

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050262	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2008
NAME OF PROVIDER OR SUPPLIER UCLA MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10833 LE CONTE AVE BH 427, CHS LOS ANGELES, CA 90095		
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E 000	Initial Comments Surveyor: 17116 The following reflects the findings of the Department of Public Health during a Complaint Investigation. Complaint Number CA00150461 Inspection was limited to the specific complaint investigated, and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: [REDACTED] RN, HFEN	E 000		
E1953	T22 DIV5 CH1 ART7-70707(b)(8) Patients' Rights (b) A list of these patients' rights shall be posted in both Spanish and English in appropriate places within the hospital so that such rights may be read by patients. This list shall include but not be limited to the patients' rights to: (8) Confidential treatment of all communications and records pertaining to the care and the stay in the hospital. Written permission shall be obtained before the medical records can be made available to anyone not directly concerned with the care. This Statute is not met as evidenced by: Surveyor: 17116 Based on record review and interviews, the facility failed to ensure their electronic medical record-keeping system contained safeguards to	E1953		

Licensing and Certification Division

TITLE

(X6) DATE

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

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E1953	<p>Continued From page 1</p> <p>prevent access of confidential patient information that was not related to care or services provided to the patient.</p> <p>Findings:</p> <p>1. In response to a report from the facility, an investigation into the breach of Patient D's medical record was conducted on 5/16/08.</p> <p>According to Employee 2, Patient D, a well-known individual, was hospitalized in October 2004. During a recent hospital examination of certain facility documents, written correspondence regarding the breach of the patient's confidential information was discovered.</p> <p>Administrative documents containing copies of the internal correspondence regarding the breach of confidentiality were reviewed. One such document contained points of a conversation with Patient D's representative, who alleged a national newspaper "ran a front page story about [Patient D's] surgery at the facility." That person also informed the facility that he was told the information was obtained from an "inside source at the hospital." Additional correspondence addressed plans to "track down the perpetrator and investigate this report."</p> <p>Facility documents indicated an audit of the patient's record was conducted at the time of the incident to detect employees and others affiliated with the facility who accessed Patient D's record at any time during the period of 6/1/04 through 11/29/04.</p> <p>On 5/16/08, at 11:10 a.m., Employee 2 disclosed, "We cannot find the final report...so we don't know what happened in the end." Personnel</p>	E1953			

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E1953	<p>Continued From page 2</p> <p>involved in the investigation could not be questioned as they were no longer employed at the facility. Employee 2 announced, "We'll do our own investigation now."</p> <p>During the facility's current investigation, Patient D's medical record was audited from 1/1/04 through 6/30/06. The audit identified the persons who accessed the record, the section(s) within the record that was accessed, plus the date(s) and time(s) it was viewed. Those persons who accessed the record in the performance of the duties of their job were eliminated.</p> <p>Although the patient had been admitted under a pseudonym (AKA), two (2) employees were able to access Patient D's medical record without authorization. Employee 3 accessed portions of the medical record in May 2005 and again in November 2005. The patient was not in the hospital either of those times. After determining Employee 3 had no job-related reason for viewing the record in 2005, the employee was suspended in July, 2008 for violation of PHI (protected health information) .</p> <p>The second employee, Employee 1, accessed Patient D's medical record on 21 separate occasions, from 10/28/04 through 11/9/04, which included 13 days after the patient was discharged. Authorized for access to electronic records through PCIMS (Patient Centric Information Management System), Employee 1 was able to view physicians' orders, case summary notes, blood type, laboratory results, and other information related to the patient's 3-day stay. It is unknown if the facility took any action at that time. Employee 1 accessed other patients' records since then, and subsequently was dismissed in May 2007.</p>	E1953			

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E1953	<p>Continued From page 3</p> <p>A review of the medical records revealed there was no documentation that Patient D had given written authorization to permit release of, or access to, medical information to any member of the facility's workforce not involved with her care.</p> <p>2. Information regarding the breach of Patient E's medical records emerged during the course of the investigation of Patient D on 5/16/08. Patient E, a well-known individual, was hospitalized from 11/16/04 through 11/23/04. According to facility documents, in November 2004, the patient's representative alleged that information pertaining to the patient's hospitalization was published in a national newspaper.</p> <p>During investigations on 5/16/08 and 5/28/08, the facility produced documents regarding the 2004 incident, which consisted of internal correspondence and some hand-written notes. Most of the documents reflected conversations with and about Patient E's representative, discussions about the news reports, and conflicting evidence about the name under which the patient was admitted.</p> <p>The facility was unable to locate any additional documentation about the incident, and could not ascertain the subsequent course of events or the final conclusion of a facility investigation when the incident occurred.</p> <p>Employee 2 reported that none of the employees involved with the 2004 investigation currently worked at the facility, therefore she was unable to interview them to obtain additional information. On 5/28/08, at 9:10 a.m., Employee 2 stated during an interview, "We'll just have to say it was</p>	E1953			

