CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	051319	A. BUILDING _____ B. WING _____	04/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mercy Medical Center Mt. Shasta	914 Pine St, Mount Shasta, CA 96067-2143 SISKIYOU COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
	The following reflects the findings of the Department of Public Health during a complaint/breach event visit: Complaint Intake Number: CA00343448 - Substantiated Representing the Department of Public Health: Surveyor ID # 22705, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. Health and Safety Code Section 1280.15(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		**CORRECTIVE ACTION PLAN (343448):** A. Immediate Corrective Action: 1) Thorough investigation of event. 2) Patient notified of incident in writing. B,C. Deficient practice identification, corrective measures, and systemic changes: 1) Education of responsible Radiology staff member February 15, 2013 and also Radiology department during staff meeting March 6, 2013 : a) Ensure information accessed is on a need to know basis b) Systemic changes include: 1. Staff are to access only the information necessary to carry out roles and functions for treatment of patients during radiology services, also education on safeguarding passwords.	Completed by Facility Privacy Official 2/19/13 Completed by Radiology Manager & Facility Privacy Official 2/15/13

Event ID:94OM11 1/10/2014 8:15:09AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE President (X6) DATE 1/21/2014

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 4

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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	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. 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. Based on interview and record review, the facility failed to safeguard confidential health information when Patient 1's record was viewed by Radiology Technician (RT) B, outside the scope of her duties as an employee. This resulted in the unauthorized access of Patient 1's confidential health information.		D. Monitoring: 1) Monitoring of access by radiology Staff member to ensure: a) Ensure access is appropriate E. Monitoring completed and education with responsible employee and Radiology Staff members. Monitoring will be conducted by the Radiology Manager/Designee and reported to the Quality Assessment and Improvement Committee and Facility Privacy Official	Monitoring done February – April 2013 by Facility Privacy Official & Radiology designee

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	Findings: 1. On 2/12/13, the California Department of Public Health (CDPH) received a faxed report, written by Administrative Staff (Admin) A, that the facility had discovered, on 2/5/13, that RT B had accessed the medical records of Patient 1 on 2/5/13, outside the scope of her duties A review of the facility's policy titled, "Privacy and Security Investigations and Reporting", revised 11/12, read as follows: "Breach of privacy and confidentiality occurs when any member of the facility workforce uses (accesses or reviews) protected health information or confidential information for any reason not necessary to the individual's role in the provision of care and treatment." A Level II Breach was defined as: "Access, use or disclosure of patient information was intentional for the purpose of curiosity or concern but not for personal gain." During an interview on 4/19/13 at 10:15 am, Admin A stated that it was discovered on 2/5/13 at 7 pm , that RT B had viewed Patient 1's CAT scan and report on 2/5/13 at 3:47 pm . Admin A confirmed this was outside the scope of RT B's duties and stated that she viewed this as a Level II Breach. During an interview on 4/19/13 at 9:20 am, RT B confirmed she had viewed Patient 1's CAT scan and there was no reason connected to her job for her to have looked at this scan. She confirmed she had received annual education regarding confidentiality and privacy. RT B stated she had			

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	verbal consent from Patient 1 and did not know that she needed written consent before viewing the record. During an interview on 4/19/13 at 10:15 am, Admin A stated that the need to have written consent as well as the correct process to view records was covered in the annual employee training.			