

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050150	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/21/2011
NAME OF PROVIDER OR SUPPLIER Sierra Nevada Memorial Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 155 Glasson Way, Grass Valley, CA 95945-5723 NEVADA 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>The following reflects the findings of the Department of Public Health during a complaint/breach event visit:</p> <p>Complaint Intake Number: CA00282653 - Substantiated</p> <p>Representing the Department of Public Health. Surveyor ID # 26611, HFEN</p> <p>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility</p> <p>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</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</p>		<p>The Sierra Nevada Memorial Hospital (SNMH) Medical Executive Committee reviewed the reportable privacy breach.</p> <p>Memo was sent to Physician B from the Chief of Staff requiring Physician B to complete the Privacy and Data Security training by October 7, 2011.</p> <p>Memo was sent to SNMH Contracted Physicians from the Chief of the Medical Staff requiring completion of the 2011 Privacy and Data Security training by December 1, 2011.</p> <p>Memo was sent to all Medical Staff Members from the Chief of the Medical Staff regarding the responsibility of the physicians to protect patient information according to Health & Safety Code Sections 1280.15 and 130203.</p> <p>Physician B completed the Privacy and Data Security training.</p> <p>Medical Staff Privacy and Data Security training completed</p> <p>Annual completion of the Dignity Health Privacy and Data Security Refresher training is required for contracted physicians by May 31st of each year.</p>	<p>09/22/11</p> <p>09/22/11</p> <p>09/22/11</p> <p>09/27/11</p> <p>10/04/11</p> <p>12/02/11</p>

Event ID: 0QO711

6/28/2013

10:44 30AM

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

TITLE

(X6) DATE

By signing this document, I am acknowledging receipt of the entire citation packet. Page(s) 1 thru 4

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.

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	<p>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>A001 Informed Medical Breach</p> <p>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."</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>Based on interview and record review, the facility failed to ensure that Patient 1's medical information was kept confidential. This failure affected Patient 1's right to confidentiality and could result in unintended adverse consequences for Patient 1.</p>		<p>Medical Staff Members are responsible to abide by Medical Staff Bylaws, Rules and Regulations, and all other lawful standards, policies rules of the Medical Staff as well as those Hospital policies required by state or federal law or by the standards of national accrediting organizations such as Joint Commission (or equivalent at the discretion of the Medical Executive Committee).</p> <p>SNMH Medical Staff Bylaws include routine monitoring and evaluation and corrective action to be taken for physicians. The Medical Executive Committee and peer review committees are responsible for carrying out delegated review and quality management functions. They may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring in the course of carrying out their duties without initiating formal corrective action. Comments, suggestions and warnings may be issued orally or in writing. The Practitioner shall be given an opportunity to meet with the Medical Executive Committee or the peer review committee. Any informal actions, monitoring or counseling shall be documented in the Practitioner's file. Medical Executive Committee approval is not required for such actions, although the actions shall be reported to the MEC.</p>	

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	<p>Findings:</p> <p>On [REDACTED] 11, Patient 1's record was reviewed. Patient 1 was admitted to the hospital, on [REDACTED] 1 with diagnoses that included sepsis (blood infection) due to aspiration pneumonia (lung infection due to inhaled food particles).</p> <p>In an interview on 10/10/11 at 9:20 am, Visitor A stated that on [REDACTED] 1 three family members and three friends of Patient 1 were present in his hospital room when Patient 1's physician (MD) B entered the room. Visitor A stated that MD B discussed Patient 1's medical care and condition in detail in front of the guests in the room without securing Patient 1's permission to do so. Visitor A expressed concern that sensitive medical information was shared and could possibly adversely affect Patient 1 if it became public information.</p> <p>On 9/13/11 at 11:30 am, MD B confirmed he spoke to Patient 1 and his guests regarding his medical condition without getting permission because he wanted Patient 1 to experience peer pressure to change his behaviors to protect his health.</p> <p>On 9/13/11, the facility's document, titled, "Privacy and Data Security Training Handbook," dated 7/09, was reviewed. The handbook read under the scenario for people at the bedside, "Prior to interaction, ask visitors to step out for a moment. The patient should be asked who, among his or her family and friends, may be allowed to receive their protected health information (PHI)."</p>		<p>Per the Medical Staff Bylaws, the criteria for initiation of Corrective Action state: Any person may provide information to the Medical Staff about the conduct, performance or competence of its Members. A corrective action investigation may be initiated whenever reliable information indicates that a Medical Staff Member may have engaged in, made, or exhibited acts, statements, demeanor, or professional conduct, either within or outside of the Hospital, and the same is or is reasonably likely to be:</p> <p>1. Detrimental to patient safety or to the delivery of quality patient care; 2. Disruptive to the Hospital operations; 3. Unethical conduct; 4. In contravention of the Bylaws, the Rules and Regulations of the Medical Staff or Departmental policies and procedures and those policies of the Hospital required by state or federal law or by the standards of national accrediting organizations such as a Joint Commission (or equivalent); or 5. The Member has sustained a summary suspension or limitation of Privileges at another hospital, for medical disciplinary cause or reason.</p> <p>SNMH workforce are required to report suspected privacy breaches through several mechanisms, including reporting to their supervisor, through the Event Reporting System (EVOS), to the Facility Privacy Liaison, or to the Dignity Health Hotline for investigation.</p>	

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	<p>On 9/13/11, the facility's medical staff rules and regulations, dated 4/14/11, were reviewed. The rules and regulations read under the section, titled, "Medical Staff and Allied Health Professional (AHP) Code of Conduct," that "Practitioners and AHPs shall maintain confidentiality of patient care information where physically possible, in a manner consistent with the HIPAA (Health Insurance Portability and Accountability Act) and state law regarding confidentiality of medical information.</p> <p>On 9/13/11, the facility policy titled, "Code of Ethical Behavior" dated 4/27/11, indicated that physician's were not to share patient information in an unauthorized manner.</p> <p>On 9/13/11 at 2:50 pm, Administrative (Admin) Staff C was asked how physicians are trained on the privacy and confidentiality of patient's medical information. Admin Staff C stated the medical executive committee had recently implemented, "required but not mandatory education." Admin Staff C was unable to explain what that term actually meant. Admin Staff C confirmed that MD B was sent the training on confidentiality but the acknowledgement of training had not been returned to her office. Admin Staff C further stated that the medical staff was expected to follow the same rules of confidentiality as the hospital employees.</p> <p>On 10/20/11 at 2:30 pm, Admin Staff C acknowledged that Patient 1's right to privacy of his medical information was violated.</p>		<p>Medical Staff Members also are expected to comply with hospital reporting requirements through many (but not all) of the same mechanisms because the</p> <p>Medical Staff Bylaws, which govern their behavior, require compliance with the Hospital's policies. SNMH monitors privacy breaches and reports compliance, trends and audit results which are submitted monthly to the Executive Council and SNMH Leadership meetings for review.</p>	

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