California Department of Public Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING CA070000184 05/29/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **625 HILBY AVENUE** PLANNED PARENTHOOD SEASIDE, CA 93955 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) 1D (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) A 001 The following is Planned Parenthood Mar Monte's A 001 Informed Medical Breach (PPMM's) response to the Department's request for a Plan of Correction with respect to Entity Reported Health and Safety Code Section 1280.15 (b)(2), Incidents CA00306419 in CDPH letter dated June 11, " A clinic, health facility, agency, or hospice shall also report any unlawful or unauthorized access to, or use or disclosure of, a patient's medical Deficiency # D071 [22 CCR 75030(a)(2) not met because of failure to ensure written policies and information to the affected patient or the patient's procedures were implemented for one patient; representative at the last known address, no later failure to provide supervision to ensure the policy than five business days after the unlawful or was implemented] unauthorized access, use, or disclosure has been detected by the clinic, health facility, agency, or (a) Corrective actions to be accomplished for the (a) 4/10/12 hospice." affected patient: As soon as the Seaside Center Manager learned about the possible breach of the patient's protected health information (PHI), a The CDPH verified that the facility informed the comprehensive investigation was begun. After it was affected patient(s) or the patient's CALIFORNIA detempined that a breach had occurred, a PPMM representative(s) of the unlawful or unauthorized OF PUBLicrepresentative called and spoke with Patient 1 access, use or disclosure of the patient's medical informing her of the breach and apologizing. PPMM's Compliance Officer also sent Patient 1 a letter information. JUN communicating similar information. There is no Statement of Deficiency concerning PPMM's D 000 SAN JOSE D 000 Initial Comments (b) Identification of other patients potentially (b) 4/9/12 affected by the same deficient practice and corrective The following reflects the findings of the California action to be taken: Department of Public Health during the investigation of an entity reported incident This situation involved Staff B impermissibly gaining conducted on 5/29/12. access to Patient 1's chart because Patient 1 was Staff B's relative and Staff B had no business reason to gain Entity Reported Incident CA00306419 regarding a that access. The breach was reported to PPMM's Compliance Officer by another employee (Staff A). breach of patient health information by the PPMM has repeatedly emphasized the importance of primary care clinic was substantiated. A employees reporting possible PHI breaches to their deficiency was identified (see California Code of supervisor, as Staff A did. None of the people to whom Regulations, Title 22, Section 75030(a)(2)). employees are directed to report this conduct (Compliance Officer, CEO, General Counsel, Seaside The affected patient was notified by the clinic of Center Manager) has received such reports or reports from any other sources about such PHI breaches. the privacy on 4/9/12. PPMM is also not aware of Staff B having any other Inspection was limited to the specific entity relatives receiving care at PPMM nor of Starr B reported incident investigated and does not impermissibly gaining access to any other patient represent the findings of a full inspection of the charts. When Staff B was approached following the clinic. breach, she said that she had never accessed a friend's or another relative's chart, except her mother's chart.

Licensing and Certification Division

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

POC accepted 6/25/12 by 5. Malan

California Department of Public Health

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING B. WING ____ CA070000184 05/29/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 625 HILBY AVENUE

PLANNE	ANNED PARENTHOOD		CA 93955		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Continued From page 1 Representing the California Department Health: 11442, Health Facilities Evaluate	of Public or Nurse.	D 000	(c) Immediate measures and systemic changes that will be put in place to ensure that deficient practice does not recur.	(c) 5/9/12
D 071 T22 DIV5 CH7 ART4-75030(a)(2) Basic ServicesPolicies and Procedures (2) Policies relating to patient care.		3	D 071	PPMM took appropriate corrective disciplinary action for Staff B on April 6 and April 20, 2012 to ensure she would not commit similar breaches. On April 19, 2012, the Seaside Center Manager conducted a staff meeting explicitly addressing intentional breaches and the Relatives policies. The Center Manager also gave staff quizzes on intentional breaches three times in 2012: April 24, May 4, and May 9.	
	This Statute is not met as evidenced by: Based on interview and record review, the clinic failed to ensure written policies and procedures were implemented for confidentiality of patient health information for one of one sampled patient (1). Findings:			On April 27, 2012, PPMM revised its Privacy Manual and posted it on PPMM's intranet. A copy of the Privacy Manual was also included in the Health Center Administrative Manual. Included in the Privacy Manual is a policy addressing provision of services to relatives (Policy 5) and a policy on sanctions for privacy breaches (Policy 19).	
	On 5/29/12, the electronic medical record (EMR) indicated Patient 1 checked in at the clinic on 4/4/12 at 3:05 p.m. for an appointment. In an interview on 5/29/12, the clinic's patient flow manager (Staff A) stated in the afternoon on 4/4/12, she saw the check-in processor's (Staff B) computer screen opened in areas that were not appropriate. The clinic's computer program has time stamps when someone accesses a patient's record. Patient 1 was a family member of Staff B. Staff B had opened the patient's record 17 times from 9:49 a.m. to 4:18 p.m. On 4/4/12, at approximately 5 p.m. Staff A called the clinic's manager and reported what she discovered. Review of the employee file indicated, on 12/6/11, Staff B signed a form which confirmed she received a copy of the clinic's policy Regarding			(d) Monitoring Process/Quality Assurance This breach was discovered by a Seaside supervisor observing that front office Staff B had her screen open to a part of the electronic medical record (EMR) that front office staff typically do not need for business purposes. Additional monitoring and supervision of Seaside front office staff will occur. Specifically, starting on June 25, 2012, the Seaside Center Manager and Patient Flow Manager (or their designees if neither is available) will circulate in the front office space on a more frequent basis to identify, if possible, whether any front office staff are accessing any of the EMR templates that are not necessary for them to view in the performance of their job. From June 25 until July 31, 2012, there will be daily visual supervision/monitoring. If any staff members are found to be on EMR templates outside those required for their job duties, the immediate follow-up will occur to determine whether PHI was impermissibly accessed. If such access is identified, the Seaside Center	3
	Provision of Services to Relatives and Known to Staff. The policy indicated." shall not provide medical-related service relatives,services shall includeacce	Others .Personnel ces to their		Manager, working with the PPMM Compliance Officer, will take appropriate steps to address the situation.	icans

Licensing and Certification Division

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PRINTED: 06/11/2012 FORM APPROVED California Department of Public Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING _ CA070000184 05/29/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **625 HILBY AVENUE** PLANNED PARENTHOOD SEASIDE, CA 93955 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 071 D 071 Continued From page 2 After July 31, 2012, the Seaside Center Manager, in consultation with the PPMM Compliance Officer and medical files/records..." other appropriate PPMM staff, will review the results of this supervision/monitoring. If there are no The clinic failed to provide supervision to ensure instances of EMR access, they will re-evaluate the need for daily visual supervisions. the policy was implemented to protect patient health information. The Compliance Officer tracks each confirmed incident of an intentional privacy breach within the affiliate as well as any violations of the PPMM's policy concerning provision of services to relatives. Certain incidents will be reviewed by PPMM's Risk and Quality Management Committee to identify issues involving these intentional breaches. When appropriate, additional corrective actions will be implemented at those sites where the intentional breaches occurred. These issues will be reinforced at periodic health center privacy training and staff will be required to attend and sign an attendance sheet and acknowledgement that they understand the contents. (e) Date corrective action will be completed: See column x5 on CMS 2567.





NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD OF CONTRA (X4) ID PREFIX TAG D 177 Continued From page 1 records for a follow-up visit Employee 1 made a list of t complete including Hospital Employee 1 called and disc on Patient 1 to Hospital 1 in error. On 05/03/2013 at 3:06 p.m. informed the Vice Presiden and Compliance Officer (Er interaction between Employ Hospital 1. Employee 3 state communication regarding the Employee 2 late Friday, 05/ stated that she would call Efor further details. There we email from Employee 2 to Ethe incident on 05/08/2013. Review of the clinic's Annual Review of	t at the clinic relephone ca I 1 and Hosp closed the in estead of Ho	STREET ADI 2185 PAC CONCOR ES Y FULL (ATION) C. alls to pital 2. uformation	B. WING		CTION OULD BE PROPRIATE cedure clude the check that I	
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Procedure: Agreement and dated 03/01/02, did not incl an employee would reques from another facility by pho would protect the patient's	mployee 3) of yee 1 and the steel that she he incident is 1/03/2013. Elemployee 2 as communicated the provision of a medical one in a maridentity.	services of the ne clerk at received from mployee 3 on Monday ication by explaining olicy and lgement ons on how record		including patient's name." All staff retrained in this addition to the poli procedures. Adherence to this procedure will be by the Director of the Medical Rest Department, All Health Center Director of Client Services and Compliance	mation will be cy and e monitored ults ectors and VP	7/5/2013
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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 CA140000238 05/21/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2185 PACHECO STREET PLANNED PARENTHOOD OF CONTRA COSTA CONCORD, CA 94520 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG DEFICIENCY) Patient 1 was notified that we inadvertently D 000 Initial Comments D 000 5/9/2012 contacted the wrong hospital to obtain her The following reflects the findings of California medical records and disclosed her name and Department of Public Health during the investigation of an entity reported incident on birth date. We apologized for the incident and medical breach. gave the patient the opportunity to contact the HIPAA Privacy Officer is she had any concerns. Entity Reported Incident Intake Number: CA00354156. She declined to do so. Representing the Department: 31387. No other patients were identified to have the 5/8/2013 The findings reflect the specific component of the potential of being affected by this same deficient entity reported incident investigated and do not practice. represent a complete inspection of the facility. D 177 T22 DIV5 CH7 ART6-75055(b) Unit Patient D 177 Employee 1 received a corrective action notice Health Records 5/8/2013 from her Supervisor Employee 2 about the (b) Information contained in the health records incident shall be confidential and shall be disclosed only to authorized persons in accordance with federal. state and local laws. All Employees in Medical Results dept received 5/9/2013 This Statute is not met as evidenced by: retraining on the importance of double checking Based on staff interview and document review, that they are calling the right provider before the clinic failed to ensure the confidentiality of disclosing any PHI Patient 1's information when Employee 1 disclosed the information to Hospital 1 when there was no need for the hospital to know. RECEIVED Findings: JUN 24 2013 During a phone interview on 05/22/2013 at 5:48 p.m., Employee 3 said that on 05/03/2013 Licensing & Certification Employee 1 had two hospitals to call concerning East Bay District Office two different patients including Patient 1. Patient 1 was seen the emergency room of Hospital 2. Employee 1 had to request the emergency room

Licensing and Certification Division

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S COMPL	
	PROVIDER OR SUPPLIER D PARENTHOOD - EL	CA0900002	STREET ADD	MAIN STE	STATE, ZIP CODE REET, SUITE 301	04/09	9/2013
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D 000	Department of Publ	ets the findings of the lic Health following a elf-reported breach o formation.	n	D 000	We apologized to Patient B reassured her that Planned I committed to protecting pat We also thanked her for retuenty bottle of medication A's name on it.	Parenthood is ient privacy. James J	3/22/13
	Complaint number: The investigation wreported and does	CA00348529 ras limited to the spe not represent the fโล๊เ	cific event.	EIVED PUBLIC H	An analagy latter was maile		3/25/13
	Representing the C	alifornia Department lities Evaluator Nurs	of Public	Z 3 2013	The Health Center Manager	n involved and edication	3/29/13
A 001	" A clinic, health factories also report any unlate, or use or disclosinformation to the a representative at the later than five busin	reach Code Section 1280.1s cility, agency, or hosp awful or unauthorized cure of, a patient's me ffected patient or the e last known address ess days after the ur	5 (b)(2), pice shall access edical spatient's s, no had accessed to a spatient's s, no hawful or	A 001	patient's chart at a time. A streamlined process has be place whereby charts are may the patient until health center to complete the orders for the will prevent errors form occurrence supports the staff in managic chart at a time.	een put into nintained with or staff is ready ne patient. This curring and	3/29/13
	been detected by the agency, or hospice. The CDPH verified affected patient(s) or representative(s) of	that the facility inforr	ned the		The Health Center Manager root cause analysis with the Quality Management to det contributing factors led to the Results will determine if ad measures should be put into what systemic changes may made.	Director of ermine what ne error, ditional place and/o	4/18/13
D 177	Health Records	6-75055(b) Unit Pati ained in the health re		D 177		Amer	icans tec
ABORATOR	naire R. Det	PERSUPPLIER REPRESEN		ATURE 1 VA (4)	TITLE Ufficer TF4W11	for 150/1	(X6) DATE

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D 177	Continued From Pa	age 1		D 177		···	
	shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws. This RULE: is not met as evidenced by:			Monitoring of compliance to the of Medication Administration incorporated into the initial assume health center staff and the performance evaluation. The Hanager is responsible for confiantial performance evaluation.	has been sessment for annual lealth Center ducting the annual	05/25/12 (Date assessment form implemented)	
	Based on interview failed to protect the one sampled patier	ner as cyndenced by and record review, to health record inform ht (Patient A) as requ Code Regulation 128	he facility nation for lired per		review process is part of our quassurance program.		
	result, the patient's compromised. Findings:	private health inform	nation was		The Health Center Manager is for continuously monitoring co all HIPAA privacy policies and in their health centers including	ompliance to d procedures g protection	
	The facility was ma information breach	ide aware of a medic on 3/22/13. The faci the incident on 3/25/	lity notified		of patient privacy through consadhering to the 5 Rights of Me Administration with every patievery transition of patient care	dication ent and with	
		d a breach of the follo mation (PHI) of Patie ion.			In addition, the HIPAA Privac conducts HIPAA training for a health center staff as part of th orientation and training progra	all new e agency's m as well as	
ļ	On 3/28/13 at 10:50 stated, she accider medication meant f	D AM, Medical Assist atly gave Patient B a for Patient A.	ant (MA) 1 bottle of		an annual HIPAA Compliance review. HIPAA compliance au conducted annually at a minim health centers.	dits are also	
		•			All corrective actions were con 4-18-13.	npleted by	
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						Amer	icans
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PRINTED: 12/23/2013 FORM APPROVED

California Department of Public Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING 12/11/2013 CA090001041 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1295 BROADWAY, #201 & #202 PLANNED PARENTHOOD - CHULA VISTA CEN CHULA VISTA, CA 91911 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 000 D 000 Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of an entity reported incident. Entity reported incident: CA00368031 Category: State Monitoring (Non-Breach Patient Medical Information Incident) Representing the Department: Lisa Cork, HFEN The inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility. No deficiencies were written as a result of entity reported incident number: CA00368031 Licensing and Certification Division LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 1/3/2014

