California Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ C B. WING CA060001620 09/10/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 S TUSTIN STREET PLANNED PARENTHOOD/ORANGE & SAN BEI ORANGE, CA 92863 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) PPOSBC Response to Amended CMS 2567 for A 000 Initial Comments A 000 9.22.14 COMPLAINT NUMBER CA00378267: **AMENDED** \*\* PPOSBC former Compliance Officer during the interval in question is no longer with PPOSBC. The following reflects the findings of the California However, senior management at PPOSBC including Department of Public Health during the the PPOSBC CEO, and COO are aware of the standard investigation of COMPLAINT NUMBER: processes engaged in by said former Compliance CA00378267. Officer including but not limited to said Compliance Inspection was limited to the specific complaint(s) Officer's adherence to PPOSBC policies regarding investigated and does not represent the findings reporting applicable incidents such as that described of a full inspection of the facility. herein, and direct communication(s) with applicable affected PPOSBC patients. Therefore, the following Representing the California Department of Public said PPOSBC response is in good faith with respect to Health: Surveyor 1835, HFEN. said former Compliance Officer's tenure at PPOSBC. Findings for Complaint Number: CA00378267. Amended CMS 2567 form CA00378267 Findings: The complaint allegation(s) were substantiated a) Patient at issue was contacted by PPOSBC's and regulatory violations written at A001 and compliance officer or his/her designee, informing said A017. patient of the respective incident, of PPOSBC policies on the same and that PPOSBC would thoroughly A 001 Informed Medical Breach A 001 investigate said incident and remedy as applicable. Said patient was provided full contact information at Health and Safety Code Section 1280.15 (b)(2). PPOSBC for any additional questions or follow up at " A clinic, health facility, agency, or hospice shall patient's discretion. PPOSBC staff involved in each also report any unlawful or unauthorized access said incident was counseled and placed on administrative to, or use or disclosure of, a patient's medical suspension as of said 11/7/2013 report by PPOSBC to information to the affected patient or the patient's CDPH. Subsequently, said staff was separated from representative at the last known address, no later employment with PPOSBC, so as to ensure optimal than five business days after the unlawful or and maximum protection of patient medical unauthorized access, use, or disclosure has been information and data privacy and security. detected by the clinic, health facility, agency, or hospice." b) PPOSBC staff involved in said incident was counseled The CDPH verified that the facility informed the and placed on administrative suspension as of said affected patient(s) or the patient's 11/7/2013 report by PPOSBC to CDPH. Subsequently, representative(s) of the unlawful or unauthorized said staff was separated from employment with access, use or disclosure of the patient's medical PPOSBC, so as to ensure optimal and maximum information. protection of patient medical information and data privacy. Licensing and Certification Division

STATE FORM 19/20/14 Acceptable POC- HFEN 1835.

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

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PRINTED: 10/09/2014 FORM APPROVED California Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING CA060001620 09/10/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 S TUSTIN STREET PLANNED PARENTHOOD/ORANGE & SAN BEI ORANGE, CA 92863 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Additionally, PPOSBC has a robust series of policies A 001 Continued From page 1 A 001 9.22.14 that all staff must adhere to regarding the optimum security and privacy of patient protected health A 017 1280.15(a) Health & Safety Code 1280 information. Staff are also regularly trained and A 017 educated on said policies. (a) A clinic, health facility, home health agency, or hospice licensed pursuant to Section 1204, I. Pertinent said policies include: 1250, 1725, or 1745 shall prevent unlawful or unauthorized access to, and use or disclosure of, PPOSBC Compliance Policy CO-600 Corporate patients' medical information, as defined in Compliance Program subdivision (a) of Section 56.05 of the Civil Code • PPOSBC Compliance Policy CO-1104 Patient and consistent with Section 130203. The Right to File Complaints About Use and Disclo department, after investigation, may assess an sure of their Protected Health Information administrative penalty for a violation of this PPOSBC Compliance Policy CO-1105 HIPAA section of up to twenty-five thousand dollars Privacy and Information Security Training (\$25,000) per patient whose medical information • PPOSBC Compliance Policy CO-1108 Minimum was unlawfully or without authorization accessed. Necessary Rule for Protected Health Information used, or disclosed, and up to seventeen PPOSBC Compliance Policy CO-111 Protected thousand five hundred dollars (\$17,500) per Health Information Breach Notification subsequent occurrence of unlawful or unauthorized access, use, or disclosure of that PPOSBC Compliance Policy CO-112 Sanctions for patients' medical information. For purposes of the Unauthorized Uses and Disclosures of a Patient's investigation, the department shall consider the Protected Health Information clinic's, health facility's, agency's, or hospice's history of compliance with this section and other II. In addition to said above-referenced incidentrelated state and federal statutes and regulations. specific retraining and counseling, as well as the the extent to which the facility detected violations promulgation of said above-referenced policies at and took preventative action to immediately PPOSBC, PPOSBC also regularly trains and educates correct and prevent past violations from recurring, staff on said agency policies; both at inception of and factors outside its control that restricted the staff's tenure at PPOSBC as well as throughout 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.

Based on interview and clinic document review. the clinic failed to prevent a disclosure of Patient

This Statute is not met as evidenced by:

agency calendar; this includes:

Protected Health Information/HIPAA in-person

Information/HIPAA Online module new staff training for new staff to be completed with a set period of time immediately post orientation/hire

training at staff orientation day/hire · An additional Protected Health

• Proactive calendared clinic/health center

Licensed Clinician trainings that also include training on Protected Health Information/HIPAA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING CA060001620 09/10/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 S TUSTIN STREET PLANNED PARENTHOOD/ORANGE & SAN BEI ORANGE, CA 92863 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) Proactive calendared non-licensed clinic/health A 017 Continued From page 2 A 017 9.22.14 center staff (e.g., Medical Assistants, reception staff) 1's protected health information (PHI) from an trainings that also include training on Protected Health unauthorized staff member. Information Health Center Managers proactively calendared Findings: trainings that focus on managing health center staff with respect to several matters, including Protected Review of the clinic's documents showed Patient Health Information/HIPAA 1 was at the clinic on 11/7/13. Before concluding Proactively calendared Annual All-Staff agency the visit, the patient reported unauthorized access Training on Compliance Policies and Procedures of her medical record by a current staff of the • PPOSBC implemented automated audit software clinic (Staff 1). Patient 1 stated Staff 1 was a that provides information on potential unauthorized paternal family member to her child. Additionally. access by/disclosure to any level of agency staff, with Patient 1 claimed Staff 1 shared the information after inappropriately accessing the patient's respect to the agency Electronic Health Records health information. system as well as related patient information systems such as those relevant to patient scheduling and Review of the clinic's investigation showed an administrative records. This audit software is breach analysis of Patient 1's electronic medical record detection technology that is fully integrated with our (EMR) was done. The analysis confirmed Staff 1 electronic health record system. On a daily basis, the accessed the patient's EMR four different times. breach detection technology/software analyzes without a need to know. During the times Staff 1 access into the agency systems, thereby automatically inappropriately accessed Patient 1's EMR, the monitoring potential unauthorized access and/or progress notes of four different clinic visits were disclosures on numerous levels of the patient record viewed. such as lab results, progress notes, appointment information, and related facets Continued review of the clinic's investigation A culture that invites reporting any suspected showed an interview with Staff 1 occurred on compliance and/or privacy matters to supervisors in 11/8/13. When asked, Staff 1 confirmed a familial any department, including but not limited to PPOSBC relationship to Patient 1's child and stated it was Human Resources Department, Patient Services possible the access to the patient's EMR was out Department, Administration and the Compliance of curiosity. When asked, Staff 1 confessed to having accessed the patient's EMR without a Department need to know. · Dedicated and consistent agency Quality Management/Quality Assurance meetings through On 9/9/14 at 1020 hours, a telephone conference the Patient Services Department to review and as with the Privacy Officer occurred regarding the applicable, improve the quality of agency processes breach as documented. Dedicated and consistent (quarterly) agency Compliance and Enterprise Risk Management Committee to review and as applicable, improve the quality of agency processes

