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
	CA090000257	A. BUILDING: ______ B. WING ______	C 11/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD ASSOC OF SAN DIE(	4575 COLLEGE AVENUE SAN DIEGO, CA 92115

(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
D 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of an Entity Reported Incident. ERI Number: CA 00413369 Category: State Monitoring Sub-category: Non-Breach Patient Medical Information Incident Representing the California Department of Public Health: 29153, Health Facilities Evaluator Nurse The inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the hospital. One deficiency was written as a result of ERI number CA 00413369	D 000	a. Since Patient 2 was still in the health center when the error was recognized, we explained and apologized to ›for the error in person and let ' know that we had already attempted to contact Patient 1 to return the medication with Patient 2's label on it. Multiple telephone contact attempts were made to Patient 1 when she failed to return the medication with Patient 2's name on it. A follow up letter was mailed to Patient 2 regarding the breach and our attempts to contact Patient 1. b. See corrective actions below. c. The Health Center Manager and Lead Clinician immediately discussed the incident with the clinician involved in the error and reminded ' that our process includes the mandatory double checking of all patient information and labels prior to handing medication to a patient.	9-12-14 9-12-14 9-13-14 9-15-14 9-16-14 9-12-14
D 177	T22 DIV5 CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws. This Statute is not met as evidenced by: Based on interview and document review the clinic failed to ensure that Patient 2's personal and protected health information (PHI) was kept confidential when a Physician Assistant (PA) 1 gave Patient 1 medications that contained a label with Patient 2's information. As a result of this failure, Patient 1 had access to Patient 2's	D 177	The Health Center Manager completed a root cause analysis with the clinician involved in the error which resulted in the need to reinforce with all staff the following: • The need to verify patient identity prior to handing the patient any information or medication • The need to only work on one patient's chart at a time The Health Center Manager reviewed these expectations with all staff at the next staff meeting.	 9-26-14

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane R DeFile — TITLE: HIPAA Privacy Officer — (X6) DATE: 12-11-14

DEC 12 2014

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D 177	Continued From page 1	D 177		

personal information.

Findings:

An investigation of an entity reported privacy breach was initiated on 10/31/14. It was reported to the California Department of Public Health that on an unauthorized and inadvertent disclosure of Patient 2's medical information was given to Patient 1 during a visit at the clinic.

The Physician Assistant (PA) 1 had seen Patient 1 on . PA 1 had ordered medications for Patient 1 during that same visit. PA 1 gave Patient 1 the medications with a label that contained Patient 2's information.

On 11/4/14 at 1:30 P.M., an interview was conducted with the Privacy Officer (PO). The PO stated that the process for ordering medications was that the clinician (doctor or PA) would see the patient, then go to their office and open up the patients electronic medical record (EMR). The clinician would then open their inbox with their scheduled appointments and click on the correct patient. Once in the patients EMR the clinician would then order the medication and print out the labels. The clinician would adhere the labels to the medications. The PO stated that the clinicians were to double check the EMR to ensure it was the correct patient. The medication would then be placed in a bag and would be given to the patient. The PO stated that in this case, PA 1 went into the EMR and opened the next patient scheduled (Patient 2). PA 1 then ordered the medications and printed out the labels and placed onto the medications. The PO stated that the medications were then given to Patient 1. The PO further stated that when the Medical Assistant (MA) 1 went to work on Patient 2's medical record that

d. The monitoring process will include a review of all patient privacy root cause analysis reports by the HIPAA Privacy Officer, Sr. Director of Quality and the Sr. Director of Center Operations. This will help to identify if any similar errors related to the process for verification of patient identity prior to handing the patient medication or information, have occurred and to address them immediately.

Monitoring of compliance to this internal process is routine. In addition, it is part of the annual performance evaluation. The Health Center Manager and Lead Clinician are responsible for conducting the annual performance evaluation. The annual review process is part of our quality assurance program.

The Health Center Manager is responsible for continuously monitoring compliance to all HIPAA privacy policies and procedures in their health centers including protection of patient privacy through mandatory double checking of all patient information and labels prior to handing to the patient.

In addition, the HIPAA Privacy Officer conducts HIPAA training for all new health center staff as part of the agency's orientation and training program as well as an annual HIPAA Compliance Training review. HIPAA compliance audits are also conducted annually at a minimum of six health centers.

e. All corrective actions were completed by 9-26-14.

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D 177	Continued From page 2 MA 1 noticed that medications had already been ordered. The PO acknowledged that the label on the medications given to Patient 1 had contained Patient 2's name, prescription, instructions for use, name of the prescriber... The PO stated that PA 1 had not double checked to ensure that she was in the correct patients EMR prior to the ordering of medications and printing of labels. The PO stated that the process of ordering medications was an "Internal Process" and that they did not a written policy and procedure. A review of the clinic's policy and procedure, entitled "Employee Handbook", not dated, indicated "...As a general matter, an individuals PHI may not be used or disclosed without proper permission..." This policy was not followed when Patient 1 was given medications that contained Patient 2's information with out proper permission from Patient 2. The Physician Assistant's failure to follow the internal process of double checking to ensure that she was in the correct patients electronic medical record, resulted in the inadvertent and unauthorized release of Patient 2's protected health record information. This was also in violation of the patient's right to confidentiality of all communications and record pertaining to health care received at the hospital.	D 177		