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California Department of Public Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 12/10/2013 CA090001041 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1295 BROADWAY, #201 & #202 PLANNED PARENTHOOD - CHULA VISTA CEN CHULA VISTA, CA 91911 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 000 Initial Comments D 000 We apologized to Patient 2 on the phone, 9-3-13 that Planned Parenthood reassured The following reflects the findings of the California is committed to protecting patient privacy Department of Public Health during the and asked that return the receipt investigation of an entity reported incident. intended for Patient 1. Patient 2 returned Patient 1's receipt within 30 minutes of Entity reported incident: CA00368794 visit and was provided with a correct receipt. Category: State Monitoring (Non-Breach Patient Medical Information Incident) An apology letter was mailed to Patient 1 9-4-13 regarding the privacy breach and reassuring Representing the Department: Lisa Cork, HFEN that Planned Parenthood is committed to protecting patient privacy. Patient 1 was The inspection was limited to the specific entity also informed in the letter that Patient 2 had reported incident investigated and does not returned the receipt to us within 30 minutes. represent the findings of a full inspection of the facility. The Health Center Manager immediately 9-3-13 discussed the incident with front office D 177 D 177 T22 DIV5 CH7 ART6-75055(b) Unit Patient staff, reviewed the policy and procedure for Health Records verifying patient identity and emphasized the importance of handling one patient's (b) Information contained in the health records paperwork at a time. shall be confidential and shall be disclosed only to authorized persons in accordance with federal, The Health Center Manager performed a 9-10-13 state and local laws. root cause analysis with Front Office Specialist (FOS) staff involved in the error to determine what contributing factors led to the error. This resulted in a new process This Statute is not met as evidenced by: whereby the FOS will ask the patient to Based on interview and record review, the clinic confirm the information on the receipt and failed to ensure the information contained in the to then initial the receipt. patient's health record be disclosed only to the patient or authorized person. The health The Health Center Manager reviewed the information of 1 of 2 sampled Patients (1) was 9-27-13 incident with all health center staff at their inadvertently disclosed to another person without next staff meeting, reminded staff about the the Patient 1's authorization. policy and procedure for verifying patient Findings: identity and the importance of handling Patient 1 and Patient 2 with identical first names one patient's paperwork at a time. were seen and examined at the facility on the same day and around the same time. An interview with the health center manager Licensing and Certification Division LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE mano

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12/10/2013

California Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

CA090001041

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING:

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1295 BROADWAY, #201 & #202

B. WING

PLANN	ED PARENTHOOD - CHULA VISTA CEN CHULA VI	STA, CA 91	911	
(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 177	Continued From page 1	D 177	Continued from page 1	
icensing a	(HCM) was conducted on 10/14/13 at 1:00 P.M. The HCM stated, "on , the nursing department was informed by Patient 2 that received a receipt which contained Patient 1's personal information to include name and address. Patient 2 contacted the clinic to inform the facility of the error. The front office specialist (FOS) was assisting another employee and had not noticed the error." A letter of notification was mailed to Patient 1 and Patient 2 of the incident. The letter explained that on visit summary note had been given another patient in error. An interview with FOS 1 was conducted on 10/23/13 at 1:30 P.M. FOS 1 stated, "there was a line in check out so went to assist. Noticed check out person was paying cash. At that time, there were two patients there with the same first name checked in and out. For the check out, she checked the chart and reviewed the fees with Patient 2. Patient 2 paid for the visit and the receipt was provided. I believe Patient 1's fees were pending so both receipts must have printed out the same time." A interview with the HCM was conducted on 10/23/13 at 1:40 P.M. The HCM stated the incident of giving Patient 1's personal information to Patient 2 was a breach in confidentiality. The HCM acknowledged that Patient 1's confidentiality had not been maintained when Patient 1 received the receipt that contained Patient 1's personal information.		Monitoring of compliance to the policy for verifying patient identity has been incorporated into the initial assessment for new health center staff and the annual performance evaluation. The Health Center Manager is 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 verification of patient identity at the time of check out. 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. All corrective actions were completed by 9-27-13.	5-25-12 (date assessm ent form impleme nted)

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California Department of Public He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

CA090001041

B. WING

11/26/2012

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PLANNED PARENTHOOD - CHULA VISTA CEN

1295 BROADWAY, #201 & #202 CHULA VISTA, CA 91911

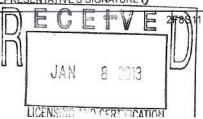
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The following reflects the findings of the California Department of Public Health during the	D 000	We apologized to Patient 1 in person and reassured that Planned Parenthood is committed to protecting patient privacy.	10/11/12
	investigation on an entity reported incident. Entity reported incident: CA00329880		A follow up apology letter was mailed to Patient 1.	10/15/12
	Category: State Monitoring: Non-Breach Patient Medical Information Incident Representing the Department: Nanette Bizzarro, HFEN		The Health Center Manager immediately spoke to the Front Office Specialist involved in the complaint and the Employee Relations Manager was contacted. Disciplinary action included a written "Employee Incident/Solution"	10/16/12
D 071	The inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility. T22 DIV5 CH7 ART4-75030(a)(2) Basic	D 071	Notice." The Health Center Manager reviewed the agency's HIPAA privacy policies and procedures with staff at their staff meeting including protection of patient privacy at the front desk.	12/14/1:
	ServicesPolicies and Procedures (2) Policies relating to patient care.		See above regarding immediate measures that were put into place to ensure deficient practice does not recur.	12/14/1
	This Statute is not met as evidenced by: Based on interview and document review, the facility failed to ensure that clinic staff followed the facility's expectations and policy, and maintained the confidentiality of Patient 1's medical information. Findings:		Monitoring of compliance to the Front Office Specialist Skills Assessment Form has been incorporated into the initial assessment for new health center staff and the annual performance evaluation. They are conducted by the Health Center Manager.	05/25/1:
	An interview with the clinic manager (CM) was conducted on 11/26/12, at 3:00 P.M. The CM stated that Patient 1 reported that, a front desk staff verbalized the reason for clinic visit, "loud enough for other patients in the waiting room to hear." The CM stated that the front desk		The Center Manager is responsible for monitoring compliance to HIPAA privacy policies and procedures in their health centers including protection of patient privacy at the front desk. American	cans

Licensing and Certification Division

Diane R. De fille, HIPAA LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE

SIGNATURE (

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STATE PLAN OF CORRECTION (X1) PROVIDER SUPPLIER (LA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCT	Californi	a Department of Pu	blic He						
PLANNED PARENTHOOD - CHULA VISTA CEN 1295 BROADWAY, #201 & #202 CHULA VISTA, CA 51911			IDENTIFICATION NU		A. BUILDING		COMPL	COMPLETED	
PLANNED PARENTHOOD - CHULA VISTA CEN 1295 BROADWAY, #201 & #202 CHULA VISTA, CA 51911	NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S'	TATE, ZIP CODE			
PRÉFIX TAG REGULATORY OR LOS DENDIFIVING INFORMATION D 071 Continued From page 1 staff should not have verbalized any identifying information and should not ask the reason for the visit when checking in patients. The CM also stated that it was the clinic's expectation and policy, and it was also part of the ront office staff skills assessment, that the confidentiality of all patients' health information would be maintained. A review of the Front Office Specialist Skills Assessment form indicated that, "Correctly maintains patient confidentiality at all times at Front Desk position (i.e. only calls patients by first name, talks to patient what they are here for today, etc.)." All corrective actions were completed by 12/14/12.			HULA VISTA CEN	1295 BRC	ADWAY, #20	1 & #202			
staff should not have verbalized any identifying information and should not ask the reason for the visit when checking in patients. The CM also stated that it was the clinic's expectation and policy, and it was also part of the front office staff skills assessment, that the confidentiality of all patients' health information would be maintained. A review of the Front Office Specialist Skills Assessment form indicated that, "Correctly maintains patient confidentiality at all times at Front Desk position (i.e. only calls patients by first name, talks to patient at window in low voice, does not ask patient what they are here for today, etc.)." All Corrective actions were completed by 12/14/12.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	COMPLETE	
Amoricans	D 071	staff should not hat information and should not have information and should have the checking stated that it was a policy, and it was a skills assessment, patients' health in A review of the Front Assessment form maintains patient of Front Desk position name, talks to patients of the p	ve verbalized any ide ould not ask the reast ould not ask the reast of in patients. The Clause part of the front of that the confidential formation would be not Office Specialist Sindicated that, "Correction of the confidentiality at all timn (i.e. only calls patient at window in low	son for the M also n and office staff ty of all naintained. Skills ectly mes at ents by first voice,	D 071	conducts HIPAA training health center staff as part agency's orientation and t program as well as an ann Compliance Training revi compliance audits are also annually at a minimum of centers. A HIPAA Privacy audit of office processes at this he was conducted by the HIF Officer.	for all new of the raining hual HIPAA ew. HIPAA conducted six health f the front alth center PAA Privacy	11/26/12	
					T control of the second		Amore	ioons	

Licensing and Certification Division

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLII			PLE CONSTRUCTION	(X3) DATE S COMPLI	
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	ROVIDER OR SUPPLIER D PARENTHOOD - EI	CAJON CLINIC	1685 EAST		TATE, ZIP CODE EET, SUITE 301	•	
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D 000	Initial Comments			D 000			
		cts the findings of the lic Health following a			We apologized to Patient B and reassured her that Plann is committed to protecting parts.	ed Parenthood	12/11/12
	investigation of a self-reported breach of a patient's medical information. Complaint number: CA00336712 The investigation was limited to the specific ever reported and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Health Facilities Evaluator Nurse				An apology letter was mailed regarding the privacy breach attached.)		12/17/12
					The Health Center Manager Patient B and asked that she birth control pill packet (corprescription) with Patient A' and receive a correctly labele pill packet with her own nan	return the rect s name on it ed birth control	12/17/12
A 001	State ID: 15932.		oe .	·A 001	The Health Center Manager all health center staff at their the policy for Verifying Clie Identification and the 5 Righ	staff meeting, nt	12/19/12
` .	" A clinic, health fa also report any unl to, or use or disclo	Code Section 1280. cility, agency, or hos awful or unauthorize sure of, a patient's m	pice shall d access edical		Medication Administration. reviewed with staff the important handling one patient's chart	She also ortance of	
	information to the affected patient or the patient representative at the last known address, no later than five business days after the unlawful unauthorized access, use, or disclosure has been detected by the clinic, health facility, agency, or hospice."		ss, no Inlawful or e has	·	The Health Center Manager root cause analysis with the Quality Management to dete contributing factors led to the resulted in a streamlined procharts are maintained with the contribution of the contribution	Director of armine what e error. This cess whereby ne patient until	1/09/13
	affected patient(s) representative(s) c	that the facility infor or the patient's If the unlawful or una closure of the patient	uthorized		health center staff is ready to orders for the patalicative errors GANGETI DIE ALIEN in managing one patient cha	Dill prevent OPTEMUTATOR rt at a time.	SS
D 177	Health Records	T6-75055(b) Unit Pa		D 177	LICENSING & CERTI SAN DIEGO NORTH DIS	FICATION	icans ted
LADODATOR	(b) Information contained in the health records RATORY DIRECTORS OR PROVIDERSUPPLIER REPRESENTATIVES S						
	liane, R. De	11	NIATIVES SIGI DAA Pん		OFFICE, TITLE 4-	JQr I	(X6)DATE C

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If continuation sheet 1 of 2

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	OF DEFICIENCIÉS F CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NO			LE CONSTRUCTION	(X3) DATE S COMPLE	URVEY ETED	
		CA090000	256	A, BUILDING B. WING		04100	10040	
NAME OF D	ROVIDER OR SUPPLIER	CA030000			TATE, ZIP CODE	01/23	3/2013	
	D PARENTHOOD - EL	CAJON CLINIC	1685 EAST		EET, SUITE 301		·	
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D 177	This RULE: is not Based on interview failed to protect the one sampled patient (Pand Safety Code R the patient's private compromised. Findings: The facility was ma 12/11/12. The facility reporte following PHI relate control information The Administrative during a telephone Administrative staff the facility that she medications that w	al and shall be disclored in accordance was. met as evidenced by and record review, and record review, and record information 1280.15. The health information ade aware of a breadity notified the Depart 17/12. The discrepance of the discrete the disc	y: the facility rmation for I per Health As a result, (PHI) was ch on rtment of cluded the e, birth incident B. The B informed ol at A.	D 177	Monitoring of compliance to the Verifying Client Identification a Rights of Medication Administr been incorporated into the initia assessment for new health center the annual performance evaluation. Health Center Manager is respondenting the annual performance evaluation. The annual review part of our quality assurance proof our quality assurance proof our quality assurance proof all HIPAA privacy policies and in their health centers including of patient privacy through verification and the new prophandling one patient chart at a time addition, the HIPAA Privacy conducts HIPAA training for all health center staff as part of the orientation and training program an annual HIPAA compliance and conducted annually at a minimulability centers. All corrective actions were compliance and 1-9-13.	nd the 5 ation has I r staff and on. The nsible for nce rocess is gram. esponsible mpliance to procedures protection cation of cess for me. Officer new agency's a sa well as Training its are also m of six pleted by	ted	
STATEFOR	JVI		021199		J54H11	Continue	ion sheet 2 of 2	

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(X2) MULTIPLE CONSTRUCTION OF PUBLIC HEALTH, DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING _ JUL 3 1 2013 CA080000255 B. WING 07/23/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER LICENSING & CERTIFICATION 347 W MISSION AVENUE PLANNED PARENTHOOD-ESCONDIDO CENTER SAN DIEGO NORTH DISTRICT OFFICE ESCONDIDO, CA 92025 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 000 Initial Comments -D 000 We apologized to Patient B in person and 7/16/13 reassured her that Planned Parenthood is committed to protecting patient privacy. We The following reflects the findings of the California took the birth control pill packet with Patient Department of Public Health following an A's name on it and provided Patient B with a investigation of a self-reported breach of a properly labeled birth control pill packet with patient's medical information. her name on it. Complaint number: CA00362725 The Health Center Manager called Patient B 7/17/13 after determining that she may have also The investigation was limited to the specific event received two boxes of emergency reported and does not represent the findings of a contraception with Patient A's name on full inspection of the facility. them. Patient B returned two boxes of emergency contraception with Patient A's Representing the California Department of Public Health: Health Facilities Evaluator Nurse name on them and was provided with State ID: 15932. properly labeled boxes of emergency contraception with her name on them. We again apologized to Patient B and thanked A 001 Informed Medical Breach A 001 her for returning the items. Health and Safety Code Section 1280.15 (b)(2). The Health Center Manager also left a phone " A clinic, health facility, agency, or hospice shall message for Patient A apologizing for the also report any unlawful or unauthorized access error and asked her to contact us. In addition. to, or use or disclosure of, a patient's medical the Health Center Manager information to the affected patient or the patient's immediately discussed the error with medical representative at the last known address, no assistant staff. later than five business days after the unlawful or unauthorized access, use, or disclosure has An apology letter was mailed 7/18/13 been detected by the clinic, health facility, to Patient A regarding the privacy breach. agency, or hospice." (Please see attached.) The CDPH verified that the facility informed the The Health Center Manager performed a root 7/19/13 affected patient(s) or the patient's cause analysis with the Director of Quality representative(s) of the unlawful or unauthorized Management to determine what contributing access, use or disclosure of the patient's medical factors led to the error. This resulted in a information. streamlined process whereby a pre-printed label with the patient's information on it, will be generated after the clinician has place the D 177 T22 DIV5 CH7 ART6-75055(b) Unit Patient D 177 order. The medical assistant will then Health Records confirm the patient's identity in th of the patient, prior to attaching the (b) Information contained in the health records the medication (s).