California Department of Public Health

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 A. BUILDING: \_\_\_\_\_ C CA060001620 B. WING \_ 09/10/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

(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) COMPLET DATE
A 017	REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3		<ul> <li>CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</li> <li>A dedicated Compliance agency Hotline 24 hours a day 7 days a week, 365 days a year</li> <li>Suspension, Separation of Employment and/or other processes for sanctioning any staff that fails to follow said processes and trainings as described above</li> <li>Accordingly, as with any healthcare agency, such as hospitals, the CDPH, DHCS and other entities, PPOSBC is subject to common human errors or independent acts against established and reinforced agency policies. However, PPOSBC sets forth robust, consistent and good faith efforts to prevent and/or as applicable remediate towards optimum protection of health information for all patients. PPOSBC also makes every effort to communicate with any applicable patients at issue to assist them with any questions or concerns, including providing contact information for relevant staff such as patient services department or compliance department staff, and providing said patients with a toll-free phone number to utilize at any time.</li> <li>c) As noted in section (b):</li> <li>PPOSBC has a robust series of policies that all staff must adhere to regarding the optimum security and</li> </ul>	
			privacy of patient protected health information. Staff are also regularly trained and educated on said policies.  I. Pertinent said policies include:  PPOSBC Compliance Policy CO-600 Corporate Compliance Program	
	i.		<ul> <li>PPOSBC Compliance Policy CO-1104 Patient Right to File Complaints About Use and Disclosure of their Protected Health Information</li> <li>PPOSBC Compliance Policy CO-1105 HIPAA Privacy and Information Security Training</li> <li>PPOSBC Compliance Policy CO-1108 Minimum Necessary Rule for Protected Health Information</li> </ul>	

STATE FORM

California Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_\_ C B. WING \_ CA060001620 09/10/2014 NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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A 017	Continued From page 4	A 017	<ul> <li>PPOSBC Compliance Policy CO-111 Protected Health Information Breach Notification</li> <li>PPOSBC Compliance Policy CO-112 Sanctions for Unauthorized Uses and Disclosures of a Patient's Protected Health Information</li> </ul>	9.22.14
			II. In addition to the promulgation of said policies at PPOSBC, PPOSBC also regularly trains and educates on said agency policies, both at inception of staff's tenure at PPOSBC as well as throughout the agency calendar; this includes:	
			center staff (e.g., Medical Assistants, reception staff) trainings that also include training on Protected Health Information  Health Center Managers proactively calendared trainings that focus on managing health center staff with respect to several matters, including Protected Health Information/HIPAA  Proactively calendared Annual All-Staff agency	2014 OCT 17 AM 9 5
			Training on Compliance Policies and Procedures  • PPOSBC implemented automated audit software that provides information on potential unauthorized access by/disclosure to any level of agency staff, with respect to the agency Electronic Health Records system as well as related patient information systems such as those relevant to patient scheduling and administrative records. This audit software is	5H

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 A. BUILDING: \_\_\_ C B. WING CA060001620 09/10/2014

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A 017	Continued From page 5	A 017	with our electronic health record system. On a daily basis, the breach detection technology/software analyzes access into the agency systems, thereby automatically monitoring potential unauthorized access and/or disclosures on numerous levels of the patient record such as lab results, progress notes, appointment information, and related facets  • A culture that invites reporting any suspected compliance and/or privacy matters to supervisors in	9.22.14
			any department, including but not limited to PPOSBC Human Resources Department, Patient Services Department, Administration and the Compliance Department  • Dedicated and consistent agency Quality Management/Quality Assurance meetings through the Patient Services Department to review and as applicable, improve the quality of agency processes  • Dedicated and consistent (quarterly) agency Compliance and Enterprise Risk Management Committee to review and as applicable, improve the quality of agency processes  • A dedicated Compliance agency Hotline 24 hours a day 7 days a week, 365 days a year  • Suspension, Separation of Employment and/or other processes for sanctioning any staff that fails to follow said processes and trainings as described above	2014
			Accordingly, as with any healthcare agency, such as hospitals, the CDPH, DHCS and other entities, PPOSBC is subject to common human errors or independent acts against established and reinforced agency policies. However, PPOSBC sets forth robust, consistent and good faith efforts to prevent and/or as applicable remediate towards optimum protection of health information for all patients.  PPOSBC also makes every effort to communicate with any applicable patients at issue to assist them with any questions or concerns, including providing contact	OCT 17 RM 9 54

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 A. BUILDING: \_\_\_ C CA060001620 B. WING 09/10/2014

NAME OF PROVIDER OR SUPPLIER

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A 017	Continued From page 6	A 017	department or compliance department staff, and providing said patients with a toll-free phone number to utilize at any time.	9.22.14
		- 1	Thereby, PPOSBC submits in good faith that it is taking	
			all measures feasible to prevent and as applicable in	
			this matter, mitigate, reduce risk, raise quality and	
			address any deficiencies that CPDH may nevertheless	
			perceive. As additional measures:	
			PPOSBC has hired a chief Compliance Officer, chief	
			Privacy Officer, and chief Security Officer to review	
			PPOSBC systems for additional quality improvement	
			as applicable. (i) One immediate result herein is the	
			updating of the agency process to include the above-	
			referenced robust Compliance & Enterprise Risk	
			Management Committee. (ii) A second immediate	
			result is an updated agency All-Staff annual training for	
			Compliance policies and procedures that includes	
			robust Protected Health Information/HIPAA training.	
			(iii) Agency HIPAA Security measures have consistently	
			also been reviewed for quality assurance; however,	
			with said new hires' recent presence at PPOSBC,	
			agency Security measures will also be re-reviewed for	
			even further optimum compliance.	
			PPOSBC has also installed a Chief Operating Officer	-
			who regularly collaborates with the Compliance	5
		- 2	Officer, Privacy Officer and Security Officer, as well as	A .
			the VP of HR, the agency Medical Director, and the	1
			Office of the CEO, to directly manage and oversee	
			ongoing training of all agency health center staff, both	3
			<ul><li>licensed and non-licensed.</li><li>With said new hires, PPOSBC is also embarking one</li></ul>	
	T		long-term plan to continue to review all said applicable	,
		1	agency policies for optimum quality and compliance	]
	1		With said new hires, PPOSBC also plans for long	-
			term subject matter expertise for matters relevant to	
			optimum protection of patient privacy and security,	
			and compliance with regulatory and agency	
			standards.	

