



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  MAY 11 2012 04/20/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER <b>SAN FRANCISCO GENERAL HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 Potrero Ave, San Francisco, Ca 94110-3518 SAN FRANCISCO COUNTY <b>L&amp;C DIVISION SAN FRANCISCO</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
	<p>Continued From page 1</p> <p>(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."</p> <p>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.</p> <p>1280.15(a) Health &amp; Safety Code 1280 (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.</p>		<p><b>Privacy Policy: Annual Update training</b> module in the on-line SFGH Health-Stream course used during annual employee training to include a slide summarizing the hospital's mobile information policy (see Attachment 2).</p> <p>The SFGH Executive Committee approved language revisions to the privacy training module in the on-line SFGH Health Stream course used during annual employee training emphasizing use of DPH-approved devices to use/store PHI and to report violations/losses to the Privacy Officer (see Attachment 3)</p> <p>The SFGH Materials Manager issued a verbal directive prohibiting the purchase of any flash drive devices through the Materials Management department and directed hospital users with needs for such a device to the Information Systems Department to obtain a password-protected, encrypted flash drive device.</p> <p>The Chief Executive Officer issued a memo to all SFGH staff via email requesting that SFGH/DPH privacy and security policies be reviewed and discussed during the July/August staff meetings including the security precautions required when using portable electronic devices:</p> <ul style="list-style-type: none"> <li>-staff may not use laptops unless it is for work purposes and approved by a supervisor and DPH/IS</li> <li>-staff may only use portable devices provided by DPH</li> <li>-staff may never under any circumstances put PHI on privately-owned flash drives, laptops or back-up drives</li> </ul>	<p>May 4, 2010</p> <p>May 2010 and ongoing</p> <p>July 12, 2010</p>

Event ID: LDDD11	4/24/2012	9:37:01AM
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  MAY 11 2012 04/20/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER <b>SAN FRANCISCO GENERAL HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 Potrero Ave, San Francisco, Ca 94110-3518 <b>L&amp;C DIVISION SAN FRANCISCO</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
	<p><b>Continued From page 2</b></p> <p>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>Violation of Health and Safety Code 1280.15(a) for failure to prevent unauthorized access to patients' medical record: Substantiated.</p> <p>This regulation was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to prevent unauthorized disclosure of 209 patients medical information when RN 1 downloaded their names, medical record numbers and procedures to a personal flash drive (against facility policy) and failed to activate a password to protect the device. RN 1 lost the flash drive while attending a conference in another state (Colorado).</p> <p>Findings:</p> <p>During an interview on 4/20/10 at 10 a.m., Staff A (Director, Regulatory Affairs) stated RN 1</p>		<p>-the penalties for violating these polices as well as the penalties for violating provisions of SB541 and AB211 (see Attachment 4).</p> <p>The SFGH Privacy Officer and the CHN Senior Information Systems Manager updated the <i>Privacy and Security at SFGH</i> training module in the on-line SFGH Health Stream course used during annual employee training directing staff to:</p> <ul style="list-style-type: none"> <li>- encrypt portable devices,</li> <li>- immediately report the loss or theft of computing devices containing PHI , and</li> <li>- immediately report known or suspected privacy breach involving PHI (see Attachment 5)</li> </ul> <p>The Department of Public Health convened a Privacy Summit attended by DPH and UCSF Privacy Officers to establish priorities, agreements, and responsibilities, including the development of a security/privacy committee at SFGH to enhance the SFGH Privacy program.</p> <p>The SFGH leadership created a multidisciplinary Privacy Program and established a hospital Privacy Committee whose membership is now composed of the SFGH Privacy Officer and staff from the SFGH Privacy Office, the SFGH Chief Medical Officer, the SFGH Chief Communications Officer, and representatives from SFGH Legal Affairs, Regulatory Affairs, Health Information Systems departments as well as representatives from both SFGH and UCSF Risk Management, and Information Systems Departments. The committee meets monthly to review, discuss, and recommend policy involving privacy compliance issues.</p>	<p>April 2011</p> <p>May 2011</p> <p>Initiated July 12, 2011 and ongoing</p>

Event ID:LDDD11

4/24/2012

9:37:01AM

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

TITLE

(X6) DATE

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.





STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/20/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER <b>SAN FRANCISCO GENERAL HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1001 Potrero Ave, San Francisco, Ca 94110-3518 SAN FRANCISCO COUNTY</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
--------------------	--	---------------	---	--------------------

	<p>Continued From page 5</p> <p>to provide accountability for device use...</p> <p>2. Policy Statements:</p> <p>2.1 Access Control</p> <p>2.1.1 Device Access. Data accessed via Portable computers is for authorized use only. Access to data is permitted only after a valid User ID and password has been entered.</p> <p>3. Standards &amp; Guidelines</p> <p>General Guideline- ... When using portable devices to display data, be especially aware of the people in your vicinity. Also be aware of the increased risk of loss or theft of portable devices (and the data stored on them).</p> <p>3.2.1 Portable Equipment and Software:</p> <p>The name and specifications of all installed and/or enabled security measures such as password controlled activation, encrypted data storage or encrypted transmission of data.</p> <p>RN 1 failed to follow the facility's Portable Computer and PDA security policy when he used a personal flash instead of a facility encrypted flash drive to download the names, medical record numbers and procedures of 209 patients and failed to activate a password to protect the device. RN 1 lost the flash drive while attending a conference in another state.</p> <p>The employee's failure to safeguard the</p>		<p>CA DEPT OF PUBLIC HEALTH</p> <p>MAY 11 2012</p> <p>L&amp;C DIVISION SAN FRANCISCO</p>	
--	--	--	--	--

Event ID: LDDD11      4/24/2012      9:37:01AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  MAY 11 2012 04/20/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  SAN FRANCISCO GENERAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 Potrero Ave, San Francisco, Ca 94110-3518 SAN FRANCISCO COUNTY L&Q DIVISION SAN FRANCISCO
--	---

(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
--------------------	--	---------------	---	--------------------

	<p>Continued From page 6</p> <p>patients' medical information against loss or use by unauthorized person or persons violated Health and Safety Code 1280.15 and is therefore subject to the applicable civil penalty assessment.</p> <p>T22 DIV5 ART7-707519b) Medical Record Availability</p> <p>(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.</p> <p>This regulation was not met as evidenced by:</p> <p>Based on interview and record review, RN 1 failed to follow the facility's Portable Computer and PDA (personal digital assistants) security policy when he used a personal flash drive (against facility policy) to download the names, medical record numbers and procedures of 209 patients and failed to activate a password to protect the device. RN 1 lost the flash drive while attending a conference in another state. (Colorado).</p> <p>Findings:</p> <p>During an interview on 4/20/10 at 10 a.m., Staff A (Director, Regulatory Affairs) stated RN 1 used a personal flash drive to download 209</p>		<p>T22 DIV5ART7-707519(b) Medical Record Availability</p> <p>(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.</p> <p>Action(s):</p> <p>As described in the 2567 received April 26, 2012, the facility had provided documentation at the time of the April 2010 investigation that the employee involved in this privacy breach had been oriented to their responsibilities to protect the confidentiality of patient protected health information (PHI) and to medical information privacy requirements.</p> <p>The employee was counseled at the time he reported the loss to his supervisor.</p> <p>Following notification of the privacy breach, the CHN Senior Information Systems Manager issued an email reminder to San Francisco General Hospital (SFGH) managers regarding the incident and instructing them to remind staff about the hospital policy prohibiting downloading or storage of patient protected information (PHI) on privately owned portable devices (see Attachment 1).</p> <p>The SFGH Privacy Officer and the CHN Senior Information Systems Manager updated the <i>DPH Privacy Policy: Annual Update</i> training module in the on-line SFGH Health-Stream</p>	<p>March 26, 2010</p> <p>April 12, 2010</p> <p>April 2010</p>
--	--	--	---	---

Event ID:LDDD11

4/24/2012

9:37:01AM

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

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  MAY 11 2010 4/20/2010
--	--	--	---

NAME OF PROVIDER OR SUPPLIER <b>SAN FRANCISCO GENERAL HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 Potrero Ave, San Francisco, Ca 94110-3518 SAN FRANCISCO DIVISION SAN FRANCISCO
---	---

