The following reflects the findings of the Department of Public Health during a complaint/breach event visit:

Complaint Intake Number: CA00207376 - Substantiated

Representing the Department of Public Health: [redacted], HFE I

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.

The following reflects the findings of the Department of Public Health during a Complaint visit:
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Complaint Intake Number:
CA00207376 - Substantiated

The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.

Representing the Department of Public Health:

[Redacted], RN-HFEN

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.

T22 DIV5 CH1 ART7-70707(b)(8) Patients' Rights

(b) A list of these patients' rights shall be posted in both Spanish and English in appropriate places within the hospital so that such rights may be read.
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by patients. This list shall include but not be limited to the patients’ rights to:

(8) Confidential treatment of all communications and records pertaining to the care and the stay in the hospital. Written permission shall be obtained before the medical records can be made available to anyone not directly concerned with the care.

Based on record review and interview, the facility failed to maintain the privacy and confidentiality of nine (9) patients’ medical records. For Patients 1, 2, 3, 4 and 5, Employee A inappropriately accessed the patients’ medical records without authorization and used patient information in a non-authorized manner. For Patients 6, 7, 8 and 9, Employee A used patient information in a non-authorized manner. Employee A obtained the patients’ personal information at the facility, gave the information to other individuals, which allowed them to open up fraudulent telephone service accounts.

Findings:

On November 6, 2009, a self reported facility incident was investigated regarding a breach in the medical records of fourteen (14) patients of the facility who had their identity stolen by a health care worker within the facility.

According to a facility letter to the Department dated October 27, 2009, the facility was in direct contact with the local police department regarding potential identity theft of "certain patients."
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During an interview with Employee B on November 6, 2009 at 9:15 a.m., she stated that Employee A "had authorized access to the medical records and used the information in a non-authorized manner." Employee B stated Employee A was arrested yesterday (11/5/09), and was "accused of using information in a non-authorized manner." Employee B stated not all fourteen (14) individuals were patients at the facility, as five (5) individuals were not found in the hospital billing system.

The personnel file of Employee A was reviewed on November 6, 2009. According to the file Employee A was hired as a Behavioral Health Worker-Inpatient Psychiatric Services in June 2002 and as a telemetry monitor technician/unit clerk on June 30, 2009. Further review of the personnel file revealed that Employee A signed a "Confidentiality Agreement" dated May 20, 2002, agreeing that "disclosing confidential information could be an invasion of privacy" and as condition of employment, the employee "may not share any information outside of this hospital, or internally without a "need to know," regarding patients, their treatment ...financial information obtained during the course of my employment." In addition, the personnel file indicated Employee A participated in an annual re-orientation, which included confidentiality of information, medical record and patient rights.

During an interview with Employee B on November 6, 2009, at 9:50 a.m., she stated that Employee A was on leave until March 16, 2009, returned to work
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on modified duty in the health information management (HIM) on March 17, 2009, then transferred to Medical/Surgical unit as a telemetry technician/unit clerk on June 28, 2009.

A review of facility documents "Visits on File" for each individual disclosed four (4) patients (Patients 6, 7, 8, & 9) were in the Behavioral Health Unit in 2008, two (2) patients (Patient 1 & 3) presented to the Emergency Room in 2009, two (2) patients (Patients 2 & 4) were in the outpatient, and one (1) patient (Patient 6) was in the Emergency Room in 1999.

A review of Patient 1's medical record revealed the patient presented to the emergency room on June 20, 2009, and was discharged the same day. There was no documented evidence that Employee A was directly involved with the care of Patient 1.

A review of Patient 2's medical record disclosed the patient presented to the outpatient department on April 10, 2009, and was discharged the same day. The patient was admitted again on September 2, 2009, and was discharged the same day. There was no documented evidence that Employee A was directly involved with the care of Patient 2.

A review of Patient 3's medical record revealed the patient presented to the emergency room on May 20, 2009, and was discharged the same day. There was no documented evidence that Employee A was directly involved with the care of Patient 3.