STATE FORM

California Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The second second	PLE CONSTRUCTION G:		SURVEY PLETED
		CA060001620	B. WING		100	C 1 <b>0/2014</b>
NAME OF I	PROVIDER OR SUPPLIER	J.1.1217		, STATE, ZIP CODE		10/2017
PLANNE	D PARENTHOOD/OF	SANGE & SAN REI	USTIN STRE SE, CA 92863			
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A 017	Continued From pa	age 7	A 017	d) and e): As noted in section (c) in sig	nificant detail:	9.22.14
				PPOSBC has a robust series of policies must adhere to regarding the optimur privacy of patient protected health infoare also regularly trained and educated or	m security and ormation. Staff	
				I. Pertinent said policies include:		
				PPOSBC Compliance Policy CO-60 Compliance Program PPOSBC Compliance Policy CO-11 Right to File Complaints About Us Disclosure of their Protected Heal PPOSBC Compliance Policy CO-11 Privacy and Information Security PPOSBC Compliance Policy CO-11 Necessary Rule for Protected Hea PPOSBC Compliance Policy CO-11 Health Information Breach Notific PPOSBC Compliance Policy CO-11 Unauthorized Uses and Disclosure Protected Health Information  II. In addition to the promulgation of Sa PPOSBC, PPOSBC also regularly trains a	LO4 Patient se and Ith Information LO5 HIPAA Training LO8 Minimum Ith Information L1 Protected cation L2 Sanctions for es of a Patient's	114 OCT 17 AM
				said agency policies, both at inception at PPOSBC as well as throughout the at this includes:		at good
				<ul> <li>Protected Health Information/HIF training at staff orientation day/hi</li> <li>An additional Protected Health In HIPAA Online module new staff tr staff to be completed with a set p immediately post-orientation/hir</li> <li>Proactive calendared clinic/health Licensed Clinician trainings that al training on Protected Health Infor</li> </ul>	ire formation/ raining for new period of time e n center lso include	

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
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-		ORANGE, CA 92863	T	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM	FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 017	Continued From page 8	A 017		9.22.14

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California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	CA060001620	B. WING	C 09/10/2014

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A 017	Continued From page 9	A 017	Accordingly, as with any healthcare agency, such as hospitals, the CDPH, DHCS and other entities, PPOSBC is subject to common human errors or independent acts against established and reinforced agency policies. However, PPOSBC sets forth robust, consistent and good faith efforts to prevent and/or as applicable remediate towards optimum protection of health information for all patients.	9.22.14
			PPOSBC also makes every effort to communicate with any applicable patients at issue to assist them with any questions or concerns, including providing contact information for relevant staff such as patient services department or compliance department staff, and providing said patients with a toll-free phone number to utilize at any time.	
			Thereby, PPOSBC submits in good faith that it is taking all measures feasible to prevent and as applicable in this matter, mitigate, reduce risk, raise quality and address any deficiencies that CPDH may nevertheless perceive. As additional measures:	20
			Privacy Officer, and chief Security Officer to review PPOSBC systems for additional quality improvement	2014 001 17
			referenced robust Compliance & Enterprise Risk Management Committee. (ii) A second immediate result is an updated agency All-Staff annual training for Compliance policies and procedures that includes robust Protected Health Information/HIPAA training.	80 <b>9</b> 54
			(iii) Agency HIPAA Security measures have consistently also been reviewed for quality assurance; however, with said new hires' recent presence at PPOSBC, agency Security measures will also be re-reviewed for even further optimum compliance	
	Certification Division		With said new hires, PPOSBC is also embarking on a long-term plan to continue to review all said applicable	

STATE FORM

California Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ C B. WING CA060001620 09/10/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 S TUSTIN STREET PLANNED PARENTHOOD/ORANGE & SAN BEI ORANGE, CA 92863 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) agency policies for optimum quality and compliance. A 017 Continued From page 10 A 017 9.22.14 • With said new hires, PPOSBC also plans for long term subject matter expertise for matters relevant to optimum protection of patient privacy and security, and compliance with regulatory and agency standards. Accordingly, and since the incident at issue is dated during calendar year 2013, PPOSBC submits in good faith that as of said current date of September 2014, it has already implemented and integrated a variety of applicable corrective actions to address the incident at issue. Any additional measures further outlined herein serve to also illustrate PPOSBC's commitment to overall continued long-term optimum management of relevant processes, and the privacy and security of protected health information for its valued patient population. PPOSBC takes the optimal customer service, and privacy and security of its patients very seriously and will continue to do so through all efforts listed herein; and any additional quality improvement measures that its quality assurance, risk management and compliance processes illuminate.

California Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING CA060001620 09/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 S TUSTIN STREET PLANNED PARENTHOOD/ORANGE & SAN BEI ORANGE, CA 92863 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) PPOSBC Response to Amended CMS 2567 for A 000 **Initial Comments** 9.22.14 A 000 COMPLAINT NUMBER CA00397908: **AMENDED** \* PPOSBC former Compliance Officer during the interval in question is no longer with PPOSBC. The following reflects the findings of the California However, senior management at PPOSBC including Department of Public Health during the the PPOSBC CEO, and COO are aware of the standard investigation of COMPLAINT NUMBER: processes engaged in by said former Compliance CA00397908. Officer including but not limited to said Compliance Inspection was limited to the specific complaint(s) Officer's adherence to PPOSBC policies regarding investigated and does not represent the findings reporting applicable incidents such as that described of a full inspection of the facility. herein, and direct communication(s) with applicable affected PPOSBC patients. Therefore, the following Representing the California Department of Public said PPOSBC response is in good faith with respect to Health: Surveyor 1835, HFEN. said former Compliance Officer's tenure at PPOSBC. Findings for Complaint Number: CA00397908. Amended CMS 2567 form CA00397908 Findings #1-#8 (inadvertent incidents): The complaint allegation(s) were substantiated and regulatory violations written at A001 and a) Patients at issue were contacted by PPOSBC's A017. compliance officer or his/her designee, informing each said patient of the respective incident, of A 001 Informed Medical Breach A 001 PPOSBC policies on the same and that PPOSBC would thoroughly investigate said incident and remedy as Health and Safety Code Section 1280.15 (b)(2), applicable. Each said patient was provided full contact " A clinic, health facility, agency, or hospice shall information at PPOSBC for any additional questions or also report any unlawful or unauthorized access follow up at patient's discretion. Given each said to, or use or disclosure of, a patient's medical incident was varying in nature, each PPOSBC staff information to the affected patient or the patient's involved in each said incident was counseled and representative at the last known address, no later retrained relevant to the incident at issue; this than five business days after the unlawful or counseling and retraining included retraining on the unauthorized access, use, or disclosure has been privacy and security of protected health information detected by the clinic, health facility, agency, or hospice." and ensuring agency policies are conformed to, so as to ensure optimal and maximum protection of The CDPH verified that the facility informed the patient medical information and data privacy and s affected patient(s) or the patient's ecurity. representative(s) of the unlawful or unauthorized access, use or disclosure of the patient's medical b) Given each said incident was varying in nature, each information. PPOSBC staff involved in each said incident was counseled and retrained relevant to the incident at issue: Licensing and Certification Division

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

President/Ce

CV0D11

If continuation sheet 1

California Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ C B. WING CA060001620 09/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 S TUSTIN STREET PLANNED PARENTHOOD/ORANGE & SAN BEI ORANGE, CA 92863 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) however, this counseling and retraining collectively A 001 Continued From page 1 A 001 9.22.14 included retraining on the privacy and security of protected health information and ensuring agency policies are conformed to, so as to ensure optimal A 017 1280.15(a) Health & Safety Code 1280 A 017 and maximum protection of patient medical information and data privacy and security. (a) A clinic, health facility, home health agency, or hospice licensed pursuant to Section 1204. 1250, 1725, or 1745 shall prevent unlawful or Additionally, PPOSBC has a robust series of policies unauthorized access to, and use or disclosure of, that all staff must adhere to regarding the optimum patients' medical information, as defined in security and privacy of patient protected health subdivision (g) of Section 56.05 of the Civil Code information. Staff are also regularly trained and and consistent with Section 130203. The educated on said policies. department, after investigation, may assess an administrative penalty for a violation of this I. Pertinent said policies include: section of up to twenty-five thousand dollars (\$25,000) per patient whose medical information • PPOSBC Compliance Policy CO-600 Corporate was unlawfully or without authorization accessed. Compliance Program used, or disclosed, and up to seventeen • PPOSBC Compliance Policy CO-1104 Patient Right thousand five hundred dollars (\$17,500) per to File Complaints About Use and Disclosure of their subsequent occurrence of unlawful or Protected Health Information unauthorized access, use, or disclosure of that PPOSBC Compliance Policy CO-1105 HIPAA Privacy patients' medical information. For purposes of the and Information Security Training investigation, the department shall consider the clinic's, health facility's, agency's, or hospice's PPOSBC Compliance Policy CO-1108 Minimum history of compliance with this section and other Necessary Rule for Protected Health Information related state and federal statutes and regulations. • PPOSBC Compliance Policy CO-111 Protected the extent to which the facility detected violations Health Information Breach Notification and took preventative action to immediately • PPOSBC Compliance Policy CO-112 Sanctions for correct and prevent past violations from recurring. Unauthorized Uses and Disclosures of a Patient's and factors outside its control that restricted the Protected Health Information facility's ability to comply with this section. The department shall have full discretion to consider II. In addition to said above-referenced incidentall factors when determining the amount of an specific retraining and counseling, as well as the administrative penalty pursuant to this section. promulgation of said above-referenced policies at PPOSBC, PPOSBC also regularly trains and educates PM staff on said agency policies; both at inception of staff's tenure at PPOSBC as well as throughout the agency calendar; this includes: This Statute is not met as evidenced by:

Based on interview and facility document review.

the facility failed to prevent the disclosure of eight

• Protected Health Information/HIPAA in-person

training at staff orientation day/hire

PRINTED: 10/09/2014

FORM APPROVED California Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING CA060001620 09/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 S TUSTIN STREET PLANNED PARENTHOOD/ORANGE & SAN BEI ORANGE, CA 92863 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) An additional Protected Health Information/HIPAA A 017 Continued From page 2 A 017 9.22.14 Online module new staff training for **new staff** to be patients (Patients A, B, C, D, E, F, G and H) completed with a set period of time immediately protected health information (PHI) to post-orientation/hire unauthorized individuals. Proactive calendared clinic/health center Licensed Clinician trainings that also include training on Findings: Protected Health Information/HIPAA Proactive calendared non-licensed clinic/health 1. Review of the clinic documentation shows a center staff (e.g., Medical Assistants, reception staff) breach of Patient A's PHI occurred at the trainings that also include training on Protected Anaheim Health Center on 12/5/12. The clinic Health Information staff were made aware the incorrect patient was Health Center Managers proactively calendared handed a urine cup labeled with Patient A's PHI trainings that focus on managing health center staff on it. with respect to several matters, including Protected Patient A's disclosed PHI included initial of first Health Information/HIPAA name, last name and date of birth (DOB). • Proactively calendared Annual All-Staff agency Training on Compliance Policies and Procedures 2. On 1/2/13, the Department was notified a PPOSBC implemented automated audit software breach of Patient B's PHI occurred at the Mission that provides information on potential unauthorized Viejo Health Center on 12/31/12. A clinic access by/disclosure to any level of agency staff, with Physician's Assistant inadvertently handed a respect to the agency Electronic Health Records prescription intended for Patient B to another system as well as related patient information systems patient. such as those relevant to patient scheduling and administrative records. This audit software is breach Patient B's disclosed PHI included first and last detection technology that is fully integrated with our name, DOB, address and phone number. electronic health record system. On a daily basis, the breach detection technology/software analyzes 3. Review of the clinic's report showed a breach access into the agency systems, thereby automatically of Patient C's PHI occurred on 1/11/13, at the monitoring potential unauthorized access and/or Westminster Health Center. The investigation disclosures on numerous levels of the patient record showed a patient checked in and stated her first such as lab results, progress notes, appointment name. An Administrative staff asked if the patient's last name began with a certain letter in information, and related facets the alphabet to which the patient agreed. The A culture that invites reporting any suspected Administrative staff typed and printed labels compliance and/or privacy matters to supervisors in which were affixed to the paperwork and handed any department, including but not limited to PPOSBC the paperwork to the patient to fill out. The patient Human Resources Department, Patient Services took the paperwork to complete and went back to Department, Administration and the Compliance

the administrative staff and stated the last name

on the labels were incorrect.

Department

· Dedicated and consistent agency Quality Management/Quality Assurance meetings through

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California Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING CA060001620 09/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 S TUSTIN STREET PLANNED PARENTHOOD/ORANGE & SAN BEI ORANGE, CA 92863 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) the Patient Services Department to review and as A 017 Continued From page 3 A 017 9.22.14 applicable, improve the quality of agency processes Patient C's disclosed PHI included first and last Dedicated and consistent (quarterly) agency name, DOB and medical record number. Compliance and Enterprise Risk Management Committee to review and as applicable, improve the 4. Review of the clinic's documentation showed. quality of agency processes on 3/5/13, clinic staff became aware a breach of A dedicated Compliance agency Hotline 24 hours a Patient D's PHI occurred at the Santa Ana Health day 7 days a week, 365 days a year Center on 2/21/13. On 2/21/13, a new patient Suspension, Separation of Employment and/or (Patient D) checked in and staff made a Family other processes for sanctioning any staff that fails to Pact Identification Card for Patient D. follow said processes and trainings as described above Just after Patient D checked in, an established Accordingly, as with any healthcare agency, such as patient checked in and handed their Family Pact Card to the staff. When finished checking in, staff hospitals, the CDPH, DHCS and other entities, PPOSBC is subject to common human errors or independent handed the established patient the newly made Family Pact Identification Card for Patient D. acts against established and reinforced agency policies. However, PPOSBC sets forth robust, Patient D's disclosed PHI included name, DOB consistent and good faith efforts to prevent and/or as and Family Pact Identification Card number. applicable remediate towards optimum protection of health information for all patients. PPOSBC also makes 5. Review of the clinic's reported incident showed every effort to communicate with any applicable a breach of Patient E's PHI occurred at the patients at issue to assist them with any questions or Anaheim Health Center on 3/21/13. Patient E had concerns, including providing contact information for already checked in at the clinic when a new relevant staff such as patient services department or walk-in patient checked in shortly afterwards. The compliance department staff, and providing said new patient completed all the paperwork and a patients with a toll-free phone number to utilize at Family PACT Identification Card was made for any time. this patient. However, after about 15 minutes of waiting, the new patient could not wait any longer. c) As noted in section (b): A staff member handed the new patient what was thought to be the Family PACT Identification Card PPOSBC has a robust series of policies that all staff made for the new patient. Later, the staff member realized Patient E's Family PACT Identification must adhere to regarding the optimum security and Card was inadvertently given to the new patient. privacy of patient protected health information. Staff are also regularly trained and educated on said Patient E's disclosed PHI included name, DOB policies. and the Family PACT Identification Card number. I. Pertinent said policies include: 6. Review of the Anaheim Health Center's documentation showed on 4/30/13, they