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

TITLE

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		` '	IPLE CONSTRUCTION	(X3) DATE SI COMPLE	
		CA0800002	255	B. WING _		07/23	3/2013
NAME OF P	ROVIDER OR SUPPLIER	 		DRESS, CITY,	STATE, ZIP CODE		,
PLANNEI	PARENTHOOD-ESC	CONDIDO CENTER		SSION AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 177	Continued From Pa	age 1		D 177	Continued From Page 1		
	to authorized perso state and local law This RULE: is not Based on interview	met as evidenced by and record review, t	th federal, r: the facility		The Health Center Manager revie all health center staff at their staff meeting, the policy for Verifying Identification and the 5 Rights of Medication Administration. She also reviewed with staff the policytric medication in the policytr.	f Client f new process	7/26/13
	failed to protect the medical record information for one sampled patient (Patient A) as required per Health and Safety Code Regulation 1280.15. As a result, the patient's private health information (PHI) was compromised. Findings: The facility was made aware of a breach on 7/17/13. The facility notified the Department of the incident on 7/22/13. The facility reported that the breach included the following PHI related to Patient A: Name, birth control pills, and emergency contraception. The Administrative staff confirmed the incident during a telephone interview on 7/23/13. The Administrative staff stated that Patient B notified the facility in person she received a medication that belonged to Patient A. After Patient B left the facility, it was determined she also received two other medications that belonged to Patient A.				Monitoring of compliance to the Verifying Client Identification at Rights of Medication Administrated into the initial for new health center staff and the performance evaluation. The Health Manager is responsible for conductional performance evaluation. The review process is part of our quarter than the performance evaluation.	ad the 5 ation has assessment e annual alth Center acting the	5/25/12 (date Assessment form implemented)
					assurance program. The Health Center Manager is refor continuously monitoring comall HIPAA privacy policies and pin their health centers including patient privacy through verificatipatient identity and the new proclabeling medication in the presentation. In addition, the HIPAA Privacy conducts HIPAA training for all center staff as part of the agency orientation and training program an annual HIPAA Compliance Treview. HIPAA compliance audiconducted annually at a minimum health centers.	sponsible pliance to procedures protection of on of ess for ce of the Officer new health s as well as craining ts are also n of six	Sicans
					All corrective actions were comp 7-26-13.	ted mi	ted
STATE FOI	: RM		021199	l	8PSF11	1 Of continue	tich sheet 2 of 2

PRINTED: 08/13/2014 FORM APPROVED

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DEPT OF PUBL STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING CA080000255 B. WING 08/13/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LICENSING & CERTIFICATION 347 W MISSION AVENUE PLANNED PARENTHOOD-ESCONDIDO CENTER ESCONDIDO, CA 92025 HADISGO MORTH DISTRICT OFFICE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) D 000 Initial Comments D 000 a) The deficiency occurred when a medical records staff person failed to follow the normal process for ensuring correct patient identity prior to releasing medical records via The following reflects the findings of the California email. That process involves comparing the Department of Public Health following an patient's email address listed on their medical investigation of a self-reported breach of a records release form against the email address patient's medical information. on the computer, prior to sending medical records via email. Complaint number: CA00407428 Performance issues related to quality of work The investigation was limited to the specific event had also been identified with the staff person reported and does not represent the findings of a involved in the error. She had difficulty full inspection of the facility. operating systematically and in a timely fashion. The staff person was acting with a Representing the California Department of Public sense of urgency to meet the patient's request Health: Health Facilities Evaluator Nurse and inappropriately ignored all procedures that State ID: 15932. were outlined. Prior to this error, the staff person had A 001 Informed Medical Breach A 001 received re-training and a detailed process for responding to medical records requests which Health and Safety Code Section 1280.15 (b)(2), had been developed for her to ensure " A clinic, health facility, agency, or hospice shall timeliness and accuracy. She received this also report any unlawful or unauthorized access policy on 7-2-14 and was being actively to, or use or disclosure of, a patient's medical monitored on a bi-weekly basis by her information to the affected patient or the patient's supervisor. representative at the last known address, no later than five business days after the unlawful or As of 8-8-14, the staff person is no longer unauthorized access, use, or disclosure has employed by the agency. been detected by the clinic, health facility. agency, or hospice." b) New written procedures have been created and provided to the current medical records The CDPH verified that the facility informed the staff. In addition, we are developing a new onboarding process for all new medical affected patient(s) or the patient's records staff. The new onboarding process representative(s) of the unlawful or unauthorized will focus on a standardized step by step access, use or disclosure of the patient's medical procedure for fulfilling medical records information. requests, including responding to requests by email. T22 DIV5 CH7 ART6-75055(b) Unit Patient D 177 c) This procedure will be used as the Health Records guideline for training and evaluating medical records staff on a regular basis. In this procedure will be used at the fo (b) Information contained in the health records

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

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If continuation sheet 1 of 2

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NAME OF PHOVIDER OR SUPPLIER PLANNED PARENTHODOD-ESCONDIDO CENTER 377 W MISSION AVENUE ESCONDIDO, CA 20205 SUMMARY STATEMENT OF DEFOUENCES PRIENT TAS CONTINUED FROM THE PRESCRIBED BY UTLL REGULATORY OR ISO DENTIFYING INFORMATION) PRIENT TAS D 177 Continued From Page 1 shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws. This RULE: Is not met as evidenced by: Based on interview and record review, the facility failed to protect the medical record information for one sampled patient (Patient A) as required per Health and Safety Code Regulation 1280.15. As a result, the patient's private health information (PHI) was compromised. Findings: Fi	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE		(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE SURVEY
PLAINED PARENTHOOD-ESCONDIDO CENTER 377 W MISSION AVENUE SCHOOL CASSON SHOULD SECONDIDO, CA 92025 PROVIDER'S PLAN OF CORRESPIONITY OF DEPICIENCES PACH OF PRETIX PLAN OF CORRESPIONITY OF DEPICE PLAN OF CORRESPIONITY OF DEPICE PLAN OF CROSS-REFERENCES OF THE APPROPRIATE OF DEPICE PLAN OF CROSS-REFERENCES OF THE APPROPRIATE OF CHARLES OF THE APPROPRIATE OF THE APPROPRI	AND FLAN U	- CONNECTION	IDENTIFICATION NU	WOEK;	A. BUILDING		O COMPLETED
This RULE: is not met as evidenced by: Based on interview and record review, the facility falled to protect the medical records ampled patient (Patient A) as required per Heatth and Safety Code Regulation 1220.15. As a result, the patients or 1728/14. The facility notified the Department of the incident on 1728/14. The facility notified the Department of the incident on 1728/14. The facility reported that the breach included the following PHI related to Patient A: Name, laboratory results, medical history, diagnosis, medications, and provider name. The Administrative staff confirmed the incident during a telephone interview on 8/13/14. The facility reported that the characteristic supposes the medical records employee failed to onsure an email address was correct prior to emails first stade a medical records employee failed to onsure an email address was correct prior to emails first stade a medical records employee failed to onsure an email address was correct prior to emails first stade a medical records employee failed to onsure an email address was correct prior to emailing PHI. As a result, PHI that belonged to Patient A, was emailed to Patient B.			CA0800002	255	B. WING	CA DEPT OF PUS	08/13/2014
ESCONDIDO, CA 92025 Continued From Page 1 Dispersion of the Continued From Page 2 Dispersion Pa	NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST		
PRIEFIX TAG D 177 Continued From Page 1 shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws. This RULE: is not met as evidenced by: Based on interview and record review, the facility failed to protect the medical record information for one sampled patient (Patient A) as required per Health and Safety Code Regulation 1280.15. As a result, the patient's private health information (PHI) was compromised. Findings: The facility was made aware of a breach on 7/23/14. The facility reported that the breach included the following PHI related to Patient A: Name, laboratory results, medical instruy, diagnosis, medicalitions, medical records are medical records staff have been trained on the procedure are affect in records and provider and on the plan of convection. The Administrative staff confirmed the incident during a telephone interview on 8/13/14. The Administrative staff stated a medical records employee failed to ensure an email address was correct prior to emailing PHI. As a result, that belonged to Patient A, was emailed to Patient B. The Administrative staff confirmed the incident during a telephone interview on 8/13/14. The Administrative staff stated a medical records employee failed to ensure an email address was correct prior to emailing PHI. As a result, PHI that belonged to Patient A, was emailed to Patient B. The Sr. Director of Quality is so met with the staff person involved to discuss the error and corrective actions. In addition, the HIPAA privacy Officer conducts unting program. An annual part of the against a review or provided and an annual basis by this previous or the against a review or provided and an annual basis by this previous or onduction and annual basis by this previous or onduct	PLANNE	PARENTHOOD-ESC	CONDIDO CENTER			JE SEP - 5 5	2014
shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws. This RULE: is not met as evidenced by: Based on interview and record review, the facility falled to protect the medical record information for one sampled patient (Patient A) as required per Health and Safety Code Regulation 1280.15. As a result, the patient's private health information (PHI) was compromised. Findings: The facility was made aware of a breach on 7/23/14. The facility reported that the Department of the incident on 7/28/14. The facility reported that the Department of the incident on 7/28/14, and the following PHI related to Patient A: Name, laboratory results, medical history, diagnosis, medications, and provider name. The Administrative staff confirmed the incident during a telephone interview on 8/13/14. The Administrative staff stated a medical records employee falled to ensure an email address was correct prior to emailing PHI. As a result, PHI that belonged to Patient A, was emailed to Patient B. A writer procedure was created and all medical records staff) as part of the agencyle original process. In addition, the HIPAA Privacy Officer conducted on an annual basis by the HIPAA Compliance Training is also required. All corrective actions. In addition, the HIPAA Privacy Officer conducted on an annual basis by the HIPAA Privacy Officer Privacy Officer All corrective actions were completed.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE COMPLETE
to authorized persons in accordance with federal, state and local laws. This RULE: is not met as evidenced by: Based on interview and record review, the facility failed to protect the medical record information for one sampled patient (Patient A) as required per Health and Safety Code Regulation 1280.15. As a result, the patient's private health information (PHI) was compromised. Findings: The facility was made aware of a breach on 7/23/14. The facility was made aware of a breach on 7/23/14. The facility reported that the breach included the following PHI related to Patient A: Name, laboratory results, medical history, diagnosis, medications, and provider name. The Administrative staff confirmed the incident during a telephone interview on 8/13/14. The Administrative staff stated a medical records employee failed to ensure an email address was correct prior to emailing PHI. As a result, PHI that belonged to Patient A, was emailed to Patient B.	D 177	Continued From Pa	age 1		D 177		
		shall be confidentia to authorized person state and local laws. This RULE: is not a Based on interview failed to protect the one sampled patient (Pand Safety Code Rathe patient's private compromised. Findings: The facility was man 7/23/14. The facility incident on 7/28/14. The facility incident on 7/28/14. The facility reported following PHI related laboratory results, medications, and protection of the Administrative staff employee failed to a correct prior to emand.	al and shall be disclosures in accordance with a sevidenced by and record review, to medical record information (attent A) as required egulation 1280.15. As health information (attent A) as required enotified the Department of the pattent A: Name medical history, diagrated a medical record attent A: Name medical history, diagrated a medical record attent A: Name medical history, diagrated a medical record attent A: Name medical history, diagrated a medical record attent A: Name medical history, diagrated a medical record attent A: Name medical history, diagrated a medical record attent A: Name medical history, diagrated a medical record attent A: Name medical history, diagrated a medical record attent A: Name medical history, diagrated a medical record attent A: Name medical history, diagrated attent A: Name medical history diagr	th federal, the facility mation for per Health as a result, PHI) was on on ment of the uded the the the cords ress was the PHI that		The Sr. Director of Quality is respondential records staff which include policies and procedures are follower the appropriate release of patient recemail. The performance review procedure quality assurance program. d) The Sr. Director of Quality is also responsible for continuously monitor compliance to all HIPAA privacy procedures in the Medical Records Department. e) The Sr. Director of Quality oversomedical Records Department and is responsible for implementing the placorrection. The Sr. Director of Quality immediate reviewed what contributing factors are error and determined that a medical staff person had not followed the performed for responding to a patient to receive records by email. A written procedure was created and medical records staff have been traithis. The Sr. Director of Quality also mestaff person involved to discuss the corrective actions. In addition, the HIPAA Privacy Officenducts training for all new staff (medical records staff) as part of the orientation and training program. A HIPAA Compliance Training is also of all staff. HIPAA compliance aud conducted on an annual basis by the Privacy Officer All corrective actions were completed.	nsible for sofor sensuring diregarding cords by cess is part so oring colicies and sees the san of sees the records dicy and st's request sit are also thir A A Cans.
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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		CA070000181	B. WING		12/0	; 4/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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	" A clinic, health factorials or report any unlate, or use or discloss information to the arepresentative at that than five business of unauthorized access detected by the clinic hospice." The CDPH verified affected patient(s) or representative(s) or	Code Section 1280.15 (b)(2), cility, agency, or hospice shall awful or unauthorized access sure of, a patient's medical affected patient or the patient's ne last known address, no later days after the unlawful or as, use, or disclosure has been nic, health facility, agency, or that the facility informed the or the patient's f the unlawful or unauthorized closure of the patient's medical				
D 001	The following reflect Department of Pub investigation of Ent CA00420349 regar Outside Facility/HC Inspection was limit reported incident in represent the finding facility. Representing the CHealth: 32398, Health: The Department was a second property of the public terms of the public t	ited to the specific entity investigated and does not ings of a full inspection of the California Department of Public alth Facilities Evaluator Nurse.	D 001			S
	violation of Federal	l or State regulations.		A	mer	cans
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

PRINTED: 03/27/2012

AMENDED 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 B. WING CA070000181 03/05/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 760 RENZ LANE PLANNED PARENTHOOD GILROY, CA 95020 SUMMARY STATEMENT OF DEFICIENCIES 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) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) A 001 Informed Medical Breach A 001 The following is Planned Parenthood Mar Monte's (PPMM's) response the Health and Safety Code Section 1280.15 (b)(2). Department's request for a Plan of Correction " A clinic, health facility, agency, or hospice shall with respect to Entity Reported Incident also report any unlawful or unauthorized access CA00300096 in CDPH letter dated March 27. to, or use or disclosure of, a patient's medical 2012. information to the affected patient or the patient's representative at the last known address, no later Deficiency # D069, D071 [policies relating to than five business days after the unlawful or patient care not implemented] unauthorized access, use, or disclosure has been detected by the clinic, health facility, agency, or (a) Corrective actions to be accomplished for hospice." the affected patient: As soon as the Gilroy Center Manager learned about the possible The CDPH verified that the facility informed the breach of the patient's protected health affected patient(s) or the patient's information (PHI), a comprehensive investigation representative(s) of the unlawful or unauthorized was begun. After it was determined that a access, use or disclosure of the patient's medical breach had occurred, a PPMM representative information. called and spoke with the patient informing her of the breach and apologizing. PPMM's Compliance Officer also sent the patient a letter D 000 Initial Comments D 000 communicating similar information. There is no Statement of Deficiency concerning reporting to The following reflects the findings of the California the patient. The patient has not requested any Department of Public Health during the further action from PPMM concerning the investigation of an entity reported incident breach. This portion of the POC is the same as conducted 3/5/12. proposed in the POC dated March 20, 2012. Entity Reported Incident CA00300096 was in (b) Identification of other patients potentially regards to breach of patient health information by affected by the same deficient practice and the primary care clinic. A deficiency was identified corrective action to be taken: CALIFORNIA DEPARTMENT
OF PUBLIC HEALTH his situation involved an employee (Staff A) (see California Code of Regulations, Title 22. Section 75030(a)(2)). APR 10 2017 relative's PHI. PPMM has repeatedly emphasized The affected patient was notified by the clinic of the privacy breach on 2/16/12. the importance of employees reporting possible L & C DIVISION PHI breaches to their supervisor, as Staff A did. Inspection was limited to the specific entity SAN JOSE None of the people to whom employees are reported incidents investigated and does not directed to report this conduct (Compliance represent the findings of a full inspection of the Officer, CEO, General Counsel, Gilroy Center primary care clinic. Manager) has received such reports or reports from any other sources about such PHI breaches

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Compliance

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The Health CTR was informed The POC was accepted 4/11/12 by S. Mahan

