CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

050315

A BUILDING

KERN MEDICAL CENTER
1700 Mount Vernon Avenue, BAKERSFIELD, CA 93306 KERN COUNTY

NAME OF PROVIDER OR SUPPLIER
STREET ADDRESS, CITY, STATE, ZIP CODE

IDENTIFICATION NUMBER: COMPLETED

A BUILDING
B WING

 Date Survey
 completed

12/22/2009

PRELIMINARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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The following reflects the findings of the Department of Public Health during a complaint/breach event visit:

Complaint Intake Number:
CA00209743 - Substantiated

Representing the Department of Public Health:

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 patient's medical information.

Health and Safety Code 1280.15(i)

For purposes of this section, the following...
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<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>WOYN11</td>
<td>9/21/2010</td>
<td>12:38:44 PM</td>
<td>Continued From page 1</td>
<td>Event</td>
<td>EVENT ID</td>
<td>DATE</td>
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1. Information Systems conducts an audit of reports that are currently being generated in paper format. A copy of this report is provided to all Administrative staff members. These reports are reviewed with the managers and supervisors to determine what other paper reports could be eliminated or placed in electronic format.

2. The Privacy Officer and a member of the Information Systems department were added to the Environment of Care Team.

3. The lockers that were located outside of the Information Systems building have been removed.

Based on observation, interview, and record review, the hospital failed to protect documents which contained protected health information from theft by unauthorized person or persons.

Findings:

On December 3, 2009, at 1:45 PM, the area containing the storage lockers used for distribution of laboratory reports was observed. The lockers had been removed from the property. The area where the lockers had been located was outside of Information Systems Building F adjacent to the west door of the building at the bottom of the stairwell. There was an access road next to the building. The area was not visible to staff in the Information Systems Building F or in

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.
Continued From page 2

Information System Trailer number 6 located across the access road from Information Systems Building F. The area was accessible to any person on the hospital property.

During an interview with Staff A, on December 3, 2009, at 2 PM, he stated he placed the daily cumulative laboratory reports in the outside locker around October 31, 2009, at 1:20 AM, but did not lock the locker because the lock was not functioning properly and the locker door was broken. Staff A (responsible for running and storing the laboratory reports) stated he was contacted by Security staff at approximately 4:30 AM on October 31, 2009, inquiring about the missing reports. He stated Security staff and he searched the immediate area for the missing reports and notified the House Supervisor of the incident. Staff A stated the locker had not been secured for several months and thought the issue had been reported to Information Systems Management but he did not report the issue himself. Staff A stated he felt putting the patient information in an unsecured locker was not the right thing to do but did not report his concern to anyone else.

During an interview with Staff B, on December 3, 2009, at 2:45 PM, he stated the incident was reported to the police department on November 6, 2009.

During an interview with the Privacy Officer (PO) on December 3, 2009 at 2:50 PM, she stated:

3. KMC has developed a privacy audit tool to prospectively audit for any potential privacy concerns, including, but not limited to, patient armbands, paperwork being left lying about the facility, employees logging off the computer systems and PHI on portable devices.

4. KMC Security as also added privacy to their rounds and report to the Privacy Office any potential privacy issues.

Administrative Safeguard

1. KMC has added patient privacy rounds to the existing environmental rounds that take place on a monthly basis.

The Privacy Officer has been added to this team.
Continued From page 3 stated she was not aware of the practice of placing laboratory reports in an outside locker and if she knew about the practice it would have been stopped immediately. She stated there were five different laboratory reports that were involved in this incident The Privacy Officer stated the reports contained different types of personal health information that included patient name, date of birth, social security number, laboratory test and results.

During an interview with the Laboratory Manager on December 22, 2009, at 12:30 PM, he stated he was not aware of the facility practice of placing the printed daily cumulative laboratory reports in a locker located outside of the Information System building. He stated all missing reports were data from one day, October 30, 2009. He stated the missing laboratory reports included:

1. Department Log Lab. This report contained patient name, date of birth, medical record number, account number, test performed, and test charge amount. This report contained information for 470 patients.

2. Contract Log Lab. This report contained patient name, date of birth, medical record number, account number of the originating contracted entity, test performed, and test charge amount. This report affected 24 patients.

3. Master Patient Index (MPI) Activity Report. This report contained changes made to patient demographics, patient name, date of birth, responsible person(s):

   Privacy Officer; ITS Director; Department Managers/Directors; Chief Executive Officer.

Monitoring:

Privacy audits will be conducted on a monthly basis with environmental round teams including, but not limited to, patient armbands and paperwork being left lying about the facility, employees logging off the computer systems, and PHI on portable devices. Staff will be provided feedback on performance with appropriate

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<th>EVENT ID: WOYN11</th>
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<th>12:38:44PM</th>
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<th>TITLE</th>
<th>(X8) DATE</th>
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| 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 40 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 required for continued program participation.
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address, and social security number on 31 of the reports. This report contained information for 107 patients.

4. Late Charge Report. This report contained patient name, date of service, account number, procedure/supply cost. This report contained information for four patients.

5. Outpatient Summary Reports. This report contained patient name, medical record number, account number, date of birth, physician, test performed, and results of test. This report contained information for 94 patients.

During an interview with the PO, on December 22, 2009, at 12:30 PM, she stated some patients were affected by multiple reports and a total of 596 patients were affected by this incident.

The hospital policy and procedure titled "Confidentiality Policy COM-IM-314" dated October 2007, indicates methods of receiving confidential information must be secure and not accessible to the general public and "Storage of confidential information must be secure, protected from unauthorized access, protected from damage, and includes the following: 1) Locked filing Cabinets 2) Locked Storage Room."

The "Confidentiality Statement" signed by Staff A on October 9, 2008 indicated "It is also your responsibility that, should you have contact with confidential information, to protect records disciplinary action taken as necessary.

Compliance with privacy audits will be reported to the Compliance Committee monthly for the next four months then biannually with follow-up action plans as necessary. Kern Medical Center is currently conducting proactive monitoring environmental rounds to address any HIPAA Privacy or Security issues.
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<th>ID PREFIX</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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against loss, destruction, tampering and inappropiate access and use,...

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