discovered a breach involving Patient F occurred

Compliance Program

PPOSBC Compliance Policy CO-600 Corporate

Californi	California Department of Public Health							
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION :	(X3) DATE :			
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE				
ΡΙ ΔΝΝΕ	D PARENTHOOD/OR	ANGE & SAN BEI 700 S TUS	STIN STREE	ET .				
LAINE	D TAILENTHOOD/OT	ORANGE,	, CA 92863					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE		
A 017	Continued From pa	ge 4	A 017	PPOSBC Compliance Policy CO-1104 Patie	ent Right	9.22.14		
		estigation showed when a		to File Complaints About Use and Disclosure	of their			
		me into the center on 4/30/13,		Protected Health Information	D 201 540000			
	the patient's card w	ith NexPlan on it had Patient		PPOSBC Compliance Policy CO-1105 HIPA	A Privacy			
	F's name on it. It wa	as discovered a Physician		and Information Security Training				
	Assistant (PA) saw	both the returning patient and		PPOSBC Compliance Policy CO-1108 Min  Necessary Pule for Protected Health Inform	Charles and the same of the sa			
		2. On 9/29/12 while the PA		Necessary Rule for Protected Health Inform  • PPOSBC Compliance Policy CO-111 Prote				
		Plan for the returning patient,		Health Information Breach Notification	cied			
	Patient F's chart wa	nented Patient F's name on		PPOSBC Compliance Policy CO-112 Sanct	ions for			
	the incorrect card.	ichted i attent i 3 ffame off		Unauthorized Uses and Disclosures of a Pat				
	the mostroot sara.			Protected Health Information	Ref 2010(1912(19)			
	Patient F's disclose	d PHI included name only.						
				II. In addition to the promulgation of said po	olicies at			
		a Mesa Health Center report		PPOSBC, PPOSBC also regularly trains and e	of Market I			
		breach of Patient G's PHI		on said agency policies, both at inception of	A STATE OF THE STA			
		3, a patient came into the clinic f their medical record. A staff		tenure at PPOSBC as well as throughout the	agency			
		record and gave it to the		calendar; this includes:				
		atient called to inform the staff		Protected Health Information/HIPAA in-p	nerson			
		medical record packet		training at staff orientation day/hire	CISOII			
	belonged to another	r patient.		An additional Protected Health Informat	ion/HIPAA			
	Dationt Cla disclara	d DLU included name DOD		Online module <b>new staff</b> training for new si				
		d PHI included name, DOB, nber, last four digits of the		completed with a set period of time immed				
	social security numb			post-orientation/hire				
	requisition.	,		Proactive calendared clinic/health center				
	30 COMO - • COMO SAND Y 2000 - CAN THAT			Clinician trainings that also include training of	on			
		rt regarding the Costa Mesa		Protected Health Information/HIPAA	, , ,	21		
		ed a patient who was at the		Proactive calendared non-licensed clinic/		111		
		ed on 6/7/13 to inform staff ation of being Web enabled to		center staff (e.g., Medical Assistants, recept		30		
		nline. However, when the		trainings that also include training on Protection  Health Information	ileu	7		
		e information belonged to		Health Center Managers proactively cale	ndared	2014 OCT 17		
		tion showed this patient and		trainings that focus on managing health cer				
	Patient H were seen	at the clinic at approximately		with respect to several matters, including Pi		BM		
		6/13 and a staff inadvertently		Health Information/HIPAA				
		mation into this other patient's		Proactively calendared Annual All-Staff a	gency	2		
	medical record.			Training on Compliance Policies and Proced		58		
	D-11	d BUIL's about a discourse and		PPOSBC implemented automated audits	oftware	5		

Patient H's disclosed PHI included name and

California Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING CA060001620 09/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 S TUSTIN STREET PLANNED PARENTHOOD/ORANGE & SAN BEI ORANGE, CA 92863 SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) that provides information on potential unauthorized 9.22.14 A 017 Continued From page 5 A 017 access by/disclosure to any level of agency staff, with year of birth. respect to the agency Electronic Health Records system as well as related patient information systems On 9/9/14 at 1020 hours, a telephone conference such as those relevant to patient scheduling and with the Privacy Officer occurred regarding the administrative records. This audit software is breach breaches as documented. detection technology that is fully integrated with our electronic health record system. On a daily basis, the breach detection technology/software analyzes access into the agency systems, thereby automatically monitoring potential unauthorized access and/or disclosures on numerous levels of the patient record such as lab results, progress notes, appointment information, and related facets · A culture that invites reporting any suspected compliance and/or privacy matters to supervisors in any department, including but not limited to PPOSBC Human Resources Department, Patient Services Department, Administration and the Compliance Department · Dedicated and consistent agency Quality Management/Quality Assurance meetings through the Patient Services Department to review and as applicable, improve the quality of agency processes Dedicated and consistent (quarterly) agency Compliance and Enterprise Risk Management Committee to review and as applicable, improve the quality of agency processes A dedicated Compliance agency Hotline 24 hours and day 7 days a week, 365 days a year Suspension, Separation of Employment and/or other processes for sanctioning any staff that fails to follow said processes and trainings as described above Accordingly, as with any healthcare agency, such as hospitals, the CDPH, DHCS and other entities, PPOSBC is subject to common human errors or

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independent acts against established and reinforced agency policies. However, PPOSBC sets forth robust

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FORM APPROVED California Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ C CA060001620 B. WING 09/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 S TUSTIN STREET PLANNED PARENTHOOD/ORANGE & SAN BEI ORANGE, CA 92863 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) consistent and good faith efforts to prevent and/or as A 017 Continued From page 6 A 017 9.22.14 applicable remediate towards optimum protection of health information for all patients. PPOSBC also makes every effort to communicate with any applicable patients at issue to assist them with any questions or concerns, including providing contact information for relevant staff such as patient services department or compliance department staff, and providing said patients with a toll-free phone number to utilize at any time. Thereby, PPOSBC submits in good faith that it is taking all measures feasible to prevent and as applicable in this matter, mitigate, reduce risk, raise quality and address any deficiencies that CPDH may nevertheless perceive. As additional measures: • PPOSBC has hired a chief Compliance Officer, chief Privacy Officer, and chief Security Officer to review PPOSBC systems for additional quality improvement as applicable. (i) One immediate result herein is the updating of the agency process to include the abovereferenced robust Compliance & Enterprise Risk Management Committee. (ii) A second immediate result is an updated agency All-Staff annual training for Compliance policies and procedures that includes robust Protected Health Information/HIPAA training. (iii) Agency HIPAA Security measures have consistently also been reviewed for quality assurance; however, with said new hires' recent presence at PPOSBC, agency Security measures will also be re-reviewed for even further optimum compliance. PPOSBC has also installed a Chief Operating Officer. who regularly collaborates with the Compliance Officer, Privacy Officer and Security Officer, as well as

Licensing and Certification Division

the VP of HR, the agency Medical Director, and the Office of the CEO, to directly manage and oversee ongoing training of all agency health center staff,

both licensed and non-licensed.

California Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ C CA060001620 B. WING 09/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 S TUSTIN STREET PLANNED PARENTHOOD/ORANGE & SAN BEI **ORANGE, CA 92863** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) · With said new hires, PPOSBC is also embarking on a 9.22.14 A 017 Continued From page 7 A 017 long-term plan to continue to review all said applicable agency policies for optimum quality and compliance. With said new hires, PPOSBC also plans for long term subject matter expertise for matters relevant to optimum protection of patient privacy and security, and compliance with regulatory and agency standards. d) and e): As noted in section (c) in significant detail: 9.22.14 PPOSBC has a robust series of policies that all staff must adhere to regarding the optimum security and privacy of patient protected health information. Staff are also regularly trained and educated on said policies. I. Pertinent said policies include: PPOSBC Compliance Policy CO-600 Corporate Compliance Program • PPOSBC Compliance Policy CO-1104 Patient Right to File Complaints About Use and Disclosure of their Protected Health Information PPOSBC Compliance Policy CO-1105 HIPAA Privacy and Information Security Training • PPOSBC Compliance Policy CO-1108 Minimum Necessary Rule for Protected Health Information PPOSBC Compliance Policy CO-111 Protected Health Information Breach Notification PPOSBC Compliance Policy CO-112 Sanctions for Unauthorized Uses and Disclosures of a Patient's Protected Health Information II. In addition to the promulgation of said policies at PPOSBC, PPOSBC also regularly trains and educates 5 on said agency policies, both at inception of staff's 55 tenure at PPOSBC as well as throughout the agency calendar; this includes:

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Protected Health Information/HIPAA in-person

PRINTED: 10/09/2014 FORM APPROVED California Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ C B. WING CA060001620 09/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 S TUSTIN STREET PLANNED PARENTHOOD/ORANGE & SAN BEI **ORANGE, CA 92863** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) A 017 Continued From page 8 training at staff orientation day/hire A 017 9.22.14 An additional Protected Health Information/HIPAA Online module **new staff** training for new staff to be completed with a set period of time immediately post-orientation/hire • Proactive calendared clinic/health center Licensed Clinician trainings that also include training on Protected Health Information/HIPAA • Proactive calendared non-licensed clinic/health center staff (e.g., Medical Assistants, reception staff) trainings that also include training on Protected Health Information Health Center Managers proactively calendared trainings that focus on managing health center staff with respect to several matters, including Protected Health Information/HIPAA Proactively calendared Annual All-Staff agency Training on Compliance Policies and Procedures PPOSBC implemented automated audit software that provides information on potential unauthorized access by/disclosure to any level of agency staff, with respect to the agency Electronic Health Records system as well as related patient information systems such as those relevant to patient scheduling and administrative records. This audit software is breach detection technology that is fully integrated with our electronic health record system. On a daily basis, the breach detection technology/software analyzes access into the agency systems, thereby automatically monitoring potential unauthorized access and/or disclosures on numerous levels of the patient record such as lab results, progress notes, appointment information, and related facets • A culture that invites reporting any suspected compliance and/or privacy matters to supervisors in

Licensing and Certification Division

Department

any department, including but not limited to PPOSBC Human Resources Department, Patient Services Department, Administration and the Compliance

California Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C CA060001620 B. WING 09/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 S TUSTIN STREET PLANNED PARENTHOOD/ORANGE & SAN BEI ORANGE, CA 92863 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Dedicated and consistent agency Quality A 017 Continued From page 9 A 017 9.22.14 Management/Quality Assurance meetings through the Patient Services Department to review and as applicable, improve the quality of agency processes Dedicated and consistent (quarterly) agency Compliance and Enterprise Risk Management Committee to review and as applicable, improve the quality of agency processes • A dedicated Compliance agency Hotline 24 hours a day 7 days a week, 365 days a year Suspension, Separation of Employment and/or other processes for sanctioning any staff that fails to follow said processes and trainings as described Accordingly, as with any healthcare agency, such as hospitals, the CDPH, DHCS and other entities, PPOSBC is subject to common human errors or independent acts against established and reinforced agency policies. However, PPOSBC sets forth robust, consistent and good faith efforts to prevent and/or as applicable remediate towards optimum protection of health information for all patients. PPOSBC also makes every effort to communicate with any applicable patients at issue to assist them with any questions or concerns, including providing contact information for relevant staff such as patient services department or compliance department staff and providing said patients with a toll-free phone number to utilize at any time. Thereby, PPOSBC submits in good faith that it is taking all measures feasible to prevent and as applicable in this matter, mitigate, reduce risk, raise quality and address any deficiencies that CPDH may nevertheless perceive. As additional measures:

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PPOSBC has hired a chief Compliance Officer, chief
 Privacy Officer, and chief Security Office to review

California Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING CA060001620 09/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **700 S TUSTIN STREET** PLANNED PARENTHOOD/ORANGE & SAN BEI ORANGE, CA 92863 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) PPOSBC systems for additional quality improvement A 017 Continued From page 10 A 017 9.22.14 as applicable. (i) One immediate result herein is the updating of the agency process to include the abovereferenced robust Compliance & Enterprise Risk Management Committee. (ii) A second immediate result is an updated agency All-Staff annual training for Compliance policies and procedures that includes robust Protected Health Information/HIPAA training. (iii) Agency HIPAA Security measures have consistently also been reviewed for quality assurance; however, with said new hires' recent presence at PPOSBC, agency Security measures will also be re-reviewed for even further optimum compliance · With said new hires, PPOSBC is also embarking on a long-term plan to continue to review all said applicable agency policies for optimum quality and compliance. With said new hires, PPOSBC also plans for long term subject matter expertise for matters relevant to optimum protection of patient privacy and security, and compliance with regulatory and agency standards. Accordingly, and since the incidents at issue span calendar years 2012 and 2013, PPOSBC submits in good faith that as of said current date of September. 2014, it has already implemented and integrated a variety of applicable corrective actions to address, the incidents at issue. Any additional measures further outlined herein serve to also illustrate PPOSBC's commitment to overall continued longterm optimum management of relevant processes, and the privacy and security of protected health information for its valued patient population. PPOSBC takes the optimal customer service, and privacy and security of its patients very seriously and will continue to do so through all efforts listed herein; and any additional quality improvement measures that its quality assurance, risk

management and compliance processes illuminate.

California Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED CA060001620 07/11/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 S TUSTIN STREET PLANNED PARENTHOOD/ORANGE & SAN BEI ORANGE, CA 92863 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) **HSC Initial Comments** A 000 The following reflects the findings of the California Response to A001 - We will work to make Department of Public Health during a complaint every attempt to provide records within a investigation for COMPLAINT NO: CA00352542. timely manner. Inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility. Corrective action for identified patients -We cannot change the charting or medical Representing the California Department of Public doctor assessment of EBL for the patients Health: Surveyor 28950, HFEN. identified in this report or any additional Deficencies were found and written at H&S past patients. We did intervene with these 1293.2. physicians and discussed clear · V documentation of EBL in the future. GLOSSARY OF ABBREVIATION: Response to D183-1 - Our recovery room CDPH - California Department of Public Health nurses are trained to measure EBL on sanitary pads, and a pictorial of sanitary pad A 001 HSC 1293.2. H & S Code 1293.2.(a) soaking is placed on the wall in the recovery A 001 room bathroom. As a result of these 1293.2. It is a misdemeanor for any person to do incidents, a direct intervention with the any of the following: physician occurred in which he was advised to more closely monitor EBL and was limited (a) Willfully prevent, interfere with, or attempt to impede in any way the work of any duly in gestational age in which he may perform authorized representative of the state department procedures. In addition, an in-service has in the lawful enforcement of this chapter. been held with the staff and MDs on September 26, 2013 that reviewed modes of estimating EBL, including weighing chucks This Statute is not met as evidenced by: and measuring suction canister volume. Based on interview, the facility failed to provide Training components included reference to access to medical records, as required by law, for visual aids, review of PPOSBC protocols, and the CDPH representative. This has the potential practice in calculating EBL to better support to impede a medical investigation. Findings: accurate EBL documentation On 4/29/13 at 1420 hours, a visit was made to the Licensing and Certification Division

