







CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>050222</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/26/2009</b>
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NAME OF PROVIDER OR SUPPLIER <b>SHARP CHULA VISTA MEDICAL CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>751 MEDICAL CENTER COURT, CHULA VISTA, CA 92010 SAN DIEGO COUNTY</b>
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	<p><b>Continued From page 3</b></p> <p>Findings:</p> <p>Patient 1 was admitted to the facility on [REDACTED]/09 with diagnoses that included acute myocardial infarction (heart attack) per the History and Physical.</p> <p>An interview with the Director of Emergency Department/Critical Care/Cardiology Services was conducted on 4/30/09 at 3:00 P.M. She stated that the facility conducted an investigation after Patient 1's wife informed them that she had a concern that some facility staff, who were not involved with the patient's care, may have accessed the patient's health care information. The Director of Emergency Department/Critical Care/Cardiology Services stated that Patient 1 was a physician at the facility. She stated that the administration discovered a number of facility staff who were not part of the patient's care team that accessed the patient's health care information. A list of the facility staff who obtained direct unauthorized access to the patient's PHI was requested from the Director of Emergency Department/Critical Care/Cardiology Services.</p> <p>An interview with a social worker (SW), whose name was included on the list, was conducted on 4/30/09 at 3:45 P.M. When asked why her name showed up as one of the staff who accessed Patient 1's health care information, the SW stated that she heard "Code Blue" being announced overhead. The SW stated that she was not familiar with the area where the "Code Blue" was called. The SW explained that she looked in the computer to familiarize herself with the area. When asked</p>		<p>California Laws that may include disciplinary action up to termination. Staff was re-educated to log out of the computer after use and privacy settings were loaded on computers to time after 10 minutes of inactivity. Cerner is being implemented at the facility 4/3/2010 and requires a reason for access to be documented in the electronic record prior to use.</p> <p>d). Random computer surveillance every six months to ensure that staff is accessing only patient information that they need to provide assigned patient care. Report compliance to Quality and Patient Safety Counsel.</p> <p>e). 6/30/2009 and 4/3/2010 for the Cerner application.</p>	
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Event ID: JQ5311

11/30/2010

1:38:28PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Christine Baschere*

CNO

12/15/2010

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.





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	<p><b>Continued From page 6</b></p> <p>informed her about Patient 1's health condition. Patient 1's wife explained that she was concerned that the breach of Patient 1's privacy may affect their business.</p> <p>An interview with LN 2 was conducted on 5/20/09 at 2:20 P.M. LN 2 stated that she worked as a charge nurse in the post anesthesia care unit (PACU). LN 2 stated that Patient 1 was never a patient in PACU. LN 2 explained that she accessed Patient 1's health care information because she was concerned about the patient. LN 2 acknowledged that she should not have accessed Patient 1's health care information without authorization. A review of LN 2's employee file indicated that she had completed the "Compliance Education 2008 - Information Security" and "Compliance Education 2008 - Privacy Education" provided by the facility on 10/30/08. In addition, LN 2 also completed the "2009 California Privacy Laws Module" provided by the facility on 4/9/09.</p> <p>An interview with LN 3 was conducted on 5/20/09 at 2:40 P.M. LN 3 stated that he worked as a charge nurse on 5 east telemetry unit (a unit that provides continuous monitoring of heart patients around the clock). LN 3 stated that one of the nurses on the unit informed him that Patient 1 was in the facility. LN 3 stated that he accessed Patient 1's health care information because he was curious and was concerned about the patient. LN 3 acknowledged that he should not have accessed Patient 1's health care information. A review of LN 3's employee file indicated that he had completed the "2009 California Privacy Laws Module" provided by the</p>			
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	<p><b>Continued From page 10</b></p> <p>"logged-on" under her user code. A review of LN 8's employee file indicated that she had completed the "Compliance Education 2008 - Information Security" and "Compliance Education 2008 - Privacy Education" provided by the facility on 10/27/08. In addition, LN 8 also completed the "2009 California Privacy Laws Module" provided by the facility on 4/30/09.</p> <p>A phone interview with Patient 2's son was conducted on 6/2/09 at 12:30 P.M. He stated that Patient 2 was a client of Patient 1. He stated that he took Patient 2 to the facility's laboratory for a blood draw. He stated that a female staff at the check-in window told them that his mother's physician (Patient 1) was in the facility as a patient because of heart problem.</p> <p>An interview with unit clerk 3 was conducted on 6/4/09 at 3:05 P.M. She stated that she accessed Patient 1's health care information because Patient 1 was her husband's physician and that she was concerned about Patient 1's health. Unit Clerk 3 acknowledged that she should not have accessed Patient 1's health care information without authorization. A review of unit clerk 3's employee file indicated that she had completed the "2009 California Privacy Laws Module" provided by the facility on 4/16/09.</p> <p>An interview with laboratory staff 1 was conducted on 6/5/09 at 7:15 A.M. She stated that she and another laboratory staff were discussing Patient 1 at the front desk area when another patient and her son came up to the window to sign-in. Laboratory</p>			

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	<p><b>Continued From page 13</b></p> <p>review of Physician 3's employee file revealed a signed document of "Acknowledgement and Agreement" regarding maintaining the confidentiality of patient information dated 12/28/08. A review of Physician 4's employee file revealed a signed document of "Acknowledgement and Agreement" regarding maintaining the confidentiality of patient information dated 1/26/09.</p> <p>Attempts to interview radiology technician 1, whose name was included on the list of facility staff that accessed Patient 1's health care information, were made but was unsuccessful. Radiology technician 1 was called three times and messages were left for him to call back. Radiology technician 1 eventually called back but surveyor missed the calls. However, on 7/1/09 at 9:45 A.M., radiology technician 1 came to the office and was interviewed. He stated that he worked at the facility's radiology area and was also an instructor at a local college. He stated that he did not remember all the details that had happened regarding Patient 1. He stated that for the purpose of teaching his students, he would look at the emergency room tracking screen in the computer and select patients with interesting cases and orders. He explained that if a patient was worked on by another radiology technician but if that particular patient's case was interesting, he would look at that patient's information to share with his students. A review of radiology technician 1's employee file indicated that he completed the "2009 California Privacy Laws Module" provided by the facility on 4/15/09.</p>			
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	<p><b>Continued From page 14</b></p> <p>A review of the facility's policy and procedure titled "Health Information: Access, Use and Disclosure" indicated that, "C. (name of the facility) Workforce Access: Access to health information will be limited to: 1. Personnel providing care and treatment 2. Individuals requiring information for payment/billing activities 3. Individuals participating in functions of health care operations." This policy and procedure was not followed when facility staff, who were not involved with Patient 1's care, accessed the patient's health care information without authorization.</p> <p>A review of the facility's policy and procedure titled "Confidentiality of Information" indicated that, "4. Strict confidentiality of computer passwords must be maintained. 5. Physical security and access control must be maintained as appropriate." This policy and procedure was not followed when facility staff did not "log-off" the computer before leaving the computer area which allowed anybody to access Patient 1's health care information.</p> <p>On 7/1/09 at 3:00 P.M., the Vice President of Patient Care Services was informed that an interview with radiology technician 1 was conducted on 7/1/09, after the exit date of 6/26/09. He was informed that the interview with radiology technician 1 did not change the outcome of the investigation.</p> <p>Twenty facility staff, which included licensed nurses, physicians, a social worker, radiology technician, and clerical staff, either obtained direct unauthorized access to the patient's PHI, or</p>			
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