(X5) COMPLETE DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDI	· · · · · · · · · · · · · · · · · · ·	(X3) DATE SURVEY COMPLETED	
		CA070000181		B. WING		03/05/2012
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY,	STATE, ZIP CODE	
PLANNE	D PARENTHOOD		760 RENZ GILROY, 0	LANE CA 95020		
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D 000	Continued From page 1 Representing the California Department of Public Health: 11442, Health Facilities Evaluator Nurse.			D 000	In addition, PPMM has take disciplinary action concerning the committed the intentional bread PPMM will be engaging in	e person who h. In addition,
D 069	T22 DIV5 CH7 AR -Policies and Proc	RT4-75030(a) Basic S edures	ervices-	D 069	proactive corrective actions intentional breaches: 1) mandat for all PPMM Health Center, Re and Education staff; 2) PPMM in	concerning ory In-Services sponse Center,
		s and procedures whi ent shall include, but			FAQs; and 3) revisions to PPN Orientation material. (see (c) be (c) Immediate measures and sy	MM New Hire low).
					that will be put in place to ensur practice does not recur:	
	This Statute is no	t met as evidenced b	y:		Mandatory Intention Training In-Service for all PPMM Response Center, and Education	Health Centers, n staff that will
D 071	ServicesPolicies		C	D 071	include: a) discussion of PPMM's policies, highlighting and confirmed intentional breach termination of the employment	affirming that nes result in
	(2) Policies relatin	g to patient care.			that suspensions may occur during consistent with PPMM's Hur policy; b) role playing of hypoth	ng investigation, man Resources
	Based on interview failed to ensure w	ot met as evidenced b w and record review, ritten policies and pro d for confidentiality of	the clinic cedures		and discussion of appropriate re acknowledgement of participal service will be signed by all staf participate at the completion o	esponses; and c) tion in the in- f members who f the In-Service.
	health information (1).	for one of one samp			The PPMM Compliance Officer written materials, with input from appropriate. The Regional Area (ASDs) will disseminate the incomplete the inco	n PPMM staff as Service Directors
	Findings:	t 1's clinical record inc	dicated the	•	Center Managers and Reg Managers (RPMs). The Directo	or of Operations
	patient had an appart and 2/10/12, for te	pointment at the clinic est procedures. On 2/ ssistance for the proc	on 2/7/12 7/12, the		for the Response Center will same materials. The Health Cen individuals with similar supervise will review the materials and Service training. The highlights	ory responsibility conduct the in- of this In-Service
	On 3/5/12, during	an interview, Staff C	stated she		will be reinforced at the annua Service (material prepared	by Compliance

Licensing and Certification Division

On 3/5/12, during an interview, Staff C stated she was related to Patient 1 and she was not aware

STATE FORM

Officer, presented by same p presented the intentional breach

management

PPMM

unless

9 otherwise).

California Department of Public Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING _ CA070000181 03/05/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **760 RENZ LANE** PLANNED PARENTHOOD **GILROY, CA 95020** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 071 D 071 Continued From page 2 the patient had an appointment at the clinic. On 2. Privacy FAQS on the intranet: PPMM 2/8/12 at approximately 7 p.m. Staff A told her will prepare Privacy FAQs to be posted on the Patient 1's test results. Patient 1 did not want internal Intranet site. The initial batch of Staff C to know she was at the clinic. On 2/10/12, questions posted will address intentional Staff C stated she was working in the back of the breaches. The Compliance Officer will work with clinic and Staff A told her Patient 1 was in the the Information Technology Department and other PPMM staff to publicize the new feature. clinic. On 3/5/12, review of Staff A's employee file 3. New Hire Orientation (NHO): NHO materials will be revised to reflect the In-Service indicated on 12/21/11, Staff A signed a statement she would comply with the clinic's requirements materials noted above. These materials will be prepared by the Compliance Officer and the for Confidentially and Nondisclosure Agreement. Director Training and discussed at NHO. The Privacy Policy indicated, the clinic, "...is committed to the protection of the confidential (d) Monitoring/Quality Assurance: information, documents and proprietary plans to undertake the following monitoring and information of which it is responsible." quality assurance activities: On 12/16/11, Staff A signed and dated the clinic's 1. Sign-ins, acknowledgments: see (a). Policy Regarding Provision of Services to The sign-ins will be maintained by the people Relatives and Others Known to Staff. The policy conducting the In-Services. tkatth CTRMan indicated,"...Staff may encounter Others when this occurs, staff should inform them that all Healthoreman services are strictly confidential and that the 2. "Huddles:" The people conducting the privacy of their health information, including In-Service (or their designees) will conduct daily patient status, will be protected.." "huddles" covering possible privacy breach examples and debriefing from previous day for The clinic failed to ensure policies were three weeks after the In-Service. implemented to respect patient's rights for confidentiality of health information. 3. Quizzes: Quizzes will be given once a week for three weeks following the In-Service. Responsible staff who conducted the In-Service training will review the quiz results and followup as appropriate. These quizzes will serve as weekly reinforcement of knowledge to increase understanding of the range of intentional privacy breaches.

Licensing and Certification Division STATE FORM

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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 CA070000181 03/05/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **760 RENZ LANE** PLANNED PARENTHOOD **GILROY, CA 95020** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 071 Continued From page 2 D 071 4. Compliance Officer Monitoring of intentional breaches: The Compliance Officer will track each confirmed incident of an intentional privacy breach within the affiliate. Certain incidents will be reviewed by PPMM's Risk and Quality Management Committee to identify issues involving these intentional breaches. When appropriate, additional corrective actions will be implemented at those sites where the intentional breaches occurred. (e) Date corrective action will be completed: For PPMM sites that have experienced intentional privacy breaches beginning in January 2011 through the present, the In-Service 4/23/12 will take place no later than April 23, 2012. The remaining sites will include the In-Service at the next regular staff meeting. The huddles and auizzes will continue for three weeks following the mandatory In-Services. The intranet FAQs and the NHO material will be completed no later than April 23, 2012.

Licensing and Certification Division

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PRINTED: 04/02/2013 FORM APPROVED

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU	ER/CLIA JMBER ,	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S COMPL	URVEY ETED
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D 000	Department of Pub investigation of a sepatient's medical in Complaint number: The investigation was reported and does full inspection of the	CA00343719 ras limited to the spenot represent the fine facility.	CA DEPT OF APPLICATION OF APPLICATIO	RECEIVED OF PUBLIC R 1 7 20	The Health Center Manager c A explained the privacy brea CATION C	renthood is not privacy the Health information with a new correct alled Patient ch, eassured her mmitted to	2/12/13 2/13/13
A 001	Health: Health Faci State ID: 15932. Informed Medical B Health and Safety (" A clinic, health fac	lities Evaluator Nurs Freach Code Section 1280.1	5 (b)(2),	A 001	protecting patient privacy. Pa also informed that the Health with her information on it was us and that a new Health Acco would be mailed out to her. A follow up apology letter was Patient A. (See Attached.)	tient A was Access Card s returned to ess Card	2/15/13
	to, or use or disclosinformation to the a representative at the later than five busing unauthorized accessibeen detected by the agency, or hospice. The CDPH verified affected patient(s) or hospice.	that the facility infor or the patient's	edical e patient's es, no nlawful or e has ty, med the		The Health Center Manager is discussed the incident with firstaff, and implemented a new process. The process involves completing a check in form, to Office Specialist writing dow Access Card number on the frimmediately returning the pat Access Card to them.	ont office check-in the patient he Front n the Health orm and then	2/12/13
	representative(s) of access, use or disc information.	the unlawful or una losure of the patient	's medical		The Health Center Manager r new check-in process with all staff at their next staff meetin reviewed the agency policy for Client Identification.	health senter g. She also	2/22/13
D 177	T22 DIV5 CH7 ART Health Records	⁻ 6-75055(b) Unit Pat	lient	D 177		Amer	
		ained in the health r				Uni	rea
ABORATOR'	Y DIRECTORS OR PROVI	ER/SUPPLIER REPRESE			TITLE	Inr	(X6) DATE
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		al and shall be disclo ons in accordance wi s.			·		
	Based on interview failed to protect the one sampled patient (Pa and Safety Code Re	met as evidenced by and record review, to medical record info- atient A) as required egulation 1280.15. As health information (the facility rmation for per Health As a result,				
	Findings:						
		de aware of a breac notified the Departr					
	The facility reported following PHI relate birth and medical re	d that the breach inc ed to Patient A: Name ecord number.	luded the e, .date of				
	during a telephone Administrative staff the facility she was	staff confirmed the i interview on 3/4/13. stated that Patient I given a Health Acce the PHI of Patient A	The 3 informed s Program	·	·		
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PRINTED: 02/07/2014 **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 CA250001816 01/23/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 49-111 HIGHWAY 111, UNIT 6 PLANNED PARENTHOOD-COACHELLA VALLE COACHELLA, CA 92236 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) We apologized to Patient B on the phone, A 000 Initial Comments A 000 07/30/13 reassured her that Planned Parenthood is committed to protecting patient privacy and The following reflects the findings of the California asked that she return the letter intended for Department of Public Health during the Patient A. Patient B returned the letter to us investigation of one entity reported incident. the same day. Entity reported incident number: CA00365335 Representing the California Department of Public An apology letter was mailed to Patient A Health: 25937 / 2122 regarding the privacy breach and reassuring 07/31/13 her that Planned Parenthood is committed The inspection was limited to the specific entity to protecting patient privacy. Patient A was reported incident investigated and does not also informed that Patient B had returned represent the findings of a full inspection of the facility. the letter to us.

Health and Safety Code Section 1280.15 (b)(2), " A clinic, health facility, agency, or hospice shall also report any unlawful or unauthorized access to, or use or disclosure of, a patient's medical information to the affected patient or the patient's representative at the last known address, no later than five business days after the unlawful or unauthorized access, use, or disclosure has been detected by the clinic, health facility, agency, or

This Department was able to substantiate a

violation of the regulations.

A 001 Informed Medical Breach

hospice." The CDPH verified that the facility informed the affected patient(s) or the patient's representative(s) of the unlawful or unauthorized access, use or disclosure of the patient's medical information.

A 001

the incident with staff at their staff meeting and they performed a root cause analysis to determine what contributing factors led to the error. The solution was determined to be the installation of personal desk printers for printing out patient lab result letters. This allows the Case Management Specialist to print the patient's lab result letter from the Electronic Medical Record at the same time that they print the patient's address label from their personal label printer. The letter and label are therefore printed in the same order and matched prior to mailing.

The Case Management Supervisor reviewed

See above regarding immediate measures that were put into place to ensure deficient practice does not recur. Printers installed shortly after solution determined.

Licensing and Certification Division

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

TITLE

07/31/13

04/12/12

assessment

implemented)

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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 B. WING CA250001816 01/23/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 49-111 HIGHWAY 111, UNIT 6 PLANNED PARENTHOOD-COACHELLA VALLE COACHELLA, CA 92236 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE

A 017

A 017

A 017	1280.15(a) Health & Safety Code 1280	
A017	(a) A clinic, health facility, home health agency, or hospice licensed pursuant to Section 1204, 1250, 1725, or 1745 shall prevent unlawful or unauthorized access to, and use or disclosure of, patients' medical information, as defined in subdivision (g) of Section 56.05 of the Civil Code and consistent with Section 130203. The department, after investigation, may assess an administrative penalty for a violation of this section of up to twenty-five thousand dollars (\$25,000) per patient whose medical information was unlawfully or without authorization accessed, used, or disclosed, and up to seventeen thousand five hundred dollars (\$17,500) per subsequent occurrence of unlawful or unauthorized access, use, or disclosure of that patients' medical information. For purposes of the investigation, the department shall consider the clinic's, health facility's, agency's, or hospice's history of compliance with this section and other related state and federal statutes and regulations,	
	the extent to which the facility detected violations and took preventative action to immediately correct and prevent past violations from recurring, and factors outside its control that restricted the facility's ability to comply with this section. The	
and the	department shall have full discretion to consider all factors when determining the amount of an administrative penalty pursuant to this section.	

Monitoring of compliance to the new process has been incorporated into the initial assessment and training for new case management staff and the annual performance evaluation. The Case Management Supervisor is responsible for conducting the annual performance evaluation. The annual review process is part of our quality assurance program.

DEFICIENCY)

Continued from page 1

The Case Management Supervisor is responsible for continuously monitoring compliance to all HIPAA privacy policies and procedures in Case Management including protection of patient privacy through use of a dedicated printer for patient lab results.

In addition, the HIPAA Privacy Officer conducts HIPAA training for all new case management staff as part of the agency's orientation and training program as well as an annual HIPAA Compliance Training review.

All corrective actions were completed by 8-20-13.

This Statute is not met as evidenced by: Based on interview and facility document review, the facility failed to prevent unauthorized access and/or disclosure of Patient 1's medical information, when Patient A's laboratory results

Licensing and Certification Division

A 017

Continued From page 1



PRINTED: 02/07/2014 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 CA250001816 01/23/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 49-111 HIGHWAY 111, UNIT 6 PLANNED PARENTHOOD-COACHELLA VALLE COACHELLA, CA 92236 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (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 DATE TAG DEFICIENCY) A 017 Continued From page 2 A 017 were sent to Patient B. This failure had the potential to result in misuse of private/protected information. Findings: On January 23, 2014, at 11:55 a.m., the Privacy officer (PO) was interviewed. The PO stated Patient B notified the facility on July 30, 2013, that she had received a letter in the mail that was intended for Patient A. The PO stated Patient B's name and address was on the outside envelope. but the letter inside was addressed to Patient A. and contained protected health information (PHI). The PO stated Patient B returned the letter to the facility. The letter sent to Patient B was reviewed. The letter contained Patient A's name, address, and positive test results for Chlamydia (a sexually transmitted disease). In addition, there was a one page information sheet describing the disease as a sexually transmitted disease. The information contained in the facility employee handbook, under Health Insurance Portability and Accountability Act (HIPAA) Privacy Statement. The information indicated the following:

Licensing and Certification Division STATE FORM

permission.



unauthorized use.

any medical records or PHI.