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

(X6) DATE

STATE FORM

If continuation sheet 1 of 4

California Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: \_ COMPLETED CA060001620 B. WING 07/11/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PLANNED PARENTHOOD/ORANGE & SAN BEI 700 S TUSTIN STREET ORANGE, CA 92863 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG COMPLETE DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 001 Continued From page 1 A 001 During the past year, we have also facility to begin a complaint investigation. Upon initiated a more vigilant incident monitoring arrival, the Facility Manager was informed a program through our Quality Management complaint investigation was being conducted, Department to identify areas for potential official state identification was provided and a request for a tour of the facility was made. The improvement in care and documentation. Facility Manager provided a tour after calling the In addition to documenting quality CDPH office to verify the identity of the surveyor. improvement activities, detailed summaries of all adverse events occurring in the health At 1500 hours, the Facility Manager was centers are reported to Planned interviewed and was asked for access to the Parenthood Federation of America (PPFA). medical records to continue the investigation. After this intervention, and routinely The manager left the room and returned a few minutes later. The manager stated the CEO had thereafter, the Director of Quality been called and would not permit access to the Management and Medical Director will medical records. The manager stated a written complete a chart audit using PPFArequest for patient records from the CDPH could approved audit tools for evaluating surgical be made and medical information would then be abortion procedures which includes the sent to the department. assessment of documented EBL At 1530 hours, a copy of the Health and Safety estimations. In addition to a review of Code 1293.2 was provided to the Facility medical records, we will also utilize the Manager. The Facility Manager still refused PPFA-approved observation tool to assess access to the medical records. adherence to PPOSBC protocols for surgical abortion procedures. The chart audit and T22 DIV5 CH7 ART6-75055(f) Unit Patient Health D 183 observations will be performed by our Records ... Director of Quality Management and supervised by the Medical Director. (f) Patients' health records shall be current and Subsequent reviews will consist of an kept in detail consistent with good medical and annual comprehensive program review of professional practice and shall describe the services provided to each patient. All entries shall surgical abortion procedures. This review be dated and be authenticated with the name, has been added to the Annual Quality professional title, and classification of the person Management calendar of activities and is making the entry. scheduled for February, 2014. In addition, we are currently redesigning our surgical abortion progress note in our electronic medical record to make it easier to This Statute is not met as evidenced by: Based on health record review and interview, the document EBL and track complications. This will be completed in September 2013.

California Department of Public Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED CA060001620 07/11/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PLANNED PARENTHOOD/ORANGE & SAN BEI 700 S TUSTIN STREET ORANGE, CA 92863 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 2 D 183 clinic failed to document accurate blood loss Response to D183-2- Our recovery room using professional practices for two of five nurses are trained to measure EBL on sampled patients (Patients 1 and 2). The estimated blood loss (EBL) for Patient 1 was sanitary pads, and a pictorial of sanitary pad documented as a total of 215 ml (milliliters). The soaking is placed on the wall in the recovery patient had a significant drop in her hemoglobin room bathroom. As a result of these from 13.8 to 8.6, indicating a higher loss of blood. incidents, a direct intervention with the Patient 2 had a drop of her hemoglobin from 11.8 physician occurred in which he was advised to 9.4; and was documented as having heavy to more closely monitor EBL. This physician bleeding. Physician 2 estimated Patient 2's blood has now retired and is no longer working for loss as less than 15 ml. This has the potential for PPOSBC. In addition, an in-service was held the patients' physical assessments to be incorrect with the staff and MDs on September 26. which can lead to complications from blood loss. 2013 that reviewed modes of estimating EBL, including weighing chucks and measuring Findings: suction canister volume. Recovery room staff 1. Health record review for Patient 1 was initiated will be empowered to quantify EBL in their on 5/7/13. Review of the Progress Notes dated notes based on their training. Of note, 2/22/13, showed at 1140 hours, Patient 1's enhanced use of the electronic medical hemoglobin level prior to her surgical procedure record system will better facilitate was 13.8 gm/dl (grams per deciliter) (normal documentation of EBL in the patient's record. 12-14 gm/dl). The procedure was initiated at 1331 During the past year, we have also initiated a more vigilant incident monitoring program hours. At the end of the procedure, the physician through our Quality Management documented an EBL of 15 ml. Patient 1 was transferred to the recovery room at 1353 hours. Department to identify areas for potential improvement in care and documentation. The progress notes show an EBL of 200 ml and a After this intervention, we will complete a hemoglobin of 11 gm/dl (a drop of 2.8) while in chart audit to assess EBL estimations going forward. The chart audit will be performed the recovery room. At 1417 hours, Patient 1 was transferred back to the procedure room for active by our Director of Quality Management and supervised by the Medical Director. As noted bleeding. in PPOSBC's Quality Management Plan, all The documentation shows at 1743 hours, the audit results will be shared with the Quality indwelling catheter was removed and Patient 1 Management Committee, Quality Improvement activities will be implemented had "copious vaginal bleeding." The hemoglobin was re-measured at 8.6 gm/dl (a total drop of 5.2 as needed to address deficiencies and strengths identified during the review. gm/dl). Patient 1 was emergently transported to an acute facility for evaluation and treatment. An interview with the Medical Director was initiated on 7/11/13 at 1000 hours. The Medical

California Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: CA060001620 B. WING 07/11/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PLANNED PARENTHOOD/ORANGE & SAN BEI 700 S TUSTIN STREET ORANGE, CA 92863 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) D 183 Continued From page 3 D 183 Director stated a drop in the hemoglobin by one Monitoring - Per PPOSBC's Quality point usually means a loss of 300 ml of blood (a Management Plan, all quality activities and 5.2 point drop x 300 ml = 1560 ml blood loss). corrective action steps will be formally An interview with Physician 1 was initiated on documented and managed by the Director 7/11/13 at 1130 hours. Physician 1 was asked of Quality Management. The Corrective about the EBL. He stated the EBL is usually done Action Plan will be signed by the Medical by a pad count and the documented estimate on Director and Chief Administrative Officer the progress note was approximate. once completed. Documentation of a pad count was not found in the progress notes. 2. Health record review for Patient 2 was initiated on 5/7/13. Review of the Progress Notes dated 3/9/13, showed Patient 2's pre procedure hemoglobin level was 11.8 gm/dl on 3/8/13. The documentation shows the procedure was initiated on 3/9/13 at 1118 hours and completed at 1133 hours. Physician 2 documented the EBL was less than 15 ml. At 1210 hours, the documentation shows Patient 2 passed a large blood clot and is having active bleeding. Patient 2 was discharged from the facility at 1351 hours. At 1430 hours, Patient 2 returned to the clinic complaining of having heavy bleeding. The hemoglobin was 9.4 gm/dl (a 2.4 gm/dl drop). An interview with the Medical Director was initiated on 7/11/13 at 1000 hours. The Medical Director stated a drop in the hemoglobin by one point usually means a loss of 300 ml of blood (2.4 point drop x 300 ml = 720 ml blood loss). 1-Licensing and Certification Division

FORM APPROVED California Department of Public Health STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING CA060001620 12/06/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **700 S TUSTIN STREET** PLANNED PARENTHOOD/ORANGE & SAN BEI ORANGE, CA 92863 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 000 Initial Comments A 000 Complaint Number CA00334630 The following reflects the findings of the California Department of Public Health during the investigation of COMPLAINT NUMBER: a) Corrective Actions accomplished for CA00334630. the patients identified to have been affected are as follows: Inspection was limited to the specific complaint(s) investigated and does not represent the findings 1. Mission Viejo Health Center of a full inspection of the facility. Letters sent to Patients A, B and F 3/19/12 notifying them of an unintentional breach Representing the California Department of Public of their personal information which Health: Surveyor 1835, HFEN. included their name, date of last menstrual period, size of family, income Findings for Complaint Number CA00334630: and the internal medical record number. The complaint allegation(s) were substantiated Letter sent to Patient C notifying her of 3/19/12 and regulatory violations written at A001 and an unintentional breach of her personal A017. information which included her name. A 001 A 001 Informed Medical Breach Letter sent to Patient D notifying her of 3/19/12 an unintentional breach of her personal Health and Safety Code Section 1280.15 (b)(2), information which included her name. " A clinic, health facility, agency, or hospice shall date of birth and date of last menstrual also report any unlawful or unauthorized access period. to, or use or disclosure of, a patient's medical information to the affected patient or the patient's Letter sent to Patient E notifying her of 3/19/12 representative at the last known address, no later an unintentional breach of her personal than five business days after the unlawful or information which included her name, unauthorized access, use, or disclosure has been date of birth, phone number, social detected by the clinic, health facility, agency, or security number, name of her insurance hospice." company and the insurance identification number. The CDPH verified that the facility informed the affected patient(s) or the patient's Provided all patients resources on how representative(s) of the unlawful or unauthorized to contact our office for additional access, use or disclosure of the patient's medical assistance information.