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E1953	<p>Continued From page 4</p> <p>dropped."</p> <p>On 5/16/08, an audit of Patient #E's medical record was requested. From that audit, the facility identified and eliminated the members of the workforce who accessed the record in the performance of the job duties. On 5/28/08, the facility concluded that Employee 1 had accessed Patient E's medical record without justification.</p> <p>A review of the records showed Patient E was hospitalized for 7 days. Employee 1 accessed the patient's medical record 24 times over a 22-day period, including 15 days beyond the patient's stay. It is unknown if the facility discovered the violation at the time of the incident, and if it had, if Employee 1 received any disciplinary action for the inappropriate access.</p> <p>Employee 1, who had "absolutely no reason" to examine Patient E's medical record, viewed additional patients' clinical files without authorization at other times, and was dismissed in May 2007.</p> <p>A review of the medical records revealed Patient E had not given written authorization to permit access to, or release of, medical information to any member of the facility's workforce not involved with her care.</p> <p>3. The facility routinely conducted "proactive audits" to determine if any member(s) of their workforce accessed a medical record inappropriately when a person who might generate interest came into the hospital. On 5/16/08, at 4:35 p.m., Employee 2 disclosed a recent breach of a well-known individual's PHI.</p> <p>Employee 2 explained that during the course of</p>	E1953			

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E1953	<p>Continued From page 5</p> <p>running audits, it occurred to them that they needed to audit "MedHost", a separate electronic patient record system in the emergency department (ED), which was described as a stand alone system, independent of the facility's main electronic patient record-keeping system. "We haven't been doing audits on Med Host," she divulged.</p> <p>The MedHost audit detected inappropriate access of a well-known individual, Patient F, who was admitted to the emergency department on 4/18/08. Access to a patient's information in the MedHost system, which is used for documentation of patients' care and treatment only while in the emergency department, entailed "clicking" on the desired bed number displayed in a schematic layout of the ED on the electronic screen. A name/AKA or MRN (medical record number) was not required.</p> <p>Employee 4 disclosed on 5/29/08, at 12:15 p.m., that the audit and subsequent investigation uncovered 3 employees who inappropriately accessed Patient F's record on the Emergency Department's MedHost system on 4/18/08. The employees were not authorized to view Patient F's confidential information, and none were assigned to provide care.</p> <p>In a facility-wide memo, the employees had received messages on 1/31/08 and 4/7/08 to "remind them of patients' right to privacy and security...and of the consequences of violating those rights."</p> <p>Employee 2 explained the degree of the employee's violation determined the severity of the discipline. "That same day, they were specifically reminded to not access Patient F's</p>	E1953			

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E1953	<p>Continued From page 6</p> <p>medical record unless they were providing care."</p> <p>One employee, an emergency care tech, was given a verbal warning, one licensed nurse was given a written reprimand, and another licensed nurse was dismissed.</p> <p>4. A facility audit of Employee 1's activity in PCIMS during the period of 1/1/04 through 6/30/06 was conducted. The audit uncovered the names of 109 patients whose confidential records were breached by Employee 1. A review of facility documents on 5/28/08 revealed more than half of the patients were noteworthy individuals, some of whom were admitted under an assumed name (AKA) to provide anonymity while receiving care within the facility's health care system.</p> <p>Through PCIMS, the least restrictive component of the facility's electronic medical record system, patients' entire health information could be obtained, as well as information relating to care provided through sister facilities, outpatient clinics, and consultants.</p> <p>Employee 2 stated that Employee 1, who was identified as "a secretary", had "no valid reason" to access any of the 109 records.</p> <p>5. Employee 4 stated they discovered Employee 1 used a former supervisor's password to access patients through ADT (Admission, Discharge, Transfer) for over 4 years. "It was disturbing," she said, "because the password expires every 90 days."</p> <p>Described as a "patient registration system," ADT contained demographic information, such as patient names, addresses, health insurance information, employment data, social security</p>	E1953			

