

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>CA230000089</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/14/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>FEATHER RIVER TRIBAL HEALTH INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2145 5TH AVENUE OROVILLE, CA 95965</b>		
(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			
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: 265525  The inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility.  Representing the Department: 28650, HFEN  A deficiency was written for entity reported incident 265525 at A 017	A 000	The provider plan of correction represents the Feather River Tribal Health, Inc. (FRTH) response to the unauthorized access, use, or disclosure of the four patient's (Patient 1-4) medical information as reported in incident #265525.5.  Preparation and execution of this plan of correction should not be construed as an admission of the deficiencies cited.		
A 017	1280.15(a) Health & Safety Code 1280	A 017			

Licensing and Certification Division

*Maria Hungler*

TITLE

(X6) DATE

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

*Executive Director*

*5/26/11*

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A 017	<p>Continued From page 1</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, 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 interview and record review, the facility failed to safeguard confidential health information for four patients. (Patients 1, 2, 3 and 4)</p> <p>Findings:</p> <p>On 4/11/11, the California Department of Public Health (CDPH) received a faxed letter written by Administrative Staff A, that indicated that the</p>	A 017	<p>FRTH responded to the complaint of Patient #1 of unauthorized access to patient information by conducting an investigation, documenting the investigation, reporting the apparent breach to appropriate agencies, informing involved patients, and taking action regarding the involved employee.</p> <p>Patients or the patient's representative of patient 1, 2, 3, and 4 were immediately notified in written form of the possible unauthorized access of their personal health information. The notification included the information accessed, suggested actions the patient or representative should take to review the safety of their personal information, information to assist the patient to file a civil complaint if they desired, and an offer to assist the patient with any concerns they might have.</p> <p>Security checks for access to the affected patients and randomly selected other patients are conducted to insure no unauthorized access to information has occurred. The random checks are part of FRTH's ongoing electronic record monitoring. The access checks are routinely run when access to a high profile patient is involved. All patient concerns regarding access to records include a review of specific staff's access to records.</p> <p style="text-align: center;">-- CONT --</p>

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A 017	<p>Continued From page 2</p> <p>facility had received a complaint involving a possible breach of personal information from Patient 1 on [REDACTED] 11.</p> <p>During a concurrent interview, with Administrative (Admin) Staff A and Admin B on 4/13/11 at 9:30 am, they related that Patient 1 had complained that Verification Clerk (VC) C, had knowledge regarding Patient 1, Patient 2, Patient 3 and Patient 4's scheduled appointments. VC C was previously counseled not to access those particular scheduling records due to a domestic dispute that involved VC C and Patient 1. According to an investigation conducted by Admin Staff B on 4/7/11, it was determined that VC C had accessed the scheduling records viewing appointment dates and registration information (this information included, name, phone number, date of appointment and physician or specialist scheduled to be seen). During the facility's investigation, VC C verified that she had been previously counseled regarding not accessing those particular scheduling records. VC C was terminated by the facility on 4/8/11.</p> <p>The facility's policy, titled, "Access to Records- Paper and Electronic" dated, 2/14/11, read, "It is the responsibility of all employees to safeguard private information, health or otherwise, and to ensure its security and confidentiality."</p> <p>The facility held an in-service/training, titled, "HIPAA- Access to Records- Paper and Electronic" on 2/22/11 and according to the attendance record, VC C had attended this course.</p> <p>VC C was interviewed on 4/13/11 at 12:50 pm, she acknowledged that she had accessed the scheduling records of Patients 1, 2, 3 and 4. She</p>	A 017	<p>Staff newsletters and staff meetings contain information regarding HIPAA and types of incidents that the facility has reviewed. New staff orientation includes HIPAA training and testing with a strong emphasis on the reporting and investigation of HIPAA concerns and employee responsibility to uphold HIPAA standards and report any known concerns.</p> <p>The Executive Director, QI Coordinator, and HIPAA Compliance Officer are responsible to investigate, report and review agency policies and practices relating to the safeguarding of the patients PHI. Incidents are reviewed by the QI committee and policy changes are reviewed and reported to all employees via the department heads and written documentation of individual staff training and during staff in-service meetings. The Board of Directors is provided with a report of issues and activities on a monthly basis.</p> <p>All staff is required to take online Security Awareness Training on a yearly basis. This training includes information on HIPAA. June 15, 2011 is the next full staff meeting and will include a review of the HIPAA policies and information.</p> <p>Employees found to be in violation of HIPAA policies are disciplined according to the severity of the incident. The employee in this incident was immediately terminated following completion of the investigation. The patients were notified following the investigation. The appropriate regulatory agencies and the agency's accrediting body, AAAHC, were notified within the required time-frames following the completion of the investigation.</p> <p>The plan of correction will be completed following the June 15th staff meeting/training. All other aspects of the plan are current practices and were used in this reported incident.</p>	

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A 017	Continued From page 3  acknowledged that she was not supposed to access those scheduling records following an issue that had occurred around 9/2010, when the facility had generated and posted a list on her computer terminal of patients names (Patients 1, 2, 3 and 4) that she was not to access. VC C acknowledged that despite the fact that she was not supposed to access those records, she had done so on multiple occasions.  During a concurrent interview and document review with Admin B, on 4/14/11 at 9 am, she confirmed that VC C does routinely have access to scheduling records as part of her regular duties, but that she had been instructed not to access any of the names from the restricted list, which included Patients 1, 2, 3 and 4. VC C's computer log reports were reviewed from 1/6/11 through 4/6/11 and according to Admin A and Admin B, the audit showed a pattern of excessive accessing of scheduling records for Patients 1, 2, 3 and 4. VC C accessed Patient 1's scheduling records 8 times. VC C accessed Patient 2's scheduling records 15 times. VC C accessed Patient 3's scheduling records 20 times. VC C accessed Patient 4's scheduling records 19 times. According to Admin B, who had previously reviewed the computer access to determine if the access was reasonable and within the scope of VC C job. The following factors were considered: 1. was the record access the result of printing a report for insurance verification. 2. was there a correlation to the dates of access and appointments. 3. was the access different than that of other patient records accessed that VC C had done during the course of her normal work week. 4. could someone else have accessed those patients under VC C's log-in. Admin B, reported that her investigation completed on 4/7/11, showed that the access did not seem to	A 017			

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A 017	Continued From page 4  be consistent with with access that VC C would have had in the normal course of her work. The access was excessive and different than that of her normal work access.	A 017			