1. Make sure all medical records are secure from

2. Never allow an unauthorized person access to

3. As a general matter, An individual's PHI may

not be used or disclosed without proper



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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU			PLE CONSTRUCTION	FLU COMPLETIED
				A. BUILDIN	PLE CONSTRUCTION RECEIV CA DEPT OF PUE	3/10 HEALTHAN
		CA0800002		B. WING _		00/13/2014
ł	PROVIDER OR SUPPLIER D PARENTHOOD - ISA	ADELLA CENTED			STATE, ZIP CODE SEP - 5	5 2014
LEMINIE	D PARENTHOOD - 18/	ADELLA CENTER		D, CA 9200	. 00,12 110	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COURING (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	TION TRICT DFFI(X5) ULD BETRICT COMPLETE ROPRIATE DATE
D 000	The following reflect Department of Publinvestigation of a spatient's medical in Complaint number: The investigation was reported and does full inspection of the Representing the CHealth: Health Facistate ID: 15932. Informed Medical EHealth and Safety (Informed Medical EHealth and Safety (Information to the arepresentative at the later than five busing unauthorized accession detected by the agency, or hospice The CDPH verified affected patient(s) or representative(s) or access, use or disconformation.	c CA00407631 vas limited to the speriot represent the finder of facility. California Department illities Evaluator Nurse of the patient or the least known addressing the clinic, health facilities, use, or disclosure of the patient's find the facility information of the patient's find unlawful or unauthorized of the patient's find the facility information of the patient's find unlawful or unauthorized of the unla	n if a cific event dings of a cific event dings of a cific exhall access edical patient's s, no has y, ned the athorized s medical	D 000	a) The deficiency occurred when Prand Patient B checked in for their appointments at the same time and a patient labels and Fee Tickets for become printed out. In this instance, or of the Front Office Staff did not proverify identification prior to placing A's label on Patient B's Health Acc (HAP) card and handing it to Patient The center was functioning with two processes to return HAP cards to pabelieve this led to the failure in this properly identify patient information HAP card information. The plan of correction will be to have consistent practice to verify identified between the HAP card and the Fee Twhereby the HAP card will not be rethe patient at the front desk. b) The procedure for implementing of correction includes a consistent pwhereby the patient's HAP card will attached to the patient's Fee Ticket will be given to the Medical Assista Medical Assistant will compare the against the Fee Ticket, call the patie back of the center and will then ask to verify their information prior to hipatient their HAP card. c) Monitoring procedures to ensure plan of correction is effective included Health Center Manager reviewing Find observing both the front office is Medical Assistants to ensure verificing patient identity.	nultiple oth patients he or both perly Patient ess Plan t B. o different tients. We case to n with /e one cation Ficket eturned to the plan rocess I be and both nt. The HAP card nt to the the patient anding the that the le the et Ticke s staff and
D 177	Health Records	r6-75055(b) Unit Pati tained in the health re		D 177	The Health Center Manager is respondenting the annual performance for Front Office Staff which include policies are followed regarding the	evaluation s custring
		DER/SUPPLIER REPRESEN	_		TITLE	OK (X6) IAFO
	iane R. De	Mile, HI		ivacy	afficer	113/14
STATE FOR	M		021199	U	2VL111	If continuation sheet 1 of 2

9/8/14

021190 J 2VL111 Occepted 9/8/14 15932

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN O	F GORHECTION	IDENTIFICATION NU	WIBER;	A. BUILDING	RECEIVE	D COMPLETED		
		CA080000	260	B. WING	CA DEPT OF PUB	08/13/2014		
NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE			
PLANNE	D PARENTHOOD - ISA	ABELLA CENTER		RON ROAD D, CA 92008		2014		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE XOTION SHOU CROSS-REFERENCED TO THE AFRIC DEFICIENCY)	OPRIATE DATE		
D 177	to authorized person state and local laws. This RULE: is not a Based on interview failed to protect the one sampled patient (Pand Safety Code Pathe patient's private compromised. Findings: The facility was man 7/26/14. The facility incident on 7/30/14. The facility incident on 7/30/14. The facility reported following PHI relate birth and medical reduring a telephone Administrative staff were in the clinic at	and shall be disclosured in accordance with accordance with and record review, to medical record information (action 1280.15. As health	th federal, the facility mation for per Health As a result, PHI) was the on ment of the uded the e, date of ncident The Patient B ent B was	D 177	handling of HAP cards and the proverifying patient identity. The annuprocess is part of our quality assurate program. The Health Center Manager is also responsible for continuously monit compliance to all HIPAA privacy procedures in the health center. The protection of patient privacy by folinew procedure outlined above. The HIPAA Privacy Officer also cannual audits that may include this d) The Health Center Manager is a for implementing the plan of correct e) The Health Center Manager impreviewed with Front Office Staff thappropriate process for handling Hand verifying patient identity on 7-also discussed with staff what contfactors may have led to the error. The Health Center Manager again the consistent process with all staff next staff meeting on 8-29-14. She them about the importance of verifidentity before providing the patient HAP card, and specifically address Medical Assistant's responsibility above. In addition, the HIPAA Privacy Officer Manager also required of all staff. HIPAA candits are also conducted on an analy the HIPAA Privacy Officer	cess for pal review ance coring colicies and is includes lowing the conducts issue. cesponsible ction. mediately he has a cards 28-14. She ributing discussed fat their reminded fying patient at with a sed the has outlined efficer has part of high program, aining is compliance hual basis		
					All corrective actions were completed.	United		
TATE FORM	А		021199		2VL111	il continuation sheet 2 of 2		

STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUITIF	LE CONSTRUCTION		State Street, Square,	
AND PLAN OF CORRECTION		F CORRECTION IDENTIFICATION NUMBER:		Name: Ook	acility Notified	(X3) DATE S	
14115.05		0300001175	B. WING	Date: (C/20) Time: Notified By:	111:00	C 08/18	/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	Name	may	2
PLANNE	ED PARENTHOOD		HENRY AVE O, CA 9535	NUE, SUITE 100	, ,		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		T			
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECT ECTIVE ACTION SHOU NCED TO THE APPRO DEFICIENCY)	II D BE	(X5) COMPLE DATE
A 000	Initial Comments		A 000				
	Clinic's policy and p	/25/14 for correction to the procedure used in Tag D177		Plan of Correction w Incident CA00405313	nned Parenthood Mai the Department's req vith respect to Entity , enclosed in CDPH let received by PPMM's	Reported	
	The following reflect Department of Publicertification during Reported Incident:		concerning an inciden to CDPH on July 9, 201	esto) on September It at Modesto that was .4 (CDPH Report).	29, 2014 s reported		
	Health Licensing an HFEN.	alifornia Department of Public ad Certification: 31360, RN,		Deficiency cited as not complying with Cal. Health & Safety Code 1280.15(b)(2), 22 CCR 75055(b)(clinic failed to ensure confidential treatment of Patient 1's protected health information (PHI) when Staff 1 disclosed to Patient's boyfriend the nature of Patient's visit when Patient told Staff 1 that Patient authorized Patient's boyfriend to take an appointment that she			
	findings of a full insp	and does not represent the pection of the facility. written as a result of Entity		could not make).	s to be accomplished		
A 001	Informed Medical Br	CA00405313.	A 001	On July 9, 2014, the I called Patient 1, discu apologized. On that day the letter to Patient Professional Code 128	ssed the incident with	her and er mailed	
	also report any unla	ode Section 1280.15 (b)(2), lity, agency, or hospice shall wful or unauthorized access ure of, a patient's medical		deficiency concerning Patient 1. (b) Identification of	PPMM's communicati	ion with	7/9/14
	representative at the than five business da	fected patient or the patient's last known address, no later ays after the unlawful or		action to be taken: PPMM has not identife	eficient practice and co	orrective	N/A
1	detected by the clinic hospice."	s, use, or disclosure has been c, health facility, agency, or		(c) Immediate measures and systemic changes that will be put in place to ensure that deficient practice			
	affected patient(s) or representative(s) of t	nat the facility informed the the patient's the unlawful or unauthorized osure of the patient's medical		does not recur: CM spoke with Staff 1 a July 16, 2014, reinfor disclosing PHI in sim authorizes. At the Sep staff meeting, CM pres discussion that was b	cing the importance ilar situation unless stember 24, 2014 cent sented a privacy quant	of not Patient ter-wide	7/24/14 CAI
sing and RATORY	Certification Division DIRECTOR'S OR PROVIDER LUGA Ch	R/SUPPLIER REPRESENTATIVE'S SIGNA		TITLE	Ĉ E I N	Jnu	PATEC
FORM	win vin	PPMM Privacy an		ne Officer	I,	MAY	

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FORM APPROVED 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 C 0300001175 08/18/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1431 MCHENRY AVENUE, SUITE 100 PLANNED PARENTHOOD MODESTO, CA 95350 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 177 T22 DIV5 CH7 ART6-75055(b) Unit Patient D 177 reiterated the importance of not sharing patient's PHI Health Records (unless prior patient explicit authorization) with someone who asks to take a patient's appointment (b) Information contained in the health records when the patient has cancelled, even though that person states that he/she already knows about the shall be confidential and shall be disclosed only patient's appointment. to authorized persons in accordance with federal, state and local laws. (d) Monitoring Process/Quality Assurance By October 10, 2014, CM's supervisor will schedule a privacy quiz for March 2015 at Modesto to monitor staff's continued understanding about protecting PHI This Statute is not met as evidenced by: in the type of circumstance described in the CDPH Based on staff interview, clinical record review Report. By October 20, 2014, PPMM's Privacy Officer and administrative document review, the clinic will begin revising PPMM's Privacy Manual to more failed to ensure confidential treatment of explicitly address the circumstance described in the protected health information (PHI) when Patient CDPH Report for dissemination in 2015. 1's information related to a medical appointment was disclosed to an unauthorized person. (d) 10/10/14, 10/20/14 This failure resulted in unauthorized access of Patient's 1 PHI and the potential for abuse of the information. Findings: On 7/25/14 at 3:00 p.m., during an interview, the Compliance Officer (CO) stated Patient 1 made an appointment for services at the clinic. When Patient 1 could not keep her appointment, her boyfriend wanted to take her time slot for himself. He phoned the Clinic's call center and was then told the nature of Patient 1's appointment without Patient 1's authorization. Patient 1's PHI breached was the nature (health related reason) of her medical appointment. The facility policy and procedure titled "Privacy Manual Policy 4: Reasonable Safeguards against Privacy Breaches" revised September 2013, indicated "Confirmation of patient identity before

Licensing and Certification Division

discussing or providing written PHI (including

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Californ	ia Department of Pul	blic Health		4	FORM	M APPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(2/2) 5 45	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		::		E SURVEY
		r.			"	
		0300001175	B. WING			C
NAMEOF	DDOMBED OF CHEEK ITT				08	/18/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PLANNE	D PARENTHOOD	1431 MCF MODESTO	HENRY AVEN D, CA 95350	NUE, SUITE 100 0		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		
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		oo ibentii tiida ini oniviation)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
D 177	Continued From pa	ne 2	D 177	DET IOIENOT)		
		JTA	0177			
	Before petients res	I forms, etc.) to patient:				
	to about PHI (Clinic	eive documents or are spoken] staff should at a minimum,				
	ask patients to prov	ide their first and last name				
	and date of birth, ar	nd check the document to				
	make sure that it co	rresponds. Staff should not		·		
	provide the informat	tion first and then ask for				
	breach if the person	that can result in a privacy				
	breach if the person	is not the correct patient.				
	Conversations: PHI	should not be discussed				
	anywhere when the	discussion is not based on a				
	need to know for pro	ofessional reasons				
	Phone calls: The ide	entity of the person on the				
	phone must be conf	irmed before any PHI is				
	provided and messa	ges should be left only in				
	accordance with [Cli	nicj policies."				
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United for Life

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU		(X2) MULTI A. BUILDIN	u	(X3) DATE SU CHICOMPLE	JRVEY TED
		CA090000	256	B. WING _	MAR 17 20	03/03	
NAME OF F	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, 8	STATE, ZIP CODE	r	
PLANNE	D PARENTHOOD - EL	CAJON CLINIC	1685 EAS EL CAJON	T MAIN STE N, CA 92020	REET, SUITE/391 NOING & CERTIFIC PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO	ATION	
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D 000	Department of Pub investigation of a sepatient's medical in Complaint number: The investigation was reported and does full inspection of the Representing the Complaint of the complaint the	CA00388190 ras limited to the spenot represent the fire	an of a ecific event ndings of a	D 000	We apologized to Patient B on the te and reassured her that Planned Parer committed to protecting patient priv Patient B agreed to return the box of emergency contraceptive pills with I name on it later that day. The Health Center Manager immedi discussed the incident with the Lead and the clinician involved in the error eviewed with them the mandatory p double checking patient labels prior handing a box of emergency contrace pills to a patient. In addition, the Health Center Manager contacted the Direct Quality Management to conduct a reanalysis to determine what contribut factors led to the over-	ately Clinician or. She process of to eptive alth tor of pot cause	2-12-14 2-12-14
A 001			pice shall	A 001	Multiple telephone contact attempts made to Patient B when she failed to the box of emergency contraceptive Patient A's name on it.	return	2-!3-14
also report a to, or use or information t representati later than fiv unauthorized been detecte	to, or use or disclos information to the a representative at th later than five busin unauthorized access	sure of, a patient's manager of the fected patient or the lest known address days after the use, use, or disclosure clinic, health facil	nedical e patient's ss, no unlawful or e has		The Health Center Manager spoke to who stated she had not viewed the labox of emergency contraceptive pill. Patient A's name on it, had taken the medication and had thrown away the An apology letter was mailed to Pati	abel on the s with e e box.	2-18-14 2-18-14
	affected patient(s) or representative(s) or	that the facility infor or the patient's f the unlawful or una losure of the patient	uthorized		regarding the privacy breach and let her know that Patient B stated she have viewed the label on the box of emergeontraceptive pills with her name on had thrown away the box. The Health Center Manager complete cause analysis with the Director of Company which resulted in the page ment which resulted in the page.	ad not gency it and ted a root Quality	S -11-14
D 177	T22 DIV5 CH7 AR1 Health Records	Г6-75055(b) Unit Pa	tient	D 177	Management which resulted in the n reinforce with all staff the following		cans
		tained in the health				Unij	ted
_ABORATOR	Y DIRECTOR'S OR PROVICE DIANE K. D				Officer TITLE	91/4	(X6)PATE
STATE FOR	VI	¥	021199	T	8LLP11	If continuati	ion sheet 1 of 2

apparent 3 (17/14

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIP A. BUILDING	LE CONSTRUCTION RE	CEIVED COMPLI	URVEY ETED
		CA090000	256	B. WING		FUBL C HEALTH	1/2014
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	1		TATE, ZIP CODE MAR	1 7 2014	0/2014
	PARENTHOOD - EL	CAJON CLINIC	1685 EAST		. Calor		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM.	/ FULL	ID PREFIX TAG	PROVIDER SPLAN OF C (EACH CORRECTIVE AGT) CROSS-REFERENCED TO TI DEFICIENCY	O STATE TO PROPERTIE TO E	(X5) COMPLETE DATE
D 177	This RULE: is not Based on interview failed to protect the one sampled patient (Prand Safety Code R the patient's private compromised. Findings: The facility was ma 2/12/14. The facility incident on 2/18/14 The facility reported following PHI relate prescribing cliniciar medication instruction. The Administrative during a telephone Administrative staff box of medication it PHI.	and shall be disclosins in accordance wis. met as evidenced by and record review, medical record infocation 1280.15. The health information of the department of the Department of the Department of the Patient A: Named, clinic address and	th federal, the facility rmation for per Health As a result, (PHI) was h on ment of the luded the e, ncident The s given a	D 177	 Verification of particular prior to handing a medication Verification of a in the patient's E Record prior to handing a medication of a in the patient any medication. Only working on chart at a time. The Health Center Manage these expectations with all staff meeting on 3-28-14. Monitoring of compliance verifying patient identity hincorporated into the initianew health center staff and performance evaluation. The Manager is responsible for annual performance evaluation. The Health Center Manager for continuously monitoriral HIPAA privacy policie in their health centers inches of patient privacy through patient identity prior to have any medication. In addition, the HIPAA Pronducts HIPAA training center staff as part of the a orientation and training private and	the patient any "4 point check" lectronic Medical anding the cation one patient's er will review staff at the next to the policy for has been all assessment for all the annual the Health Center conducting the ation. The annual the Health Center conducting the ation. The annual the patient of and procedures adding protection verification of anding the patient the patient of all new health agency's ogram as well as ance Training the audits are also inimum of six	
					···	101 1	

