

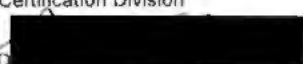
California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA230000030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/23/2012
NAME OF PROVIDER OR SUPPLIER WINDSOR REDDING CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2490 COURT STREET REDDING, CA 96001		
(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	<u>Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts or conclusions set forth in the statement of deficiencies.</u> <u>This plan of correction constitutes the facility's allegation of compliance with the cited deficiencies.</u> <u>How Corrective Action will be accomplished for residents affected:</u> The resident affected was apologized to by the Administrator, Director of Nursing and the Social Worker. She was reassured that the facility has done an immediate check of the internet to see if the picture was posted anywhere in the websites- such as Facebook, Wikipedia, or any other social networking sites, and so far none was found. She was informed that the police was notified of the incident. The police did visit her on 12/13/11 and took	
A 000	Initial Comment The following reflects the findings of the California Department of Public Health during the investigation of a complaint and an entity reported incident. Complaint number: 292959 Entity reported incident: 292648 The inspection was limited to the specific complaint and entity reported incident and does not represent the findings of a full inspection of the facility. Representing the Department: 22705, HFEN A deficiency was written at A 017 for complaint 292959 and entity reported incident 292648.	A 000		

Licensing and Certification Division

LABORATORY DIVISION

STATE FORM



LABORATORY REPRESENTATIVE'S SIGNATURE

Administrator

TITLE

(X5) DATE

6/1/12

8999

EKOL11

If continuation sheet 1 of 5

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A 017 A 017	<p>Continued From page 1</p> <p>1280.15(a) Health & Safety Code 1280</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 observation, interview, and record review, the facility failed to ensure confidential health information for one patient was not disclosed to unauthorized individuals outside the facility. This occurred when Certified Nursing</p>	A 017 A 017	<p>all the information about the employee. The police also temporarily confiscated the Administrator's cell phone until the picture taken was removed from the cell phone's digital file. The resident was informed of her right to press charges against the employee.</p> <p><u>Identification of Residents with the Potential to be Affected:</u></p> <p>All residents who reside in the facility and are cared for by staff members have the potential to be affected.</p> <p><u>Measures to Prevent Recurrence:</u></p> <p>Staff were in-serviced by the Administrator during the all staff meeting on 12/23/11 & 1/23/12. The in-service included the facility policy on cell phone use during work time, HIPPA and abuse. DSD to continue to in-service on the use of electronic devices such as, but not limited to cell phones with built in cameras, HIPPA, and abuse policies.</p>	

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A 017	<p>Continued From page 2</p> <p>Assistant (CNA) C used her cell phone to send a nude photograph of the patient to someone outside the facility. This caused anxiety and emotional distress to the patient. (Patient 1)</p> <p>Findings:</p> <p>On 12/12/11, the California Department of Public Health received a faxed report, written by Administrative Staff (Admin) A that indicated that a former employee, CNA B, had received a photograph taken on a cell phone of Patient 1 while in the shower. The phone number the photograph was sent from was the phone number of a current employee, CNA C.</p> <p>During an interview on 12/15/11 at 12:40 pm, CNA B, a former employee of the facility, stated she had received a text with a nude picture of a patient from the facility whom she recognized as Patient 1. CNA B stated that on 12/11/11, she had received the text of "Hi Guys" with a photograph that showed Patient 1, nude and in the shower. CNA B stated she did not recognize the cell phone number that the text and photograph had come from. She said she called and reported this to Admin A on 12/12/11. CNA B was not a current employee of the facility when she received the text and photograph.</p> <p>During an interview on 12/21/11 at 8 am, Admin A stated that CNA B told her she had received a text and nude photograph of Patient 1 in the shower. CNA B forwarded the photograph and text to Admin A and told her the number of the cell phone that she had received it from. Admin A said she asked Scheduling Staff D, to call that number and discovered it belonged to a current employee, CNA C. Admin A stated she confirmed that CNA C had assisted another CNA</p>	A 017	<p><u>Monitoring Corrective Action and Responsibility:</u></p> <ol style="list-style-type: none"> 1. The Social Service Director and/or her designee will perform random interviews with the facility residents 2-3 x a week x 3 months to ensure that residents' rights are upheld. 2. The DSD and/or his designee will do random audits of direct care staff 2-3x a week x 3 months to ensure that personal devices, such as a cell phone with built in camera are not brought in nor used in care areas throughout the facility. <p>The results of interviews and observation and any corrective action that was taken will be reported to the QA and A committee for follow up and recommendation. Administrator responsible in ensuring</p>	

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A 017	<p>Continued From page 3</p> <p>to give a shower to Patient 1 on 12/11/11. Admin A stated that CNA C was suspended immediately then terminated as a result of this incident.</p> <p>The photograph that Admin A had received was also viewed at this time. It showed a photograph of Patient 1 sitting on a shower chair, holding a spray nozzle with one hand. It showed her face and full frontal nudity.</p> <p>During an interview on 12/15/11 at 1:25 pm, Scheduling Staff D stated she called the cell phone number given to her by Admin A and it was answered by an employee who identified herself as CNA C.</p> <p>During an interview on 12/15/11 at 2 pm, Patient 1 confirmed that CNA C had helped another CNA give her a shower on 12/11/11. Patient 1 stated that CNA C was just playing with her phone while the other CNA gave her a shower. Patient 1 stated she did not know that CNA C had taken a photograph of her until 12/13/11 when Admin A showed her the photograph. She stated, "I can't believe anyone would do that. If the picture is put on the web or you-tube they would probably get a million hits." She said her biggest fear was that her husband and son would find out about the photograph. She also said she wondered if CNA C had taken other photographs of her besides this one.</p> <p>A review of CNA C's personnel file showed she had signed a facility document titled, "Oath of Confidentiality" on 2/11/11. It read as follows, I agree to respect and abide by all federal, state, and local laws pertaining to the confidentiality of identifiable medical, personal, and financial information that I may have access to . . . "</p>	A 017	<p>corrections are achieved and sustained.</p> <p>Date of compliance: 5/30/12</p>

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A 017	<p>Continued From page 4</p> <p>CNA C had also received a copy of the facility's Resident Rights, on 2/11/11 that read as follows, "each and every resident in this facility had the right to be treated with consideration and respect for their personal privacy." The facility's employee handbook, revised 9/1/11, read as follows, "the use of personal communication devices, such as cell phones, is prohibited during work hours and in all work areas." The facility's policy regarding "Photography of Residents" read as follows, "the facility will ensure that all residents/responsible parties give specific permission prior to photographing the resident."</p> <p>CNA C had received abuse training on 2/11/11. The facility's "Abuse Prevention, Investigation and Reporting" policy, revised 7/08, read as follows, "Each resident has the right to be free from verbal, sexual, physical, and mental abuse . . . Residents must not be subjected to abuse by anyone, including but not limited to facility staff, . . ."</p> <p>A form titled, "Notice of Employee Separation", disclosed that CNA C had been involuntarily terminated on 12/14/11 for violation of company policies.</p>	A 017	<p>2012 JUN - 1 PM 2:50</p> <p>RECEIVED</p>