

(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	<p>Initial Comment</p> <p>The following reflects the findings of the Department of Public Health during a Complaint Investigation.</p> <p>Amended 11/27/2013</p> <p>Complaint Intake Number: CA00297295</p> <p>The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.</p> <p>Representing the Department of Public Health:</p> <p>Evaluator ID #17116, RN, HFEN</p>	A 000	<p>Torrance Memorial acknowledges that the anesthesiologist placed stickers in the form of a mustache and teardrops on the patient's face and one employee, at the direction of the anesthesiologist, took one photograph. It was not widely published, shown or distributed. While Torrance Memorial does not ratify or condone any of these actions, we dispute many of the statements in this Summary Statement of Deficiencies and refer DPH to our previously submitted Separate Statement of Facts.</p>	
A 017	<p>1280.15(a) Health & Safety Code 1280</p> <p>(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.</p>	A 017		

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Lizzy Perwick RN, MSN, NEA-BC *Asst. VP. Pt. Service/CNO* *12-11-13*

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A 017	<p>Continued From page 1</p> <p>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>This Statute is not met as evidenced by: Based on interviews and review of records, the facility failed to protect Patient 1's right to privacy and confidentiality of her medical information.</p> <p>Patient 1 was admitted as an outpatient for a surgical procedure. While under sedation, stickers replicating tears and a moustache were placed on the patient's face, and an unauthorized photograph was taken. The photograph was viewed by an undetermined number of people.</p> <p>The recording of Patient 1's likeness without permission, and the facility's failure to prevent the unauthorized disbursement of the photograph and identity of the patient to an undisclosed number of people, directly or through electronic systems, violated Patient 1's right to privacy and confidentiality of her medical information.</p> <p>Findings:</p> <p>On January 25, 2012, an unannounced complaint investigation was conducted at the facility in response to a report of a photograph taken of a patient during a surgical procedure without prior authorization from the patient. The photograph was allegedly viewed by unidentified persons.</p>	A 017		

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A 017	<p>Continued From page 2</p> <p>Allegations were made that while Patient 1, who was a long-time employee at the facility, was unconscious after being sedated for surgery, stickers with drawings of tears and a moustache were placed on the patient's face. A cellular phone was brought into the operating room (OR) and a photograph was taken of the patient. That photograph was allegedly viewed by others.</p> <p>On January 25, 2012, at 1:30 p.m., Administrator B confirmed during an interview, "Some employees in the OR applied stickers [to the patient's face], and took a picture."</p> <p>Administrator A said their investigation, which began upon their discovery of the incident on November 8, 2011, produced "only three (3) employees" (Employees J, R, and Nurse Q) who had knowledge of the incident. Employee B added, "Two of them were disciplined for failure to report [the incident], but they did not participate."</p> <p>A review of Patient 1's surgical record produced a form entitled "Surgery Documentation." On that form, participants in Patient 1's surgical care were identified, and included Physician L, Physician M, Employee J, and Employee K. No other staff members were noted.</p> <p>"Human Resources (Admin X and Employee H) interviewed all the employees who provided Patient 1's care in the OR," Admin B stated at 2:00 p.m. "No one else was involved," she said.</p> <p>At 2:10 p.m., Admin A disclosed the anesthesiologist (Physician L) who provided care to Patient 1 during the surgery was also found to have participated in the incident. "It was the</p>	A 017	<p>The statement that Administrator B confirmed during an interview that "some employees in the OR applied stickers to the patient's face" is inaccurate. (Refer to previously submitted declaration of Administrator B.) By the time of the interview, Administrator B had the admission from the anesthesiologist that he, and he alone, applied the stickers. He is not an employee of Torrance Memorial. No employee knew that he did this until after the procedure was over and the drapes came down.</p>	