(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
	<p>Continued From page 7</p> <p>patient's names, medical records and procedures. RN 1 took the flash drive with him when he went to Denver to attend a conference as he planned to work on a quality project while he was away. When RN 1 returned from the conference he realized he had lost the flash drive. Staff A said employees are not allowed to use their own personal flash drives as they are not encrypted as required by the facility. He stated RN 1 failed to activate a password on the personal flash drive he used to download the patients information.</p> <p>Staff A stated the Risk Management department was notified of the potential privacy breach on 4/5/10.</p> <p>On 4/20/10 at 10:45 a.m., RN 1 stated that on [REDACTED] 2010, he downloaded the information from his desk top computer (at work) onto his own personal flash drive. He said he had "a disconnect" about the facility policy regarding the use of personal flash drives which are not encrypted. RN 1 stated the Information Systems Department does not supply or condone the use of flash drives that are not encrypted. He said he forgot he was violating hospital policy by using his own personal flash drive. He said he thought it was okay as long as the flash drive was password protected but because he was in a rush he forgot to put a password on the device. He said he attended a conference in Colorado from [REDACTED] 10 through [REDACTED] 10. RN 1 said he first realized the flash drive was missing on [REDACTED] 12</p>		<p>course used during annual employee training to include a slide summarizing the hospital's mobile information policy (see Attachment 2).</p> <p>The SFGH Executive Committee approved language revisions to the privacy training module in the on-line SFGH Health Stream course used during annual employee training emphasizing use of DPH-approved devices to use/store PHI and to report violations/losses to the Privacy Officer (see Attachment 3)</p> <p>The SFGH Materials Manager issued a verbal directive prohibiting the purchase of any flash drive devices through the Materials Management department and directed hospital users with needs for such a device to the Information Systems Department to obtain a password-protected, encrypted flash drive device.</p> <p>The Chief Executive Officer issued a memo to all SFGH staff via email requesting that SFGH/DPH privacy and security policies be reviewed and discussed during the July/August staff meetings including the security precautions required when using portable electronic devices:</p> <ul style="list-style-type: none"> <li>-staff may not use laptops unless it is for work purposes and approved by a supervisor and DPH/IS</li> <li>-staff may only use portable devices provided by DPH</li> <li>-staff may never under any circumstances put PHI on privately-owned flash drives, laptops or back-up drives</li> </ul>	<p>May 4, 2010</p> <p>May 2010 and ongoing.</p> <p>July 12, 2010</p>

Event ID:LDDD11 4/24/2012 9:37:01AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETED  MAY 11 2012 04/20/2010
--	--	--	---

NAME OF PROVIDER OR SUPPLIER <b>SAN FRANCISCO GENERAL HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 Potrero Ave, San Francisco, Ca 94110-3518 SAN FRANCISCO COUNTY L&C DIVISION SAN FRANCISCO
---	---

(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
	<p><b>Continued From page 8</b></p> <p>but did not think it was "lost." He stated he continued to look for the device but could not find it so he notified the OR Manager on [REDACTED] 10.</p> <p>During an interview on 4/20/10, Staff B (director of operating room services) stated as far as she could recall, she was notified of the incident on [REDACTED] 10 and she notified Risk Management on [REDACTED] 10 after RN 1 confirmed he could not find the flash drive.</p> <p>A review of RN 1's training record indicated he completed the facility's "Information Services Security" training and "Hospital Privacy" training on 4/10/09.</p> <p>The facility's Portable Computer and PDA Security Policy with effective date of 10/01/03, was reviewed and indicated the following:</p> <p>1. Portable Computer Policy Intent This document establishes the security policy for deployment and use of Portable Computers. For the purpose of this policy "Portable Computers" include Personal Digital assistants (PDAs), Laptops, Notebooks, Palmtops and their associated peripherals. It intends to protect all (name of facility) information accessed through, displayed on, output from and stored on such devices from being revealed to unauthorized persons, and to provide accountability for device use...</p> <p>2. Policy Statements:</p>		<p>-the penalties for violating these polices as well as the penalties for violating provisions of SB541 and AB211 (see Attachment 4).</p> <p>The SFGH Privacy Officer and the CHN Senior Information Systems Manager updated the <b>Privacy and Security at SFGH</b> training module in the on-line SFGH Health Stream course used during annual employee training directing staff to:</p> <ul style="list-style-type: none"> <li>- encrypt portable devices,</li> <li>- immediately report the loss or theft of computing devices containing PHI , and</li> <li>- immediately report known or suspected privacy breach involving PHI (see Attachment 5)</li> </ul> <p>The Department of Public Health convened a Privacy Summit attended by DPH and UCSF Privacy Officers to establish priorities, agreements, and responsibilities, including the development of a security/privacy committee at SFGH to enhance the SFGH Privacy program.</p> <p>The SFGH leadership created a multidisciplinary Privacy Program and established a hospital Privacy Committee whose membership is now composed of the SFGH Privacy Officer and staff from the SFGH Privacy Office, the SFGH Chief Medical Officer, the SFGH Chief Communications Officer, and representatives from SFGH Legal Affairs, Regulatory Affairs, Health Information Systems departments as well as representatives from both SFGH and UCSF Risk Management, and Information Systems Departments. The committee meets monthly to review, discuss, and recommend policy involving privacy compliance issues.</p>	<p>April 2011</p> <p>May 2011</p> <p>Initiated July 12, 2011 and ongoing</p>