A review of Patient 4’s medical record indicated the
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patient presented to the outpatient area on May 21, 2009, and was discharged the same day. There was no documented evidence that Employee A was directly involved with the care of Patient 4.

A review of Patient 5's medical record disclosed the patient presented to the emergency room on November 5, 1999, in full arrest and was pronounced dead the same day. There was no documented evidence that Employee A was directly involved with the care of Patient 5. In addition, Employee A did not start work in the facility until June 2002.

A review of Patient 6's medical record indicated the patient was admitted to the Behavioral Health Unit (BHU) on September 2, 2008, and was discharged on September 12, 2009. The patient was admitted again on October 25, 2008, and was discharged on November 10, 2008. The Close Observation record for the patient dated November 10, 2008, indicated Employee A performed the observation during the day shift.

A review of Patient 7's medical record disclosed the patient was admitted to the BHU on November 29, 2008, and was discharged on December 4, 2008. The Close Observation record for the patient dated November 30, 2008, disclosed Employee A performed the observation during the day shift.

A review of Patient 8's medical record revealed the patient was admitted to the BHU on March 31, 2009, and was discharged on April 14, 2009. The patient was admitted to the BHU three times in
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2008. The Close Observation record for the patient dated January 21, 2008, disclosed Employee A performed the observation during the day shift.

A review of Patient 9's medical record disclosed the patient presented to the emergency room multiple times and was also admitted to the facility multiple times in 2009. The Close Observation record for the patient dated April 8, 2008, disclosed Employee A performed the observation from 9 a.m. to 9:30 a.m.

During an interview with Employee C on November 30, 2009, at 11:55 a.m., she stated that Employee A was assigned to health information management (HIM) from March 2009 to June 2009. Employee C stated Employee A was involved in the "purge project" and "destroyed 1997 and below emergency room records." Employee C stated that in April 2009, Employee A assembled in-patient BHU records for one month. When asked if Employee A had reason to access 2009 emergency record and outpatient records, Employee C stated, "Not that I know of." Employee C also stated that, "Someone is assigned specifically for that." and Employee A had, "No other duties."

A review of the local police department crime report for Employee A on December 8, 2009, disclosed the following:

1. Employee A "Admitted to memorizing several patients' profiles, going home, and writing the memorized profiles on papers. She then allowed other people to use this information in order to open up fraud accounts with Verizon." Employee A,
"memorized names, date of births and social security numbers of patients" while at the facility.

2. The police report indicated that Patients 1, 2, 3, 4, 6, 8, and 9 were patients at the facility and "went to the hospital before the fraud accounts were opened."

3. Patient 2 stated, "Someone used her personal information to obtain... account without her knowledge or permission."

4. Patient 5 was Employee A's deceased relative. However, there was conflicting first names noted in the report.

5. Patient 6 denied knowing Employee A and "desires prosecution."

6. Patient 7 denied opening up an account and giving anyone permission to open up the account. The report indicated Patient 7 "was very upset that someone used her name and personal information to ruin her credit; and therefore, she desires prosecution against all involved persons."

Based upon review of the medical records, facility documents, local police department report, and interviews with facility staff, Employee A obtained the patients' personal information at the facility and allowed other people to use the information to open up fraudulent accounts. For Patients 1, 2, 3, 4 and 5, Employee A inappropriately accessed the patients' medical records without authorization and used patient information in a non-authorized...
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For Patients 6, 7, 8 and 9, Employee A used patient information in a non-authorized manner. Employee A obtained the patients' personal information at the facility, gave the information to other individuals, which allowed them to open up fraudulent telephone service accounts.

**T22 DIV5 CH1 ART7-70751(b) Medical Record Availability**

(b) The medical record, including X-ray films, is the property of the hospital and is maintained for the benefit of the patient, the medical staff and the hospital. The hospital shall safeguard the information in the record against loss, defacement, tampering or use by unauthorized persons.

Based on record review and interview, the facility failed to safeguard nine (9) patients' medical records against used in a non-authorized manner for Patients 1, 2, 3, 4, 5, 6, 7, 8 and 9. The facility failed to prevent access to confidential medical record information and safeguard Patients 1, 2, 3, 4 and 5's medical records against use by unauthorized individuals.