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A 017	<p>Continued From page 3</p> <p>Physician L who put the stickers on Patient 1's face," Admin B stated. "He was referred to the Medical Staff for review." Physician L was not available for interview.</p> <p>Administrator A disclosed an employee who was not listed in the surgical record, Employee R, who used her cell phone to take a photograph of Patient 1 with the stickers on. "She didn't share it with anyone. No one else [outside of the OR] knew about it," she said. Employee R was not available for interview.</p> <p>Patient 1's boss, Supervisor D, stated at 2:15 p.m., "The picture was sent to Patient 1's cell phone." He added, "They are good friends; it was all in fun. No one said anyone shared it or put the picture on Facebook."</p> <p>On January 25, 2012, at 2:20 p.m., an interview was conducted with Employee E, who was identified as "a friend of Patient 1." She stated, "It was all over the hospital. I think a lot of people heard about it. Patient 1 was upset."</p> <p>At 2:30 p.m., Employee I, was also interviewed. "Everyone was talking about it at work," she said. They sent the picture to their friends. They showed the picture to other co-workers." No one could identify who actually had the picture, who was sharing it, or who had received or seen it.</p> <p>Employee I stated that Patient 1 showed her the picture from a personal cell phone several days after her return to work following her surgery. "When I saw how upset and sad Patient 1 was, I was concerned."</p> <p>Employee I reported the photograph and the incident to her supervisor, Supervisor W, who</p>	A 017	<p>Employee E is unable to provide any facts to support this. When questioned further, Employee E acknowledged this was speculation. This Summary fails to cite the responses of the other employees who reported otherwise.</p>	

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A 017	<p>Continued From page 4</p> <p>reported it to Patient 1's supervisor (D). "That was the first I had heard of it," Supervisor D said in an interview at 2:45 p.m. "I immediately reported it to Administrator B."</p> <p>A document provided by the facility noted Patient 1 met with Supervisor D and Administrator B on the morning of November 8, 2011. "She was upset and asked if she could go [home] after that. She hasn't come back, or talked to anyone since," Administrator B stated.</p> <p>During the interviews on January 25, 2012, Administrator H stated all employees go through HIPAA (Health Insurance Portability and Accountability Act) inservice upon hire. "It is a standard part of orientation," she explained. Administrator C presented a sample of the documents containing a list of the issues covered during new employee orientation, which included legal issues, such as HIPAA. Updates were provided annually. They could not explain why none of their staff, except Employee I, made an effort to report the event.</p> <p>A review of personnel files of all the employees involved confirmed HIPAA training had been provided, as reported.</p> <p>A follow up visit was conducted with Administrator A on April 8, 2012, at 9:10 a.m. Also present was Administrator X, who had interviewed all the employees involved in the incident with Patient 1.</p> <p>Admin X stated during her investigation, "I learned the sequence of events and each individual with knowledge of the incident."</p> <p>During the interview, Administrators A and X reported they had identified additional staff</p>	A 017		

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A 017	<p>Continued From page 5</p> <p>members who were present while Patient 1 was still in the OR. Although not noted in Patient 1's surgical record, facility documents reviewed showed Employees E, R, T, U, and Nurse Q were in the OR at the time of the incident.</p> <p>Admin X explained each employee's task in the OR, and presented documents of the interviews the facility conducted with each one. Employee R, who took the picture of patient 1, was a nurse assistant who reportedly arrived to transport the patient to the recovery area. Employee T was "in orientation" and following Employee R. She was "picking up trash" and "didn't see anything." Employee U, an anesthesia tech, was said to be present only "at the beginning of the procedure" and then left.</p> <p>Nurse Q was an unscheduled relief nurse for the circulating nurse (Nurse K), who arrived at the end of the case, "to help out." She saw the stickers on the patient's face and demanded they be removed, but she did not intervene when a picture(s) was taken. She'd declared in an interview with staff, "I guess I missed the HIPAA thing."</p> <p>Employee I had testified during one interview that a representative from an outside company commented about hearing "what happened" and said he saw a picture resembling Patient 1's likeness on a social media platform (Facebook). Another non-employee (Y) testified he saw a picture that "looked like" Patient 1 posted on Facebook.</p> <p>Although not available for interview, records of interviews contained documentation of Physician</p>	A 017	<p>The statement that "although not noted in Patient's surgical record," implies these employees had no right to be present. The interview revealed that all individuals present were there for legitimate business purposes.</p> <p>There is no evidence that the photograph was ever published on Facebook or any other social media. Nonemployee (Y), when shown the photograph of the patient, testified at his deposition that he had not seen this photograph on Facebook.</p>	

