray results dated September 21, 2009.</p> <p>Further review of the audit showed that Employee 1 had accessed Patient A's record again on February 1, 2013 and had viewed laboratory results, dated August 14, 2012.</p> <p>Review of the electronic audit showed that next to each entry under the section entitled, "Authorization" was listed: "No". When the FPO/HIM Director was asked how she would determined when Employee 1 was authorized in the role of Medical Records Clerk to access patient medical information, she stated that, "A file or a portion of the file will have a request submitted by a doctor, insurance company etc." She further advised that, "My audit system would show me it was requested, and then whether it was faxed, or mailed." The FPO/HIM Director advised that there had been no request submitted for Patient A's clinical record or medical information.</p> <p>During continued interview with the FPO/HIM Director on April 1, 2014, at 10:00 AM, she advised that Patient A's spouse (Patient B), also contacted her on September 13, 2013, and also requested that an audit be completed regarding access by Employee 1 of Patient B's medical records. An audit was conducted by the FPO/HIM Director on</p>			

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	<p>September 24, 2013.</p> <p>A review of the medical record audit for Patient B, dated September 24, 2013, was conducted on April 4, 2014 at 2:30 PM. The document contained a computerized record of log-ins made by Employee 1 on February 1, 2013 from 3:34 PM to 3:35 PM, which indicated Employee 1 had accessed the following medical information of Patient B:</p> <ul style="list-style-type: none"> a. Emergency room visit dated February 5, 2012 b. Emergency room laboratory results dated February 5, 2012 c. Emergency room x-ray results dated February 5, 2012 d. Outpatient x-ray results dated January 7, 2011 e. Outpatient laboratory results dated December 1, 2010 f. Laboratory results dated June 11, 2012 g. Physician Orders dated June 11, 2012 h. Laboratory results dated June 14, 2013 <p>On the audit document, next to each record entry accessed by Employee 1, was a column with a section entitled, "Authorization on file." For each record entry under this authorization on file column, it was listed: "No". The FPQ/HIM Director was asked how she would determine when Employee 1</p>			

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	<p>was authorized in the role of Medical Records Clerk to access patient medical information, she stated that, "A file or a portion of the file will have a request submitted by a doctor, insurance company etc." She further advised that, "My audit system would show me it was requested, and then whether it was faxed, or mailed." The FPO/HIM Director advised that there had been no request submitted for Patient B's clinical record or medical information.</p> <p>On April 4, 2014 at 11:00 AM, a review was conducted of the face sheets (a form that contains the patient's demographic information) for Patient A and Patient B. As explained by the FPO/Director of Medical Records, face sheets can be viewed when entering a patient's electronic file if the person activated that tab under the patients' name. The FPO/Director of Medical Records further explained that the face sheets contain information with patient's name, address, home and work phone numbers, social security number, admission date, date of birth, emergency contact information, insurance information and workers' compensation information.</p> <p>An interview was conducted on April 4, 2014 at 4:15 PM, with the FPO. The FPO advised that Employee 1 was employed in the role of admissions clerk from July 10, 2010 through October 12, 2012, and was employed in the role of medical records clerk from October 2012 through August 2013.</p> <p>A review of Employee 1 termination letter, dated</p>			

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	<p>August 7, 2013, was conducted and reflected Employee 1 was terminated following a previous incident of "deliberate violation of hospital policy resulting in a breach of patient privacy and unlawful access to patient health information." The letter was signed by the Health Information Management Director (HIM Director).</p> <p>During a review of the facility's admission clerk job description/evaluation signed by Employee 1 on July 13, 2010, the duties included: "inputting data of new patients into the computer" and "obtaining signatures on consents and admission forms."</p> <p>During a review of the facility's medical record clerk job description/evaluation signed by Employee 1 on September 27, 2012, the duties included: "Conducting hospital business in an ethical and lawful manner." Other duties listed included: "File all records ready for destruction, Perform quality review check on records ready for destruction...Answer telephones when necessary; Helps physicians and staff locate needed records. Takes information for records releases."</p> <p>When the FPO/HIM Director was asked how she determined when Employee 1 was authorized in the role of Medical Records Clerk to access patient medical information, she stated that, "A file or a portion of the file will have a request submitted by a doctor, insurance company etc." She further advised that, "My audit system would show me it was requested, and then whether it was faxed, or mailed." The FPO/HIM Director advised that there had been no request submitted for Patients A or</p>			

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	<p>B's clinical record or medical information.</p> <p>The FPO provided copies of Employee 1's training in protecting patient confidentiality. A document entitled, "Statement of Confidentiality," dated July 12, 2010, which included information concerning Employee 1's annual updated training in confidentiality through September 2012, was reviewed. The documents indicated that Employee 1 was aware that access to patient's medical information was on a "need to know" basis, "In order to carry out the duties involved in the treatment, billing, or healthcare operations of the hospital," and had been trained in patient confidentiality. In addition, on July 12, 2010, Employee 1 signed a "Statement of Confidentiality," which indicated, "I further understand that ignoring or disregarding the principles of this confidentiality acknowledgment subjects me to appropriate disciplinary actions as outlined in the personnel policies, medical staff bylaws and ...other applicable policies. Employee 1 signed the acknowledgement on July 12, 2010.</p> <p>The facility failed to ensure that confidentiality of patient medical information was maintained. when portions of electronic medical records of both Patient A and Patient B, were accessed by Employee 1, without authorization. This failure of the facility to ensure the confidentiality and security of Patients' A and B's medical information resulted in breaches of medical information, and which placed both patients at risk for identity theft.</p>			<p>STATE DEPT. OF HEALTH SERVICES 15 SEP -8 AM 7:48 LIC. & CERT. SAN BERNARDINO COUNTY</p>	

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