Licensing and Certification Division

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

Operations Manager for CORM

1/25/13

STATE FORM

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1/20/13 - Accepted - 1836 HFON

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

CA060001620

A. BUILDING B. WING

C 12/06/2012

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PLANNED PARENTHOOD/ORANGE & SAN BEI

700 S TUSTIN STREET

PLANNE	D PARENTHOOD/ORANGE & SAN BEI ORANGE	, CA 92863	*	
(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 017	Continued From page 1	A 017	a) Corrective Actions Continued	
A 017	1280.15(a) Health & Safety Code 1280	A 017	2. Costa Mesa Health Center Letter sent to Patient H notifying them of	6/21/12
	(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		an unintentional breach of their name, date of birth, the health center's internal chart number and their Health Access Program number. Also provided patient resources on how to contact our office for additional assistance.	
	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		3. Anaheim Health Center Letter sent to Patient J notifying her of an unintentional breach of her first initial, last name and date of birth. Also provided patient resources on how to contact our office for additional assistance.	10/19/12
	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,		4. Orange Administration Office Letter sent to Patient G notifying her of an unintentional breach of her name, date of birth, the health center's internal medical record number, income and phone number. Also provided patient resources on how to contact our office for additional assistance.	5/3/12
=	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.		5. Santa Ana Health Center Letter sent to Patient I notifying her of an unintentional breach of her name, date of birth and her Family Pact card identification number. Also provided patient resources on how to contact our office for additional assistance.	8/2/12
censing and	This Statute is not met as evidenced by: Based on interview and hospital document review, the facility failed to prevent the disclosure of 11 patients' protected health information (PHI) to unauthorized individuals (Patients A, B, C, D, E, F, G, H, I, J and K).		6. Westminster Health Center Letter sent to Patient K notifying her of an unintentional breach of her name and test results. Also provided patient resources on how to contact our office for additional assistance.	11/9/12

PRINTED: 01/10/2013 FORM APPROVED California Department of Public Health STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING CA060001620 12/06/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 S TUSTIN STREET PLANNED PARENTHOOD/ORANGE & SAN BEI ORANGE, CA 92863 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) b) How other patients having the A 017 Continued From page 2 A 017 potential to be affected by the same deficient practice can be identified and Findings: what corrective actions will be taken. 1. Review of Mission Viejo Health Center In the above findings members of our documentation showed a breach of PHI involving staff neglected to follow our procedure six patients. for verifying the identity of a patient before giving them a urine cup, supply or On 3/14/12, a back office Medical Assistant was prescription. We continue to education handed four pieces of paper, folded in half, and our staff on patient verification before dated 3/13/12, by a patient. The papers contained distribution of supplies or paperwork. the hand written PHI of Patients A. B. C. D. E. and F. We also stress the importance of verifying FAX numbers before Further review of the health center's investigation transmitting information. We remind staff showed on 3/13/12, a call center representative to follow our FAX policy regarding PHI was taking the four pieces of paper with the six information. patient's PHI to the shredder. However, the call center representative had to go to the bathroom. When a HIPAA violation occurs the The patient, who returned the papers stated they health center manager investigates the were found on top of the paper towel dispenser in situation, talks to our compliance office the bathroom. and we work on solutions so these types of errors will not happen in the future. The disclosed PHI belonging to Patients A. B. C. When required, new policies are written D, E and F are as follows: and communicated with staff. Patients A, B, and F's name, date of last Employees we were able to identify as menstrual period, size of family, income and the violators of HIPAA incidents receive internal medical record number were disclosed. Corrective Action Warning Notices. Patient C's name was disclosed. Patient D's name, date of birth and date of last menstrual period were disclosed.

Patient E's name, date of birth, phone number. social security number and the name of their insurance company and the insurance identification number were disclosed.

2. Review of Costa Mesa Health Center's

FORM APPROVED California Department of Public Health STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING CA060001620 12/06/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **700 S TUSTIN STREET** PLANNED PARENTHOOD/ORANGE & SAN BEI ORANGE, CA 92863 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) c) What immediate measures and A 017 A 017 Continued From page 3 systemic changes will be put in place to documentation showed on 6/19/12, it was ensure that deficient practices do not discovered two urine cups with Patient H's PHI. recur? had been given to another patient to take home on 12/20/11. On the above listed findings we made the following changes: The PHI disclosed belonging to Patient H We placed a personal shredder next to included name, date of birth, the health center's the health center's call representative's internal chart number and the Health Access desk so they could shred documents Program number. before they left their desk. Since this incident occurred we moved our call Further review of the Health Center's center representatives from each health investigation showed staff neglected to follow the center location to one location. They policy on verifying patient identity on labeled now have their own secure area with supplies and/or documents before distribution. shred bins and no patients have access to the documents or the paperwork on 3. On 8/14/12, the Anaheim Health Center their desks. discovered staff inadvertently handed a patient a urine cup labeled with Patient J's PHI. The patient We remind staff and include in our new went to the bathroom and noticed the urine cup hire training that staff should always with Patient J's name and returned it to a staff confirm the patient's full name and date member. of birth before handing a patient anything that has patient information written on it. The PHI disclosed included first initial, last name This includes urine cups, Family Pact and date of birth of Patient J. cards, prescriptions, test results, supplies etc. 4. Review of documentation showed, on 4/26/12, the Orange Health Center discovered Patient G's PHI was faxed to a private citizen instead of the We continue to remind staff to be familiar intended recipient on 4/25/12. with our new FAX policy and to pres program those FAX numbers that are Through investigation the health center used repeatedly. One must always discovered staff had inadvertently switched the verify the numbers they have entered

last two numbers of the fax number.

number, income and phone number.

5. On 7/24/12, the Santa Ana Health Center inadvertently handed a patient a Family Pact

Patient G's PHI disclosed included name, date of birth, the health center's internal medical record

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before transmitting a FAX.

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

CA060001620

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

A. BUILDING

B. WING \_

C 12/06/2012

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

700 S TUSTIN STREET

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 017	Continued From page 4		A 017	d) Description of the monitoring process.	
	identification card belonging to Patient I. The alth center discovered the inadvertent at 7/29/2012.  The PHI belonging to Patient I that was di included name, date of birth, and the Famicard identification number.  6. On 11/5/12, the Westminster Health Cediscovered staff had inadvertently given a patient a form belonging to Patient K on 1.  The PHI disclosed on the form showed Park's name and a test result.  The above breaches of PHI were confirmed during a telephone interview with the heal centers' Operations Manager for Complian Quality and Risk Management and the Service President of Compliance and Privacy 12/6/12 at 1400 hours.	enter unother 1/1/12. atient ed ith nce, enior		Monitoring process includes Management overseeing the operations of our health centers including the distribution of supplies and prescriptions. Newly hired staff receive HIPAA training on their first day of work before going to their worksite. Health Center Medical Assistants receive additional HIPAA training during their weeklong orientation training within 30 days of new hire. We also have quarterly Medical Assistant trainings where we train and reinforce the importance of Privacy and following HIPAA requirements and regulations. This training is provided by the Compliance Department. Health Center staff are also reminded of the staff are also reminded of the meetings. At quarterly Quality & Risk Management Meetings, HIPAA preaches are discussed and monitored by management. We also have spot checking audits conducted by the Compliance Office throughout the compliance Office throughout the communicated to staff and they understand the importance of following our policies.	Ongoing
		y .		e) Date when corrective action will be completed.	1/6/13

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