Event ID: LDDD11	4/24/2012	9:37:01AM
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  MAY 11 2012 04/20/2010
NAME OF PROVIDER OR SUPPLIER  SAN FRANCISCO GENERAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 Potrero Ave, San Francisco, Ca 94110-3518 SAN FRANCISCO COUNTY L&C DIVISION SAN FRANCISCO		
(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
	<p>Continued From page 9</p> <p>2.1 Access Control</p> <p>2.1.1 Device Access. Data accessed via Portable computers is for authorized use only. Access to data is permitted only after a valid User ID and password has been entered.</p> <p>3. Standards &amp; Guidelines</p> <p>General Guideline- ... When using portable devices to display data, be especially aware of the people in your vicinity. Also be aware of the increased risk of loss or theft of portable devices (and the data stored on them).</p> <p>3.2.1 Portable Equipment and Software:</p> <p>The name and specifications of all installed and/or enabled security measures such as password controlled activation, encrypted data storage or encrypted transmission of data.</p> <p>RN 1 failed to follow the facility's Portable Computer and PDA security policy when he used a personal flash drive instead of a facility encrypted device to download the names, medical record numbers and procedures of 209 patients and failed to activate a password to protect the device. RN 1 lost the flash drive while attending a conference in another state.</p> <p>The employee's failure to safeguard the patients' medical information against loss or use by unauthorized person or persons violated Health and Safety Code 1280.15 and</p>		<p>The SFGH CEO issued a memo reiterating employee responsibilities to password protect/encrypt portable electronic devices on which patient protected health information (PHI) is stored. (see Attachment 6).</p> <p>The memo was also posted on the Community Health Network (CHN) webpage for all CHN users (see Attachment 7).</p> <p>In consultation with the SFGH Privacy Officer, the SFGH Directors of Risk Management and Regulatory Affairs reviewed the <i>Privacy and Security</i> training module in the on-line <i>SFGH Health Stream</i> course as well as reviewed and updated the power point presentations about privacy and patient information security to selected employee and manager groups to include SB 541 and AB 211 provisions (see Attachments 8, 9, 10).</p> <p>The SFGH Privacy Officer and the Director of Regulatory Affairs are conducting educational information sessions regarding the provisions of SB 541 and AB211 as well as the investigation findings from recent privacy breaches within the organization at the following meetings:</p> <ul style="list-style-type: none"> <li>o Management Forum Meeting</li> <li>o Nursing Administrative Forum</li> <li>o Executive Staff Committee</li> <li>o Medical Executive Committee (see Attachment 10 );</li> </ul>	<p>April 10, 2012</p> <p>April 13, 2012</p> <p>April 2012</p> <p>Initiated with the April 24, 2012 Management Forum meeting and anticipate completion by May 30, 2012.</p>

Event ID:LDDD11 4/24/2012 9:37:01AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/20/2010	
NAME OF PROVIDER OR SUPPLIER  SAN FRANCISCO GENERAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 Potrero Ave, San Francisco, Ca 94110-3518 SAN FRANCISCO COUNTY		
(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
	<p>Continued From page 10</p> <p>is therefore subject to the applicable civil penalty assessment.</p> <p style="text-align: center;">CA DEPT OF PUBLIC HEALTH</p> <p style="text-align: center;">MAY 11 2012</p> <p style="text-align: center;">L&amp;C DIVISION SAN FRANCISCO</p>		<p>Following receipt of the 2567, the Director of Materials Management issued a memo to all staff to :</p> <p>*officially establish the policy prohibiting the purchase of any flash drive devices through the Materials Management department,</p> <p>*direct hospital users with needs for such a device to the SFGH or UCSF Information Systems Department to obtain a password-protected, encrypted flash drive device and,</p> <p>*remind hospital staff about the SFGH and DPH policies prohibiting downloading or storage of patient protected information (PHI) on privately owned portable devices (see attachment (see Attachment 11).</p> <p><b>Monitoring:</b> The SFGH Privacy Officer and the CHN Senior Information Systems Manager present an annual report regarding privacy issues to the <i>SFGH Quality Council</i>. In addition, they report any incidents of non-compliance with DPH and SFGH privacy policies which occur during the year at the next scheduled <i>SFGH Quality Council</i></p> <p><b>Responsible Person(s):</b> SFGH Privacy Officer CHN Senior Information Systems Manager</p>	<p>May 11, 2012</p> <p>Ongoing</p>

Event ID:LDDD11

4/24/2012

9:37:01AM

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

TITLE

(X6) DATE

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.