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E1953	<p>Continued From page 7</p> <p>numbers, and some medical information (i.e., treatment dates, diagnoses, biopsy results), plus the MRN. Subsequently, Employee 1 was able to obtain MRNs and/or AKAs through ADT, which the employee needed to access patients' records.</p> <p>On 5/29/08, at 3:05 p.m., Employee 4 reported on the results of an audit of Employee 1's activity in the ADT system, accessed with her former supervisor's password. From 1/1/04 through 6/30/06, "we discovered close to 700 names," Employee 4 disclosed.</p> <p>A report of a combined ADT/PCIMS audit, extending from 4/13/03 through 5/21/07, concluded that Employee 1 had accessed a total of 939 patients' records without any legitimate reason. Forty-three (43) of those patients had previously experienced similar breaches of their PHI.</p> <p>6. On 6/19/08, the facility submitted the results of audits requested on each of the 109 patient records accessed by Employee 1, to explore the possibility of additional breaches by other members of their workforce.</p> <p>The audits for the period of 1/1/04 through 6/30/06 produced 64 additional names of workforce members, employees, contracted personnel, volunteers, and physicians, from areas such as the emergency department, the eye institute, pediatrics, clinical trials, research, neuropsychiatry, and surgery whose access to the records could not be justified.</p> <p>Of the 24 current workforce members, the facility proposed the following disciplinary actions: seven (7) terminations, six (6) 2- and 3-week suspensions; five (5) verbal counseling; and,</p>	E1953			

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E1953	Continued From page 8 three (3) written warnings. Currently, three (3) workforce members remain under investigation. The remaining 40, identified as "former employees," included five (5) who had already been dismissed, allowed to resign, or retire, for breaches detected prior to the ones that were discovered during the current investigation. Currently, (3) remain under investigation.	E1953			
E2236	T22 DIV5 CH1 ART7-70751(b) Medical Record Availability (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. This Statute is not met as evidenced by: Surveyor: 17116 Based on interviews and reviews of documents, the facility failed to design and implement safeguards to protect sensitive information in patients' records from exposure to unauthorized persons. The facility further failed to maintain a medical record system that prevented unauthorized access to their patients' confidential information by employees from a distinct, separate facility. Findings: 1. On 5/29/08, Employee 4 announced the discovery that additional confidential information had possibly been viewed inappropriately. During the investigation of Employee 1's unauthorized	E2236			

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E2236	<p>Continued From page 9</p> <p>access in the ADT (Admission, Discharge, Transfer)system, Employee 4 stated she became "concerned about which screens in ADT showed social security numbers (SSN)."</p> <p>In addition to patient demographics (i.e., name , address, social security number, and health insurance information, etc.), similar information about the patient's "related party" (representative, family member, spouse, etc.) and "payor" (the insured or responsible person, if other than the patient) could be viewed in ADT.</p> <p>In order to identify which of the screens exposed SSNs, Employee 4 ran an audit of the patients Employee 1 accessed through ADT from 4/14/03 through 5/21/07. Employee 4 divulged, "The investigation was an exercise in futility, because all but one (1) screen displayed the SSNs."</p> <p>Investigation of Employee 1's access of records uncovered 879 patients whose social security numbers and health information were exposed while Employee 1 inappropriately accessed their medical records. In addition, 146 related parties' SSNs were exposed, as well as 14 payors whose health insurance information was exposed along with their SSNs.</p> <p>The facility maintained there was "no evidence that Employee 1 ever used the (individuals') SSNs."</p> <p>2. A report was requested on the 64 members of the work force who also may have been exposed to SSN/health insurance information when they inappropriately accessed the 109 patients' records.</p> <p>A review of that report was conducted on 7/1/08.</p>	E2236			

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E2236	<p>Continued From page 10</p> <p>According to the facility's audit, 40 of the 64 employees who accessed the 109 records were exposed to SSNs 61 times.</p> <p>Employee 2 stated, "Just because it [the SSN] came up on a screen, doesn't mean they actually looked at it."</p> <p>3. A facility-specific audit was requested on the 64 previously-identified individuals who accessed the 109 records .</p> <p>That audit revealed one (1) employee who had accessed four (4) patients' records at this medical facility. This employee worked at Sister Facility 1, an acute psychiatric facility, and had no medically-related justification for accessing those patients' records.</p> <p>Due to the sensitive nature of the services provided, Sister Facility 1 is blocked from sharing patient information between outpatient areas and other hospitals within the facility's healthcare system.</p> <p>When asked why employees at Sister Facility 1 were not blocked from accessing medical records of individuals who were not, and had never been, patients at that facility, Employee 2 divulged on 7/11/08, at 1 p.m., "The MPI (Master Patient Index) system allows access to our Westwood, Santa Monica [facilities], outpatient services, and all over." She explained, "We share all kinds of contracted services," and added, "That's what happens when one hospital is part of another one."</p>	E2236			