

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050455	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING 2010 JUN 17 PM 3:55 307	(X3) DATE SURVEY COMPLETED 08/11/2009
NAME OF PROVIDER OR SUPPLIER SAN JOAQUIN COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE ZIP CODE 2615 Chester Avenue, BAKERSFIELD, CA 93301 KERN 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: CA00197270 - Substantiated</p> <p>Representing the Department of Public Health: [REDACTED]</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>Entity Reported Incident No: CA00197270</p> <p>Representing the Department:</p>		<p>1280.15(a) Health & Safety Code 1280</p> <p>HIM Director discussed specific privacy breach and reviewed chart assembly process with involved Analyst, Coder and Physician Workroom Coordinator.</p> <p>HIM Director advised HIM staff of the incident and importance of following established process of chart assembly to minimize potential for privacy breach.</p> <p>To ensure compliance three medical records will be selected at random per month to be reviewed for accuracy. Audits to be conducted by the Risk Manager or her designee and will continue until 100% compliance for three consecutive months. Audit results to be reported to Patient Safety Committee.</p> <p>New process implemented for scanning and filing paper documents in electronic record.</p>	<p>August 3 2009</p> <p>August 3 2009</p> <p>September 2009</p> <p>January 19, 2010</p>

Event ID: 9E5U11

8/7/2010

3:36:30PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *James Haberk* TITLE: *Risk manager* (X6) DATE: *4/17/10*

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.

7/7/10 POC accepted

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	<p>Continued From page 1</p> <p>██████████</p> <p>The inspection was limited to the specific entity reported incident and does not represent the findings of a full inspection of the facility</p> <p>One deficiency was written for Entity Reported Incident CA00197270.</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</p>		<p>Process involves three steps to ensure correct filing of paper documents.</p> <p>Each step in the process is completed by a separate individual and provides a triple check system.</p> <ol style="list-style-type: none"> 1. Document Imaging Specialist reviews medical record for accuracy including verification of correct patient identification 2. Document Imaging Specialist reviews documents for accuracy and scans document into application. 3. Document Imaging Specialist reviews documents to verify accuracy. Once accuracy has been verified the document is uploaded to the electronic file. <p>To ensure compliance three medical records selected at random per month to be reviewed for accuracy. Audits to be conducted by the Risk Manager or her designee and will continue until 100% compliance for three consecutive months. Audit</p>	<p>March, 2010</p>

Event ID:9ESU11

6/7/2010

3:36:30PM

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

TITLE

(X6) DATE

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	<p>Continued From page 3</p> <p>hospital's attorney on July 31, 2009 at 4:28 PM that the copied chart of Patient A, the Plaintiff in a lawsuit against the hospital for care given in 2008 contained one laboratory report of Patient B, three laboratory reports of Patient C, and fifteen laboratory reports of Patient D. Patients B, C, and D were not involved in the lawsuit filed by Patient A and had not given prior authorization to the hospital to release any part of their medical record.</p> <p>The Risk Manager further stated during the same interview that an internal investigation concluded the laboratory reports of the three patients not involved in the lawsuit were mistakenly filed in Patient A's chart by laboratory personnel. Consequently, when the Plaintiff's Attorney's copy service, and the Co-Defendant's Attorney's copy service subpoenaed the medical record of Patient A, the laboratory reports of Patient's B, C, and D inadvertently went to the two attorney's offices, and to the hospital attorney's office. She further explained that it is standard practice for the copy services to come into Medical Records and copy the medical record, and that Medical Records does not typically, make the copies and send them to the individual attorney's offices. She stated, "This is just one that fell through the cracks."</p> <p>During an interview with The Director of Medical Records on August 25, 2009 at 10 AM she explained the process at the time was redundant. It is now changed. Paper laboratory reports were filed by laboratory personal in the patients charts daily as well as electronically. After the patients are discharged from the hospital the paper medical</p>			2010 JUN 17 PM 3:55	

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