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A 017	<p>Continued From page 6</p> <p>L's statements regarding the incident on [REDACTED] 2011 with Patient 1. A review of those documents revealed that Physician L disclosed he drew tear drops and a moustache on stickers and placed them on Patient 1's face.</p> <p>He reported, "it was towards the end of surgery," and explained a barrier drape that exposed only the patient's surgical site blocked the staff's view of him and his actions. The operating room staff were not aware of the stickers until the surgery ended and the drape was removed, at which time Patient 1's face became visible to them.</p> <p>In interviews documented by the facility, employees R and E laughed when they saw the stickers on the patient's face, and remarked the patient would "like it," and think it was funny. When "someone" suggested they should take a photograph of the patient before the stickers were removed, Employee R retrieved her cellular phone and took a picture.</p> <p>Physician L stated he removed all but one teardrop sticker when Nurse Q said they had to be taken off before Patient 1 was taken to Recovery.</p> <p>Employee R said when the patient was in the Recovery Room (RR), she showed the photograph on her cell phone to Patient 1, who reportedly asked her to send it to the patient's cell phone. Employee R said then she deleted it, and declared she never showed the picture or sent it to anyone else.</p> <p>Patient 1 was interviewed on April 22, 2013, at 2 p.m. "When I woke [in recovery room] the teardrop sticker on my face was pointed out to me." A friend said, "What's that on your face?"</p>	A 017		

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A 017	<p>Continued From page 7</p> <p>The patient said she felt the sticker and removed it, but was not aware of what it was.</p> <p>Patient 1 was discharged and walking towards the recovery room exit door when Employee R approached and held up her cellular phone to show the picture that she had taken in the OR. Patient 1 said, "I was still dazed, and didn't understand at the time. I might have told her to 'just send it.' I don't remember really seeing the picture." The patient said, "I didn't know what to think, why they did that. I just focused on getting better [from surgery]."</p> <p>Upon returning to work on November 1, 2011, Patient 1 reported feeling sad and humiliated when people who had previously been friendly, became cool and aloof.</p> <p>The patient felt ostracized and believed the photograph taken in the OR had "gotten around." "People came up to me and remarked on how I looked [in the picture or in the OR] or commented what a bad thing was done to me," Patient 1 divulged.</p> <p>"I thought, 'How would they know?'" Patient 1 said. "I figured the only way was if they had been in the OR, too, or seen the picture. And I wondered who else had been in there? What else had been done to me?"</p> <p>A review of Patient 1's surgical record produced a form entitled, "Patients' Rights" and was signed by Patient 1 on [REDACTED] 2011. The form listed all patient rights, including the right to confidential treatment of all communications and records pertaining tot he patient's care and stay in the hospital. It declared that written permission would be obtained before medical or personal</p>	A 017	<p>The Summary omits statements made by other employees regarding the patient's return to work.</p>	

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A 017	<p>Continued From page 8</p> <p>information was made available to anyone "not directly concerned with the patient's care."</p> <p>Further review of the record revealed no documented evidence that written permission was obtained from the patient before anyone, who was not directly concerned with her care, was given access to information about, and the identity of, Patient 1.</p> <p>Based on the findings, the facility failed to prevent unlawful or unauthorized disclosure and disbursement of the photographic identity and protected health information of Patient 1 to an undisclosed number of people, directly or through electronic systems, without the patient's consent, in violation of Health and Safety Code Section 1280.15(a).</p>	A 017	<p><u>Plan of Correction:</u></p> <p>The anesthesiologist, who is not an employee, placed stickers on the patient's face. This was not known or discovered by any hospital employee until after the drapes came down. He was instructed by a nurse to remove the stickers immediately. The anesthesiologist's behavior, upon discovery by Administration, was reported to the Medical Staff and to his medical group for investigation and disciplinary action. He was suspended from practice for 2 weeks and provided with privacy training. Disciplinary action completed by anesthesiologist's medical group and privacy training completed by Torrance Memorial HIPAA Compliance Manager.</p> <p>The nurse attendant, who was instructed by the anesthesiologist to take a photo, was suspended. After the investigation, this employee was disciplined and placed on a final written warning. (Two steps in the disciplinary process were skipped due to the seriousness of her actions.) The two employees who learned of the incident but failed to timely report the event were also placed on investigatory suspension. They were subsequently disciplined. Director of Perioperative Services and VP Human Resources are responsible.</p> <p>Re-training for all O.R. staff, including these 3 employees, took place on patient privacy. HIPAA Compliance Manager is responsible.</p> <p>All employees undergo HIPAA and privacy training upon hire and annually at a minimum. All employees sign a confidentiality agreement upon hire and annually to protect patients' private health information. We take our patients' privacy very seriously and do not condone the actions of the anesthesiologist or the nurse attendant.</p> <p>Monitoring process: 100% employee training/testing on Privacy annually and executed Confidentiality Agreements. VP Human Resource is responsible.</p>	<p>October 2013</p> <p>October 2013 and ongoing</p> <p>October 2013 and ongoing</p> <p>Ongoing</p>