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 CA250000210 10/08/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3772 TIBBETS STREET** PLANNED PARENTHOOD - RIVERSIDE CLINIC RIVERSIDE, CA 92506 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE **DEFICIENCY**) A. A 000 Initial Comments A 000 The MA was immediately terminated 9-17-14 following an investigation. The following reflects the findings of the California The Health Center Manager called the Department of Public Health during an entity 9-18-14 patient, explained that the MA was no reported incident investigation visit: longer working for us and provided her with her phone number if she had any Entity Reported Incident: CA00413852 questions or concerns. Inspection does not represent the findings of a full В. inspection of the facility. Planned Parenthood will continue to thoroughly screen potential job candidates including asking interview questions related to Representing the California Department of Public Health: Surveyor Federal/State ID# 18918/1729 the protection of patient privacy. New employees receive training by the HIPAA This Department was able to substantiate a Privacy Officer as part of their onboarding violation of the regulations. process and sign an Acknowledgement to abide by the Agency's privacy policies and procedures. In addition, an annual HIPAA A 001 Informed Medical Breach A 001 Compliance Training is required of all staff. Health and Safety Code Section 1280.15 (b)(2), C. " A clinic, health facility, agency, or hospice shall Planned Parenthood will continue its practice also report any unlawful or unauthorized access to immediately investigate any suspected to, or use or disclosure of, a patient's medical violations of our privacy policies and information to the affected patient or the patient's procedures and to immediately implement representative at the last known address, no later appropriate disciplinary action, up to, and than five business days after the unlawful or including termination of employment. unauthorized access, use, or disclosure has been detected by the clinic, health facility, agency, or D. hospice." The Health Center Manager is responsible for continuously monitoring compliance to The CDPH verified that the facility informed the all HIPAA privacy policies and procedures in the health center including appropriate affected patient(s) or the patient's access to patient records. The MA violated representative(s) of the unlawful or unauthorized our policies and procedures when he access, use or disclosure of the patient's medical inappropriately accessed Patient A's information. medical record and was promptly terminated as a result. HIPAA compliance audits are conducted A 017 1280.15(a) Health & Safety Code 1280 on an annual basis by the HIPAA Privacy Officer. (a) A clinic, health facility, home health agency, or

Licensing and Certification Division

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

If continuation sheet 1 of 4



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
	CA250000210	B. WING	 C 10/08/2014

NAME OF F	PROVIDER OR SUPPLIER STREET AL	DDRESS, CITY,	STATE, ZIP CODE	
PLANNE	D PARENTHOOD - RIVERSIDE CLINIC	BETS STRE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	DE, CA 9250 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5 COMPL DAT	ETE
A 017	Continued From page 1 hospice licensed pursuant to Section 1204, 1250, 1725, or 1745 shall prevent unlawful or unauthorized access to, and use or disclosure of, patients' medical information, as defined in subdivision (g) of Section 56.05 of the Civil Code and consistent with Section 130203. The department, after investigation, may assess an administrative penalty for a violation of this section of up to twenty-five thousand dollars (\$25,000) per patient whose medical information was unlawfully or without authorization accessed, used, or disclosed, and up to seventeen thousand five hundred dollars (\$17,500) per subsequent occurrence of unlawful or unauthorized access, use, or disclosure of that patients' medical information. For purposes of the investigation, the department shall consider the clinic's, health facility's, agency's, or hospice's history of compliance with this section and other related state and federal statutes and regulations, the extent to which the facility detected violations and took preventative action to immediately correct and prevent past violations from recurring and 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.		The MA was immediately suspended pending an investigation. The MA's employment was terminated after the investigation. The Health Center Manager called Patient A to let her know the MA was no longer employed by Planned Parenthood. The HIPAA Privacy Officer sent Patient A an apology follow up letter. All corrective actions were completed by 9-19-14.	80 90
	This Statute is not met as evidenced by: Based on interview and record review, the facility failed to prevent the intentional unauthorized access of Patient A's protected health information (PHI), when Medical Assistant (MA) 1 accessed Patient A's medical record, without a job related need to access the information. On September 15, 2014, MA 1 accessed Patient A's record to		American	15
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PRINTED: 10/17/2014

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 CA250000210 10/08/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3772 TIBBETS STREET** PLANNED PARENTHOOD - RIVERSIDE CLINIC RIVERSIDE, CA 92506 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (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 DATE TAG DEFICIENCY) A 017 Continued From page 2 A 017 obtain the patient's cell phone number, for MA 1's personal use. This resulted in the misuse of Patient A's private information by MA 1. Findings: During a telephonic interview with the facility Privacy Officer (PO), on October 1, 2014, at 4:30 p.m., the PO stated on September 16, 2014, the facility was notified by Patient A that MA 1 had contacted her and asked if he could "text her." The PO stated MA 1, was performing intakes on September 15, 2014, when he met and obtained intake information for Patient A's visit. The PO stated the facility investigation revealed, MA 1 initially entered Patient A's information into the patient's medical record, in the course of his job duties, but later that same day, MA 1 re-entered Patient A's record to obtain Patient A's phone number. The PO stated MA 1 then sent a text message via a cell phone to Patient A, asking if he could text her. The PO stated Patient A called the facility on September 16, 2014, to report the incident. The facility provided a "print screen" copy of the text messages between MA 1 and Patient A. A review of the text revealed there was no work related purpose (direct need) for MA 1 to contact Patient A. The facility's Employee Handbook section titled, "Health Insurance Portability and Accountability Act (HIPAA) Privacy Statement," was reviewed and indicated, "You may never have unauthorized access to the PHI of any client or employee. Unauthorized access is defined as the inappropriate review or viewing of client medical

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information without a direct need for diagnosis.

treatment, or other lawful use..."

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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 CA250000210 10/08/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3772 TIBBETS STREET** PLANNED PARENTHOOD - RIVERSIDE CLINIC RIVERSIDE, CA 92506 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG DEFICIENCY) A 017 Continued From page 3 A 017 The facility failed to prevent the intentional unauthorized access to Patient A's medical information by MA 1, in accordance with the facility policy, when MA 1 accessed the patient's medical record to obtain Patient A's phone number. (1)

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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 CA060000264 09/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1421 E 17TH STREET **PLANNED PARENTHOOD ORANGE & SAN BEI** SANTA ANA, CA 92705 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) PPOSBC Response to Amended CMS 2567 for 9.22.14 A 000 Initial Comments A 000 COMPLAINT NUMBER CA00379879: **AMENDED** * PPOSBC former Compliance Officer during the interval in question is no longer with PPOSBC. However, senior The following reflects the findings of the California management at PPOSBC including the PPOSBC CEO, and Department of Public Health during the COO are aware of the standard processes engaged in by said investigation of COMPLAINT NUMBER: former Compliance Officer including but not limited to said CA00379879. Compliance Officer's adherence to PPOSBC policies regarding reporting applicable incidents such as that described herein, and direct communication(s) with Inspection was limited to the specific complaint(s) applicable affected PPOSBC patients. Therefore, the investigated and does not represent the findings following said PPOSBC response is in good faith with respect of a full inspection of the facility. to said former Compliance Officer's tenure at PPOSBC. Representing the California Department of Public Amended CMS 2567 form CA00379879 Findings: Health: Surveyor 1835, HFEN. Findings for Complaint Number: CA00379879. a) Patient at issue was contacted by PPOSBC's compliance officer informing patient of the incident, The complaint allegation(s) were substantiated PPOSBC policies on the same and that PPOSBC would and regulatory violations written at A001 and thoroughly investigate said incident and remedy as A017. applicable. Patient was provided full contact information at PPOSBC for any additional questions or follow up at A 001 Informed Medical Breach A 001 patient's discretion. To concretely ensure ongoing safety and privacy of patient's protected health Health and Safety Code Section 1280.15 (b)(2), information to the best of PPOSBC's ability, PPOSBC " A clinic, health facility, agency, or hospice shall staff at issue was promptly separated from also report any unlawful or unauthorized access employment by PPOSBC on or about August 23. to, or use or disclosure of, a patient's medical 2013. information to the affected patient or the patient's representative at the last known address, no later b) PPOSBC has a robust series of policies that all staff than five business days after the unlawful or must adhere to regarding the optimum security and unauthorized access, use, or disclosure has been privacy of patient protected health information. Staff detected by the clinic, health facility, agency, or are also regularly trained and educated on said hospice." policies. The CDPH verified that the facility informed the I. Pertinent said policies include: affected patient(s) or the patient's PPOSBC Compliance Policy CO-600 Corporate representative(s) of the unlawful or unauthorized Compliance Program access, use or disclosure of the patient's medical PPOSBC Compliance Policy CO-1104 Patient Righ information. to File Complaints About Use and Disclo Licensing and Certification Division TITLE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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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
	CA060000264	B. WING	C 09/09/2014

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1421 E 17TH STREET

PLANNE	PLANNED PARENTHOOD ORANGE & SAN BEI 1421 E 17TH STREET SANTA ANA, CA 92705							
(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 001	Continued From page 1	A 001	Protected Health Information • PPOSBC Compliance Policy CO-1105 HIPAA Privacy	9.22.14				
	(a) A clinic, health & Safety Code 1280 (a) A clinic, health facility, home health agency, or hospice licensed pursuant to Section 1204, 1250, 1725, or 1745 shall prevent unlawful or unauthorized access to, and use or disclosure of, patients' medical information, as defined in subdivision (g) of Section 56.05 of the Civil Code and consistent with Section 130203. The department, after investigation, may assess an administrative penalty for a violation of this section of up to twenty-five thousand dollars (\$25,000) per patient whose medical information was unlawfully or without authorization accessed, used, or disclosed, and up to seventeen thousand five hundred dollars (\$17,500) per subsequent occurrence of unlawful or unauthorized access, use, or disclosure of that patients' medical information. For purposes of the investigation, the department shall consider the clinic's, health facility's, agency's, or hospice's history of compliance with this section and other related state and federal statutes and regulations, the extent to which the facility detected violations and took preventative action to immediately correct and prevent past violations from recurring, and 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.	A 017	 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 on said agency policies, both at inception of staff's tenure at PPOSBC as well as throughout the agency calendar; this includes: Protected Health Information/HIPAA in-person training at staff orientation day/hire 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 Pro- tected 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 	2014 OCT 17 AM 9 55				
	This Statute is not met as evidenced by: Based on interview and facility document review, the facility failed to prevent the disclosure of		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	cans				
	Certification Division		respect to the agency Electronic Health Records	ted				

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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 CA060000264 09/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1421 E 17TH STREET PLANNED PARENTHOOD ORANGE & SAN BEI SANTA ANA, CA 92705 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE **DEFICIENCY**) system as well as related patient information systems A 017 A 017 9.22.14 Continued From page 2 such as those relevant to patient scheduling and Patient I's protected health information (PHI) from administrative records. This audit software is breach one staff member (Staff 1). detection technology that is fully integrated with our electronic health record system. On a daily basis, the Review of facility documents show on 8/19/13, a breach detection technology/software analyzes caller reported knowing and named a staff access into the agency systems, thereby automatically member who accessed patient medical records monitoring potential unauthorized access and/or without the need to know and was sharing the disclosures on numerous levels of the patient record information to others. The caller also identified such as lab results, progress notes, appointment the four patients of whose medical records the information, and related facets staff allegedly accessed. • A culture that invites reporting any suspected compliance and/or privacy matters to supervisors in Further review showed the facility investigated the any department, including but not limited to PPOSBC allegation and found evidence the named staff Human Resources Department, Patient Services (Staff 1) accessed the medical records of one of Department, Administration and the Compliance the four patients identified. The medical record Department belonging to Patient I was found accessed by · Dedicated and consistent agency Quality Staff 1 on four different occasions without a need to know. Management/Quality Assurance meetings through the Patient Services Department to review and as On 8/21/13, an interview with Staff 1 was applicable, improve the quality of agency processes conducted. During the interview, Staff 1 admitted • Dedicated and consistent (quarterly) agency to knowing Patient I and denied sharing the Compliance and Enterprise Risk Management medical information accessed. However, Staff 1 Committee to review and as applicable, improve the was unable to explain the reason she accessed quality of agency processes Patient I's medical record on four different A dedicated Compliance agency Hotline 24 hours a occasions. day 7 days a week, 365 days a year • Suspension, Separation of Employment and/or D Patient I's disclosed PHI may have included the other processes for sanctioning any staff that fails to entire medical record including name, follow said processes and trainings as described above demographic data, financial information and physician progress notes, nurses notes and any Accordingly, as with any healthcare agency, such as or all medications, treatments or procedures done hospitals, the CDPH, DHCS and other entities, PPQSBQ within the facility. is subject to common human errors or independent acts against established and reinforced agency policies. On 9/9/14 at 1020 hours, a telephone conference with the Privacy Officer occurred regarding the However, PPOSBC sets forth robust, consistent and breach as documented. good faith efforts to prevent and/or as applicable remediate towards optimum protection of health information for all patients. PPOSBC also makes every

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effort to communicate with any applicable parte



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PRINTED: 10/09/2014 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 CA060000264 09/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1421 E 17TH STREET PLANNED PARENTHOOD ORANGE & SAN BEI SANTA ANA, CA 92705 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) issue to assist them with any questions or concerns, 9.22.14 A 017 Continued From page 3 A 017 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. c) As noted in section (b): 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 9 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:

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Protected Health Information/HIPAAIn-person

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



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Department

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

 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

· Dedicated and consistent agency Quality Management/Quality Assurance meeting the Patient Services Department to rev

information, and related facets



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PLANNED PARENTHOOD ORANGE & SAN BEI 1421 E 17TH STREET SANTA ANA, CA 92705							
(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 5	A 017	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 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.	9.22.14			
	Certification Division		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 A erain is the updating of the agency process to include the above-referenced robust Compliance & Enter rise Fish	2014 OCT 17 AM cass			

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policies.

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

• PPOSBC Compliance Policy CO-600 Corporate

PPOSBC Compliance Policy CO-1104 Patient Right

I. Pertinent said policies include:

to File Complaints About Use and Discl

Compliance Program



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training at staff orientation day/hire

post-orientation/hire

Health Information

Health Information/HIPAA

 An additional Protected Health Information/HIPAA Online module new staff training for new staff to be completed with a set period of time immediately

• 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 Center Managers proactively calendared trainings that focus on managing health center staff with respect to several matters, including Protected

 Proactively calendared Annual All-Staff agency Training on Compliance Policies and Procedures, PPOSBC implemented automated audit software that provides information on potential unauth prize a access by/disclosure to any level of agency staff, with

respect to the agency Electronic Health



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policies. However, PPOSBC sets forth robust,

health information for all patients.

consistent and good faith efforts to prevent and/or as applicable remediate towards optimum or of a tion of



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 CA060000264 09/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1421 E 17TH STREET PLANNED PARENTHOOD ORANGE & SAN BEI SANTA ANA, CA 92705 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) PPOSBC also makes every effort to communicate 9.22.14 A 017 Continued From page 9 A 017 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 • 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

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standards.

term subject matter expertise for matters relevant to optimum protection of patient privacy and security, and compliance with regulatory and agency

Accordingly, and since over a year has



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 CA060000264 09/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1421 E 17TH STREET PLANNED PARENTHOOD ORANGE & SAN BEI SANTA ANA, CA 92705 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES 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) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) the incident at issue, PPOSBC submits in good faith A 017 Continued From page 10 A 017 9.22.14 that it currently has already implemented and integrated a variety of applicable corrective actions to address the August 2013 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 patient 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. 9