**Findings:**

On November 6, 2009, a self reported facility incident was investigated regarding a breach in the medical records of fourteen (14) patients of the facility who had their identity stolen by a health care worker within the facility.

According to a facility letter to the Department
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dated October 27, 2009, the facility was in direct contact with the local police department regarding potential identity theft of "certain patients."

During an interview with Employee B on November 6, 2009, at 9:15 a.m., she stated that Employee A "had-authorized access to the medical records and used the information in a non-authorized manner." Employee B stated Employee A was arrested yesterday (11/5/09), "accused of using information in a non-authorized manner." Employee B stated that a search warrant was served by the local police but no medical records were found in Employee A's home. Employee B also stated not all fourteen (14) individuals were patients at the facility, as five (5) individuals were not found in the hospital billing system.

The personnel file of Employee A was reviewed on November 6, 2009. According to the file, Employee A was hired as a Behavioral Health Worker-Inpatient Psychiatric Services in June 2002 and as a telemetry monitor technician/unit clerk on June 30, 2009. Further review of the personnel file revealed that Employee A signed a "Confidentiality Agreement" dated May 20, 2002, agreeing that "disclosing confidential information could be an invasion of privacy" and as condition of employment, the employee "may not share any information outside of this hospital, or internally without a "need to know," regarding patients, their treatment ...financial information obtained during the course of my employment." In addition, the personnel file indicated Employee A participated in an annual re-orientation, which included...
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confidentiality of information, medical record and patient rights.

During an interview with Employee B on November 6, 2009, at 9:50 a.m., she stated that Employee A was on leave until March 16, 2009, returned to work on modified duty in the health information management (HIM) on March 17, 2009, then transferred to Medical/Surgical unit as a telemetry technician/unit clerk on June 28, 2009.

A review of facility documents, "Visits on File" for each individual disclosed four (4) patients (Patients 6, 7, 8, & 9) were at the Behavioral Health Unit in 2008, two (2) patients (Patient 1 & 3) presented to the Emergency Room in 2009, two (2) patients (Patients 2 & 4) were in the outpatient area and one (1) patient (Patient 6) was in the Emergency Room in 1999.

A review of records for Patients 1, 2, 3, 4, and 5 revealed no documented evidence that Employee A was directly involved with the care of Patients 1, 2, 3, 4, and 5.

A review of records for Patients 6, 7, 8 and 9 revealed Employee A was directly involved with the care by performing close observation while the patients were in the Behavioral Health Unit.

During an interview with Employee C on November 30, 2009, at 11:55 a.m., she stated that Employee A was assigned to health information management (HIM) from March 2009 to June 2009. Employee C stated Employee A was involved in the "purge
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project" and "destroyed 1997 and below emergency room records." Employee C stated that in April 2009, Employee A assembled in-patient BHU records for one month. When asked if Employee A had reason to access 2009 emergency room's record and outpatient department's records, Employee C stated, "Not that I know of." Employee C also stated, "Someone is assigned specifically for that." and Employee A had, "No other duties."

A review of the local police department report on December 8, 2009 disclosed that Employee A "Admitted to memorizing several patients' profiles, going home, and writing the memorized profiles on papers. She then allowed other people to use this information in order to open up fraud accounts with Verizon." Employee A, "memorized names, date of births and social security numbers of patients" while at the facility. The report also indicated that Patient 1, 2, 3, 4, 6, 8, and 9 were patients at the facility and "went to the hospital before the fraud accounts were opened."

The facility failed to prevent access to confidential medical record information for Patients 1, 2, 3, 4 and 5 and safeguard the patients medical record against use by unauthorized individuals. In addition, the facility failed to safeguard Patients 1, 2, 3, 4, 5, 6, 7, 8 and 9's medical records against use in a non-authorized manner. Based upon review of the local police department report, Employee A obtained the patients' personal information at the facility and allowed other people to use the information to open up fraudulent telephone service accounts.