California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA010000077	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD CARE CENTER OF FAIRFIELD	1260 TRAVIS BLVD FAIRFIELD, CA 94533

(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 000	Initial Comments The following reflects the findings of the California Department of Public Health during a facility visit for complaint, CA00277062 and an ERI (Entity Report Incident), CA 00277602. The inspection was limited to the specific complaint and the ERI investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Health Facility Evaluator Nurse (Surveyor) # 28521. THE DEPARTMENT SUBSTANTIATED A VIOLATION OF THE REGULATIONS.	A 000	"Preparation and execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged in conclusion set forth on the statement of deficiency. This Plan of Correction is prepared and executed solely because it is required by the provision of Health and Safety code Section 1280 and 42 CFR 483 ET SEG. This Plan of Correction serves as our written credible allegation of compliance for the deficiency notes. The following abbreviations were used: DON – Director of Nursing DSD – Director of Staff Development HIPAA – Health Information Portability Accountability Act	8/25/11
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	A017 1280.15 (a) Health & Safety Code 1280 - On 7/25/11, the following immediate investigation and actions were taken by the facility's compliance officer and the DON upon receipt of a telephone notification of a complaint from the California Department of Public Health (Department) informing about Resident 1's "Physician Order Sheet" containing identifiable patient information and physician's orders dated 6/16 – 6/19/11 discovered n a street in another county near the location of another health facility as follows:	
A 017	1280.15(a) Health & Safety Code 1280	A 017		

Licensing and Certification Division

Theresa J. Cadenas, NHA — Administrator — 10/18/11

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

revision to the approved POC 10/24/11 @ 4pm per phone conversation with Theresa Cadenas, Administrator. Original copy will be sent via U.S. Postal Service per T Cadenas request 2338/28521

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A 017	Continued From page 1 (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. This Statute is not met as evidenced by: Based on interviews and review of the investigative report and the facility policy and procedure, the facility failed to ensure Resident 1's medical record was protected against access from unauthorized individuals.	A 017	Continued Page 2. 1) The DON and facility's compliance officer reviewed Resident 1's medical records and found that the original physician's order dated 6/16 – 6/19/11 was intact and is in resident's medical record being kept safely in the facility. 2) The facility's compliance officer reviewed employee files to check if any employees with access to medical records live or work around the county where Resident 1's "Physician Order Sheet" was found. None were found. 3) The facility's compliance officer and the DON contacted the facility consultants to check which consultant is servicing the facility in the county where Resident 1's "Physician Order Sheet" was found. It was then known that the facility contracted Pharmacy is the same provider of the said facility. The Administrator contacted the Pharmacy liaison to report to her about this incident. The Pharmacy liaison informed the Pharmacy Compliance Officer of the concern for immediate investigation and actions.	8/25/11

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A 017	Continued From page 2 Findings: On 7/25/11, the California Department of Public Health (Department) received a complaint that indicated on 7/25/11, Resident 1's "Physician Order Sheet" containing identifiable patient information and physician orders dated 6/16 - 6/19/11 was discovered on a street in another county. This document was found near the location of another health facility. The Department notified Management Staff A of the finding on 7/25/11 at 3:19 p.m. at which time the facility's compliance officer (Management Staff A) launched an investigation. The facility notified the Department by reporting the event as an Entity Reported Incident (ERI) on 7/29/11, four days after the occurrence. During a review of the investigative report with concurrent interview on 8/3/11 at 9:15 a.m., Management Staff A corroborated that a copy of Resident 1's "Physician Order Sheet" had been accessible to unauthorized persons. In addition, Management Staff A stated that the pharmacy that provides their service is also contracted with a health facility in the location where the document was found. During a review of the facility's policy and procedures on 8/3/11 related to Disclosure of Protected Health Information (PHI) and the Health Insurance Portability and Accountability Act (HIPAA) (Patient Care Policy Committee review on 4/29/11), verified that residents' health information should be kept safeguarded.	A 017	Continued Page 3. 4) The Administrator informed the company's corporate compliance officer regarding the HIPAA concern. 5) The Administrator notified the family representative regarding the HIPAA concern. The resident's representative understood and agreed that the incident is not due to improper disclosure of information and believes that it was not done for personal gain or with an intention for malicious harm. The resident's primary physician was also notified about the incident. 6) The facility's policies and procedures regarding Disclosure of Protected Health Information and HIPAA Privacy Compliance was reviewed and approved by the Quality Assurance Team on April 29, 2011 and July 26, 2011. The policies and procedures are in place and is being followed by the facility. 7) On 7/29/11, the facility's compliance officer notified the Department in writing by reporting the event as an Entity Reported Incident.	7/29/11

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		A 017	Continued Page 4. - On 7/25/11 the facility's compliance officer checked with the company's corporate compliance officer for HIPAA regarding any other similar incident in the past regarding medical breach. No similar incident happened in the past. - The facility staff and contracted consultants were rein-serviced by the facility's compliance officer on 7/26/111, 7/27/11, 7/28/11, 7/29/11 & 8/16/11 regarding the strict compliance of HIPAA regulations and Confidentiality of Information & Medical Records. - The company's compliance officer rein-serviced staff on 8/12/11 regarding strict compliance of HIPAA regulations and Confidentiality of Medical Records. - In-service regarding HIPAA regulations and Confidentiality of Medical Records will be provided by the DSD or facility's corporate compliance officer to employees during new hire orientation, annually and when needed - On 7/28/11, a HIPAA Privacy Compliance Report was completed by the facility's compliance officer to ensure that the facility practice of HIPAA regulations are being followed.	8/12/11

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		A 017	Continued Page 5. - A letter was received from the facility contracted Pharmacy on 8/15/11 stating the actions taken by them regarding the medical breach including but not limited to result of the investigation, in-service of the pharmacy staff regarding HIPAA on orientation for new hires & annually and informing the facility that medical documents retrieved from the facility will be safeguarded in a sealed envelope prior to leaving the facility to ensure security and protection of resident's medical information. The sealed envelope will only be opened when the pharmacy staff arrived in the pharmacy office. - The Administrator or Director of Nursing will ensure compliance of HIPAA regulations of facility consultants during their monthly visits by reminding them of the facility's policies and procedures for copying of resident's medical records. - The Administrator or Designee will sign the sealed envelope, where copies of medical records are placed by the pharmacy staff during their monthly visits.	8/15/11 8/25/11

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		A 017	Continued Page 6. - The Medical Records Coordinator or Designee will monitor by checking residents medical records being copied requested by resident, resident's representative, consultants, agencies and companies to ensure appropriate and complete authorization for release of information is provided. Any medical records released by the facility will be recorded in the Release of Information log. The following will be recorded on the Release of information log when copies of medical records are requested: date medical records copied, resident's name, room number, person/company requesting for copies of medical records, date release of information was received, signature & title of authorized staff releasing/copying the information - The Administrator will monitor for compliance of HIPAA regulations by doing a quarterly "HIPAA Privacy Compliance Report" any concerns or problems identified will be corrected immediately. Results of findings and corrections will be reported by the Administrator during quarterly Continuous Quality Improvement meeting.	8/25/11