Licensing and Certification Division

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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 CA250000210 03/11/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3772 TIBBETS STREET** PLANNED PARENTHOOD - RIVERSIDE CLINIC RIVERSIDE, CA 92506 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) A 000 Initial Comments A 000 We apologized to Patient B in person. 2-19-14 reassured her that Planned Parenthood is The following reflects the findings of the California committed to protecting patient privacy and Department of Public Health during the retrieved the Health Access Plan (HAP) investigation of one entity reported incident. card with Patient A's information on it from her. We provided Patient B with a new HAP Entity Reported Incident Number: CA00388906 card with her correct information on it. Representing the California Department of Public The Health Center Manager immediately Health: Surveyor 2138/26288, HFEN discussed the incident with the Front Office 2-20-14 Specialist involved in the error and The inspection was limited to the specific entity reminded her that our process includes the reported incident investigated and does not mandatory cross checking of all patient represent the findings of a full inspection of the labels before they are affixed to the HAP facility. card. The Health Center Manager also immediately implemented a new process The Department was able to substantiate a that involves cross checking the label on the violation of the regulations and a deficiency was HAP card against the demographic written for Entity Reported Incident Number: information on the patient's "Fee Ticket". CA00388906 An apology letter was mailed to Patient A A 001 Informed Medical Breach A 001 informing her about the breach, reassuring 2-24-14 her that Planned Parenthood is committed to Health and Safety Code Section 1280.15 (b)(2). protecting patient privacy and to " A clinic, health facility, agency, or hospice shall investigating the incident. We also informed also report any unlawful or unauthorized access Patient A that the HAP card with her to, or use or disclosure of, a patient's medical information on it had been returned to us. information to the affected patient or the patient's representative at the last known address, no later The Health Center Manager conducted a 3-5-14 than five business days after the unlawful or root cause analysis with the Director of unauthorized access, use, or disclosure has been Quality Management in order to determine detected by the clinic, health facility, agency, or what contributing factors led to the error hospice." and to implement any identified system improvements. This led to the following The CDPH verified that the facility informed the actions and changes: affected patient(s) or the patient's (1) More label printers were ordered representative(s) of the unlawful or unauthorized for the front desk staff access, use or disclosure of the patient's medical information. Licensing and Certification Division LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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: _ B. WING CA250000210 03/11/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3772 TIBBETS STREET** PLANNED PARENTHOOD - RIVERSIDE CLINIC RIVERSIDE, CA 92506 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) A 017 1280.15(a) Health & Safety Code 1280 A 017 (2) Front desk staff will double check every printed patient label (a) A clinic, health facility, home health agency, or against the printed Fee Ticket hospice licensed pursuant to Section 1204, with the patient's demographic 1250, 1725, or 1745 shall prevent unlawful or information on it prior to unauthorized access to, and use or disclosure of, affixing the label to the HAP patients' medical information, as defined in card subdivision (g) of Section 56.05 of the Civil Code (3) Front desk staff will ensure that and consistent with Section 130203. The the HAP card is labeled with the department, after investigation, may assess an correct patient's information administrative penalty for a violation of this prior to placing it in the patient's section of up to twenty-five thousand dollars mini chart and handing it to the (\$25,000) per patient whose medical information Medical Assistant. was unlawfully or without authorization accessed. (4) The Medical Assistant will cross used, or disclosed, and up to seventeen reference the patient information thousand five hundred dollars (\$17,500) per on the HAP card against the subsequent occurrence of unlawful or patient's Fee Ticket unauthorized access, use, or disclosure of that (5) The Medical Assistant will ask patients' medical information. For purposes of the the patient to verify that the investigation, the department shall consider the information matches and is clinic's, health facility's, agency's, or hospice's correct by initialing the Fee history of compliance with this section and other Ticket next to their name related state and federal statutes and regulations, the extent to which the facility detected violations The Health Center Manager reviewed the 3-28-14 and took preventative action to immediately new process with all health center staff at correct and prevent past violations from recurring, their staff meeting. and factors outside its control that restricted the facility's ability to comply with this section. The department shall have full discretion to consider Monitoring of compliance to the policy all factors when determining the amount of an 5-25-12 for verifying patient identity has been administrative penalty pursuant to this section. (date incorporated into the initial assessment assessment for new health center staff and the annual form implemented) performance evaluation. The Health Center Manager is responsible for conducting the annual performance This Statute is not met as evidenced by: evaluation. The annual review process is Based on interview and record review, the facility part of our quality assurance program. failed to ensure for one patient (Patient A), that her protected health information (PHI) was not disclosed to another patient (Patient B). This

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failure resulted in unauthorized access to Patient





PRINTED: 04/07/2014 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: _ B. WING CA250000210 03/11/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3772 TIBBETS STREET** PLANNED PARENTHOOD - RIVERSIDE CLINIC RIVERSIDE, CA 92506 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE TAG DEFICIENCY) The Health Center Manager is responsible A 017 Continued From page 2 A 017 for continuously monitoring compliance A's demographic information. to all HIPAA privacy policies and procedures in their health centers Finding: including protection of patient privacy through verification of patient identity via A telephone interview was conducted on March the new system outlined above. 11, 2013, at 3:00 p.m., with the HIPAA (Health Insurance Portability And Accountability Act) In addition, the HIPAA Privacy Officer Privacy Officer (PO). The PO stated on February conducts HIPAA training for all new 19, 2014, Patient B was checking in for a health center staff as part of the agency's scheduled appointment at the facility. A staff orientation and training program as well member noticed that Patient B's identification as an annual HIPAA Compliance card and health access program card had Patient Training review. HIPAA compliance A's demographic information listed on the cards. audits are also conducted annually at a The demographic information included Patient A's minimum of six health centers. name, date of birth, and medical record number. The PO stated when Patient B was asked by the All corrective actions were completed by staff why her cards had a different patient's 3-28-14. information on them Patient B stated those were the cards she was given by the staff. The PO stated that a staff member must have placed Patient A's identification labels on Patient B's health cards by mistake, therefore, Patient A's PHI was disclosed to Patient B. The facility's policy and procedure titled "HIPAA," undated, was reviewed. The policy indicated that staff were to not "reveal any aspect of a client's medical record or PHI to unauthorized individuals. or ever allow an unauthorized person access to



any medical record or PHI."

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION Facility Noticed	(X3) DATE SUR\	
IND I DAIN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDIN	reality, core	COMPLETE	ט
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		040000683		Nothed By: 0 0 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	06/12/20)14
IAME OF F	PROVIDER OR SUPPLIER			, STATE, ZIP CODE Name		
AMILY F	FIRST HEALTH CARE	E, A SERVICE OF FRESNO,				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE CO	MPLET DATE
A 000	Initial Comments		A 000	The following is Planned Parenthood		
	Amended to change	e Facility Name	And the control of th	(PPMM's) response to the Department's Plan of Correction with respect to Enl Incident CA00401395, enclosed in CDPH	tity Reported	
	The following reflec	cts the findings of the California	Service of the servic	October 6, 2014, received by PPMM's	Family First	
	Department of Pub	lic Health-Licensing and	difference and definition of the second	Health Center (Family First) on Octo concerning an incident at Family Fir		
	Certification, during Reported Incident:	the investigation of Entity CA00401395.	-	reported to CDPH on June 5, 2014 (CDPH	Report).	
	Donrosonting the C	California Danartmant of Dublia		Deficiency cited as not complying with (Safety Code 1280.15(b)(2), 22 CCR 7		
		California Department of Public and Certification: 32306 RN,		failed to ensure confidential treatment of	of Patient 1's	
	HFEN.		Transportation control of the contro	protected health information (PHI) whe chart had Patient 1's label attached to it).	n Patient 2's	
	The inspection was	limited to the specific Entity		(a) Corrective actions to be accomplis	shod for the	
		limited to the specific Entity nvestigated and does not	TO DESCRIPTION	affected patient:	ned for the	
	represent the findin	gs of a full inspection of the		On June 5, 2014, a Family First supe	ervisor called	
	facility.			Patient 1 to inform her about the mis-	take and the	
	One deficiency was	issued for Entity Reported		required letter, confirm mailing address, a for the error. On that day, the Compl	and apologize (a)	6/5/3
j.	Incident: CA00401			mailed the letter to Patient required by	Cal. Health &	
		,		Professional Code 1280.15. CDPH does deficiency concerning PPMM's communications.		
A 001	Informed Medical B	reach	A 001	Patient 1.		
	Health and Safety (Code Section 1280.15 (b)(2),		(b) Identification of other patients		
	" A clinic, health fac	cility, agency, or hospice shall		affected by the same deficient practice a action to be taken:	nd corrective	
		awful or unauthorized access sure of, a patient's medical				
		ffected patient or the patient's		PPMM has not identified other patient affected in this instance.		N/A
	representative at th	e last known address, no later			, ,	
		days after the unlawful or ss, use, or disclosure has been		(c) Immediate measures and systemic will be put in place to ensure that defice		
		ic, health facility, agency, or		does not recur:	,	
	hospice."			From June 12 through June 18, 2014, the	e Family Fir	
	The CDDU verified	that the facility informed the		Front Office Coordinator (FOC) monitore	d the Health	6/18
	affected patient(s)	that the facility informed the or the patient's		Service Specialist 1's (HSS 1's) check-in-p patients to ensure that she correctly to		5
	representative(s) of	the unlawful or unauthorized		needed to save the changes in the en	tire NextGeh	
	access, use or disc	losure of the patient's medical		(electronic patient record) medical record During that same period, FOC monitored	HSS 2's label	21
	information.			printing for 25 patients to ensure that she	checked that	al
				the patient's first name, last name, and	date of birth	ρ
	Certification Division	SERVICIONE DE DECRESATATIVES CONTRA	LATURE	in) E.C. EIW		
OKATORY	DIRECTOR'S OR PROVID	PPMM Payara N	^	TITLE V.	for I'm	
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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 B. WING 040000683 06/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6095 N FIRST STREET FAMILY FIRST HEALTH CARE, A SERVICE OF FRESNO, CA 93710 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (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 DATE TAG DEFICIENCY) D 177 T22 DIV5 CH7 ART6-75055(b) Unit Patient D 177 match the chart on which she puts the label. These Health Records employees did not make any mistakes during this monitoring process. On June 17, 2014, Family First (b) Information contained in the health records had a center-wide training on a privacy question shall be confidential and shall be disclosed only involving joint responsibility for checking PHI, led by the Registered Nurse. to authorized persons in accordance with federal, state and local laws. (d) Monitoring Process/Quality Assurance During December, 2014, the Front Office Coordinator (or other CM designee) will conduct the same HSS 1 This Statute is not met as evidenced by: and HSS 2 monitoring described in (c) above. Also (d) 12/31/14 during December, 2014, PPMM's Privacy Officer will Based on staff interview, clinical record review. review Privacy Manual Policy 4 (reasonable safeguards) and administrative document review, the clinic to specifically include checking chart labels as failed to ensure confidential treatment of Patient described above for the 2015 Privacy Manual revision. 1's protected health information (PHI) when Patient 2's chart had Patient 1's label attached to it. This failure resulted in unauthorized access to Patient 1's PHI and the potential for abuse of that information. Findings: On 6/12/14 at 1:10 p.m., during a telephone interview, the Compliance Officer (CO) stated that on 5/29/14 Patient 2 had come in to the clinic for services. During the registration procedure, clinic employees (Registered Nurse and Health Services Specialists) printed Patient 1's label and placed it onto the chart of Patient 2. Patient 2. subsequently saw this label. The CO stated that the employees should have double checked the label against the chart, but this was not done. Patient 1's PHI breached included her name, date of birth, medical record number, clinic visited, encounter number, date of service, insurance provider and subscriber number.

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The clinic's policy and procedure titled, "PRIVACY

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		
		040000683	B. WING		C 06/12/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
FAMILY	FIRST HEALTH CARE	. A SERVICE OF	RST STREE	Т	
		FRESNO,	CA 93710		
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D 177	.Confirmation of particle or providing written referral forms, etc.) receive documents [Clinic] staff should, provide the first ANI and check the docu corresponds. Staff information first and	4: REASONABLE AINST PRIVACY 4/2012, indicated " tient identity before discussing PHI (including prescription, to patient: Before patients or are spoken to about PHI, at a minimum, ask patients to D last name and date of birth, ment to make sure that it should NOT provide the I then ask for confirmation, t in a privacy breach if the	D 177		
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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
	CA090000257	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	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.	9-12-14
	Category: State Monitoring Sub-category: Non-Breach Patient Medical Information Incident		Multiple telephone contact attempts were made to Patient 1 when she failed to return the medication with Patient 2's name on it.	9-12-14 9-13-14 9-15-14
	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		A follow up letter was mailed to Patient 2 regarding the breach and our attempts to contact Patient 1. b. See corrective actions below.	9-16-1
D 177	represent the findings of a full inspection of the hospital. One deficiency was written as a result of ERI number CA 00413369 T22 DIV5 CH7 ART6-75055(b) Unit Patient	D 177	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	9-12-1
	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.		handing medication to a patient. 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	
	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		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.	9-26-1 cans

Licensing and Certification Division

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

HIPAA Privacy Officer

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STATEMEN	a Department of Pub IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
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D 177	personal information Findings: An investigation of breach was initiated to the California De on an unaudisclosure of Patier given to Patient 1 d. The Physician Assi 1 on Patient 1 during that 1 the medications of Patient 2's information of Patient 2's informatio	an entity reported privacy d on 10/31/14. It was reported partment of Public Health that atthorized and inadvertent at 2's medical information was during a visit at the clinic. Stant (PA) 1 had seen Patient had ordered medications for at same visit. PA 1 gave Patient with a label that contained		d. The monitoring process will inchreview of all patient privacy root cate analysis reports by the HIPAA Privacy Officer, Sr. Director of Quality and Director of Center Operations. This help to identify if any similar errors to the process for verification of patientity prior to handing the patient medication or information, have occand to address them immediately. Monitoring of compliance to this in process is routine. In addition, it is the annual performance evaluation. Health Center Manager and Lead Care responsible for conducting the aperformance evaluation. The annual process is part of our quality assural program. The Health Center Manager is responsible to the continuously monitoring compliant HIPAA privacy policies and profine their health centers including profine their health centers including profine the patient privacy through mandato double checking of all patient informand labels prior to handing to the patient privacy through the patient informand labels prior to handing to the patient staff as part of the agency's orientation and training program as an annual HIPAA compliance Trair review. HIPAA compliance audits a conducted annually at a minimum of health centers.	the Sr. will related tient curred ternal part of The clinician mual l review nce consible tiance to becdures of tection ry mation attent. ficer w health well as ning are also of six	ne

Licensing and Certification Division

stated that when the Medical Assistant (MA) 1

went to work on Patient 2's medical record that

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9-26-14.



e. All corrective actions were con precity

California Department of Public Health

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
		CA090000257	B, WING		11/06	/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PLANNE	D PARENTHOOD AS:	SOC OF SAN DIFI	LLEGE AVEN			
		SAN DIE	GO, CA 9211		OTION	
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D 177	Continued From pa	age 2	D 177			
	MA 1 noticed that rordered. The PO athe medications given Patient 2's name, puse, name of the permission" This Patient 1 was given to redering of medications was athey did not a writted A review of the clinentitled "Employee indicated"As a gent PHI may not be uspermission" This Patient 1 was given	medications had already been cknowledged that the label on ven to Patient 1 had contained prescription, instructions for prescriber The PO stated that le checked to ensure that she patients EMR prior to the ations and printing of labels. It the process of ordering an "Internal Process" and that en policy and procedure, and procedure, and the process of the ations and procedure, and procedure and procedure, and procedure and	t			
	internal process of that she was in the medical record, re unauthorized relea health record infor violation of the pat	sistant's failure to follow the f double checking to ensure e correct patients electronic sulted in the inadvertent and ase of Patient 2's protected mation. This was also in tient's right to confidentiality of as and record pertaining to red at the hospital.			Ameri	Scans



STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	ER/CLIA MBER:	1, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		CA0800002	254	B. WING _		12/22/2014
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, 8	STATE, ZIP CODE	IL/LL/LU14
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D 000	Department of Publinvestigation of a sepatient's medical in Complaint number: The investigation were ported and does full inspection of the Representing the CHealth: Health Facistate ID: 2794. Informed Medical Best Health and Safety Cest A clinic, health facials report any unlate, or use or disclosinformation to the arepresentative at the later than five busing unauthorized accessions been detected by the agency, or hospice. The CDPH verified affected patient(s) or access, use or disconformation.	cA00419617 Tas limited to the spector represent the finder facility. California Department lities Evaluator Nurse streach Code Section 1280.15 cility, agency, or hosp awful or unauthorized sure of, a patient's me ffected patient or the e last known address less days after the units, use, or disclosure the clinic, health facility."	cific event dings of a of Public eshall access edical epatient's s, no has y, ned the athorized s medical	D 000	a. The deficiency occurred when one clinadvertently selected the wrong printer resulted in incorrect prescription labels printed to the wrong exam room. The chat exam room then failed to follow the process for reviewing prescription label placing them on medications and handit to the patient. AN — The plan is to ensure that clinicians (a) select and print to the compation informatic printed label matches the electronic merecord prior to placing the label on the medication and handing it to the patient. A breach notification letter was sent to The medications labeled with Patient A information on them, were returned to the center by Patient B. b. The procedure will include reviewing licensed staff our established process with includes (a) the need to print to the comprinter and (b) mandatory double check prescription labels prior to placing labe medications and handing them to the patient. The Health Center Manager and Lead Care responsible for continuously monitor compliance to all HIPAA privacy polic procedures in their health centers include protection of patient privacy through medicating them on medications and handit to the patient.	which being linician in emotival split to the mal split to the man split t
		tained in the health re	i i			Jinea
aboratory Di A	OIRECTOR'S OR PROYID	ER/SUPPLIER REPRESENT	TATIVE'S SIGNA HTPNA P.		OFFICE , TITLE	or Life
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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE		(X2) MULTI	PLE CONSTRUCTION PT OF PUBLIC	1(X3)(DATE	SURVEY
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		CA0800002	254	B. WING _	JAN - 8 20	12/2	2/2014
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
PLANNE	PARENTHOOD ASS	N OF SAN DIEGO CC	7526 CLAI SAN DIEG	IREMONT M O, CA 9211	IESA BLVD LICENSING & CERTIF 1 SAN DIEGO NORTH DISTE	CATION	
(X4) ID		TEMENT OF DEFICIENCIE		[D	PROVIDER'S PLAN OF CORRE	CTION	
PREFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL ATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)		(X5) COMPLETE DATE
D 177	This RULE: is not a Based on interview failed to protect the one sampled patien Health and Safety Cresult, the patient's (PHI) was compromed Findings: The facility was man 10/31/14. The facility the incident on 11/6. The facility reported following PHI relate body mass index (was medications, instructions, instructions and the name of the number. The Administrative and the name of the number. The Administrative and the name of the number.	I and shall be disclosure in accordance with accordance with an accordance with an accordance by and record review, to medical record informat (Patient A) as requivate health informations accordance.	th federal, the facility mation for ired per 0.15. As a lation on on ment of lating the end of lating the end of lating the end on lating the end of	D 177	In addition, the HIPAA Privacy Office HIPAA training for all new health cerpart of the agency's orientation and training review. HIPAA Compliance Training review. HIPAA compliance audits are also conducted a minimum of six health centers. HIP breaches are also reviewed and discusshealth center leadership at bi-annual in the monitoring process will also incompliance of all patient privacy root cause reports by the HIPAA Privacy Office Director of Quality and the Sr. Direct Operations. We will identify any similar address them immediately. d. The Health Center Manager and Le Clinician are responsible for implementation of correction. e. The Lead Clinician immediately rewhat contributing factors led to the enconducting a root cause analysis and that a clinician had not followed our internal process for reviewing prescription to placing them on medications handing them over to the patient. The Lead Clinician reviewed and distincident with all licensed staff at the meeting and reminded them of the intensuring that correct prescription laberlaced on medications prior to dispert to patients. All corrective actions were completed 11-26-14.	er conducts ater staff as aining annually at AA privacy seed with neetings. ude a see analysis r, Sr. or of Center lar errors ead enting the viewed ror by determined mandatory ption labels and extended the enext staff aportance of els are using them	I1-26-14
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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 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) 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 reporting applicable incidents such as that described investigated and does not represent the findings 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 couns€ ea The CDPH verified that the facility informed the and placed on administrative suspension as of scid 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 (A) information. protection of patient medical information a privacy. Licensing and Certification Division LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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

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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

This Statute is not met as evidenced by: Based on interview and clinic document review, the clinic failed to prevent a disclosure of Patient

facility's ability to comply with this section. The

administrative penalty pursuant to this section.

department shall have full discretion to consider all factors when determining the amount of an

Proactive calendared clinic/health cell term ellicensed Clinician trainings that also include training on Protected Health Information/IFM

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

agency calendar; this includes:

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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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

CA060001620

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

CA060001620

(X3) DATE SURVEY COMPLETED

C O9/10/2014

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
A 017 Continued From page 3	A 017	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 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. c) As noted in section (b): 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 Patien Right to File Complaints About Use and Disclosure of their Protected Health Information PPOSBC Compliance Policy CO-1105 HIPAA	9.22.14 2014 OCT 17 PM 9 54

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California Department of Public Health

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	(X3) DATE SURVEY COMPLETED
	CA060001620	B. WING	C 09/10/2014

(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 4	A 017	 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 	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:	
				2014 OCT 17 AM 9 54 Coican

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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 (X3) DATE SURVEY COMPLETED A. BUILDING: ___ C B. WING CA060001620 09/10/2014

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STREET ADDRESS, CITY, STATE, ZIP CODE

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A 017	Continued From page 5	A 017	with our electronic health record system. On a daily	9.22.14
,,,,,,	Continued From page 3	7017	basis, the breach detection technology/software	9.22.14
			analyzes access into the agency systems, thereby	
		1	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	
			1 27.00	
		-1	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	
0.00			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	
		100	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	CONTRACT DE
-			other processes for sanctioning any staff that fails to	2014
			follow said processes and trainings as described above	
			Tollow salu processes and trainings as described above	00
			Accordingly, as with any healthcare agency such as	
			Accordingly, as with any healthcare agency, such as	 _ \
			hospitals, the CDPH, DHCS and other entities, PPOSBC	~1
			is subject to common human errors or independent	TD
- 1			acts against established and reinforced agency poli-	3
			cies. However, PPOSBC sets forth robust, consistent	CO
			and good faith efforts to prevent and/or as applicable	
			remediate towards optimum protection of health in	(2)
			formation for all patients.	P)
			PPOSBC also makes every effort to communicate with	
			any applicable patients at issue to assist them vithary	inn
			questions or concerns, including providing contact	ical
_ 1				4~
sing and	on the second the tea on the H. Tye the H.A.	121 12 2	information for relevant staff such as patient styles	

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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 (X3) DATE SURVEY COMPLETED A. BUILDING: ___ C CA060001620 B. WING 09/10/2014

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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
			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	
			Officer, Privacy Officer and Security Officer, as well as 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. • With said new hires, PPOSBC is also embarking on a long-term plan to continue to review all said applicable.	2
	i I		agency policies for optimum quality and compliance. • With said new hires, PPOSBC also plans for long term subject matter expertise for matters relevant to	3
			optimum protection of patient privacy and set u it is and compliance with regulatory and agency standards.	icai

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California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

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A. BUILDING:

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CA060001620

(X3) DATE SURVEY COMPLETED

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A 017	Continued From page 7	A 017	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:	
		1	PPOSBC Compliance Policy CO-600 Corporate	
			Compliance Program	
			 PPOSBC Compliance Policy CO-1104 Patient 	
			Right to File Complaints About Use and	
		E- 7	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	
		1000	PPOSBC Compliance Policy CO-111 Protected	1
-			Health Information Breach Notification PPOSBC Compliance Policy CO-112 Sanctions for	3
			Unauthorized Uses and Disclosures of a Patient's	
			Protected Health Information	7
			II. In addition to the promulgation of said policies at	AM
			PPOSBC, PPOSBC also regularly trains and educates or	ക
			said agency policies, both at inception of staff's tenure	
			at PPOSBC as well as throughout the agency calendar;	5
			this includes:	
			Protected Health Information/HIPAA in-person	
			training at staff orientation day/hire	
			An additional Protected Health Information/	
			HIPAA Online module new staff training for new	5
			staff to be completed with a set period of time	Cm
			immediately post-orientation/hire	ソ
			Proactive calendared clinic/health center	
			Licensed Clinician trainings that also include en	'icar
			training on Protected Health Information/HIPAA	

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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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A 017	Continued From page 8	A 017	 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 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 training as a fail and described above 	9.22.14 3 ican

California Department of Public Health

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

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(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) COMPLETI DATE
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 9 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 • With said new hires, PPOSBC is also embarking on a	S icar

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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 09/10/2014 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 REGULATORY OR LSC IDENTIFYING INFORMATION) TAG 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.

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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 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 a ture each information. PPOSBC staff involved in each said incident was counseled and retrained relevant to the incident at Licensing and Certification Division LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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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 DATE 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 TAG DEFICIENCY) however, this counseling and retraining collectively A 001 Continued From page 1 9.22.14 A 001 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 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:

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Based on interview and facility document review.

the facility failed to prevent the disclosure of eight

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Protected Health Information/HIPAA in-

training at staff orientation day/hire



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the administrative staff and stated the last name

on the labels were incorrect.

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Department

Department, Administration and the Compliance

· Dedicated and consistent agency Quality Management/Quality Assurance meetin



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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 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 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) • PPOSBC Compliance Policy CO-1104 Patient Right A 017 Continued From page 4 A 017 9.22.14 to File Complaints About Use and Disclosure of their on 9/29/12. The investigation showed when a Protected Health Information returning patient came into the center on 4/30/13, PPOSBC Compliance Policy CO-1105 HIPAA Privacy the patient's card with NexPlan on it had Patient and Information Security Training F's name on it. It was discovered a Physician PPOSBC Compliance Policy CO-1108 Minimum Assistant (PA) saw both the returning patient and Necessary Rule for Protected Health Information Patient F on 9/29/12. On 9/29/12 while the PA • PPOSBC Compliance Policy CO-111 Protected was preparing NexPlan for the returning patient. Health Information Breach Notification Patient F's chart was open and the PA • PPOSBC Compliance Policy CO-112 Sanctions for inadvertently documented Patient F's name on Unauthorized Uses and Disclosures of a Patient's the incorrect card. Protected Health Information Patient F's disclosed PHI included name only. II. In addition to the promulgation of said policies at 7. Review of a Costa Mesa Health Center report PPOSBC, PPOSBC also regularly trains and educates showed on 6/7/13 a breach of Patient G's PHI on said agency policies, both at inception of staff's occurred. On 6/7/13, a patient came into the clinic tenure at PPOSBC as well as throughout the agency requesting a copy of their medical record. A staff calendar; this includes: printed the medical record and gave it to the patient. Later the patient called to inform the staff • Protected Health Information/HIPAA in-person the last page in the medical record packet training at staff orientation day/hire belonged to another patient. An additional Protected Health Information/HIPAA Online module **new staff** training for new staff to be Patient G's disclosed PHI included name, DOB, completed with a set period of time immediately address, phone number, last four digits of the post-orientation/hire social security number and a laboratory Proactive calendared clinic/health center Licensed requisition. Clinician trainings that also include training on Protected Health Information/HIPAA 8. Review of a report regarding the Costa Mesa • Proactive calendared non-licensed clinic/health Health Center showed a patient who was at the center staff (e.g., Medical Assistants, reception staff) clinic on 6/6/13, called on 6/7/13 to inform staff she received notification of being Web enabled to trainings that also include training on Protected the Patient Portal online. However, when the Health Information patient logged on the information belonged to · Health Center Managers proactively calendared Patient H. Investigation showed this patient and trainings that focus on managing health center staft) Patient H were seen at the clinic at approximately with respect to several matters, including Protected the same time on 6/6/13 and a staff inadvertently Health Information/HIPAA put Patient H's information into this other patient's Proactively calendared Annual All-Staff agency medical record. Training on Compliance Policies and Procedura C1 PPOSBC implemented automated autit software

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Patient H's disclosed PHI included name and

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independent acts against established and reinforced

agency policies. However, PPOSBC sets for

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(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 6	A 017	consistent and good faith efforts to prevent and/or as	9.22.14
7.017	Continued i form page o	AUIT	applicable remediate towards optimum protection of	5.22.14
			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	
-		n k i _ F L	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	
		e er a so	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	25
			result is an updated agency All-Staff annual training	2014
			for Compliance policies and procedures that includes	30
			robust Protected Health Information/HIPAA training.	3
-				-
			consistently also been reviewed for quality assurance;	J
				B
			1, 1, 2, 2, 3, 4, 6, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	
			re-reviewed for even further optimum compliance	٥
			PPOSBC has also installed a Chief Operating Office part of the Prospective Community of the Prospe	
			who regularly collaborates with the Compliance	CPA
			Officer, Privacy Officer and Security Officer, as well as	J
		1	the VP of HR, the agency Medical Director, and the	•
			Office of the CEO, to directly manage and over see	icar
			ongoing training of all agency health center staff,	4
sing and		1	both licensed and non-licensed.	TO

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calendar; this includes:



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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG 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

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information, and related facets

 A culture that invites reporting any suspected compliance and/or privacy matters to superviso s in any department, including but not limited to PPOSEC. Human Resources Department, Patient Services Department, Administration and the Compliance



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 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 of Privacy Officer, and chief Security Office



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 (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 improve nent measures that its quality assurance, risk

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management and compliance processe

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 IV 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

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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. The manager left the room and returned a few After this intervention, and routinely 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.

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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 more closely monitor EBL. This physician to 9.4; and was documented as having heavy 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 documentation of EBL in the patient's record. was 13.8 gm/dl (grams per deciliter) (normal 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 by our Director of Quality Management and transferred back to the procedure room for active 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

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D 183 Continued From page 3 Director stated a drop in the hemoglobin by one point usually means a loss of 300 ml of blood (a 5.2 point drop x 300 ml = 1560 ml blood loss). An interview with Physician 1 was initiated on 7/11/13 at 1130 hours. Physician 1 was asked about the EBL. He stated the EBL is usually done by a pad count and the documented estimate on the progress note was approximate. 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	ROVE
CA060001620 B. WING CA060001620 B. WING CA07/11/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 S TUSTIN STREET ORANGE, CA 92863 CX4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 183 Continued From page 3 Director stated a drop in the hemoglobin by one point usually means a loss of 300 ml of blood (a 5.2 point drop x 300 ml = 1560 ml blood loss). An interview with Physician 1 was initiated on 7/11/13 at 1130 hours. Physician 1 was asked about the EBL. He stated the EBL is usually done by a pad count and the documented estimate on the progress note was approximate. 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.	
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PLANNED PARENTHOOD/ORANGE & SAN BEI (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 183 Continued From page 3 Director stated a drop in the hemoglobin by one point usually means a loss of 300 ml of blood (a 5.2 point drop x 300 ml = 1560 ml blood loss). An interview with Physician 1 was initiated on 7/11/13 at 1130 hours. Physician 1 was asked about the EBL. He stated the EBL is usually done by a pad count and the documented estimate on the progress note was approximate. 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.	713
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CONTINUED FROM IT TO THE APPROPRIATE DEFICIENCY D 183 Continued From page 3 Director stated a drop in the hemoglobin by one point usually means a loss of 300 ml of blood (a 5.2 point drop x 300 ml = 1560 ml blood loss). An interview with Physician 1 was initiated on 7/11/13 at 1130 hours. Physician 1 was asked about the EBL. He stated the EBL is usually done by a pad count and the documented estimate on the progress note was approximate. 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 10 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMITTED TO THE APPROPRIATE DEFICIENCY CACHO CRRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACHO CRRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACHO CRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACHO CRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACHO CRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACHO CRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACHO CRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACHO CRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACHO CRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACHO CRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACHO CRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACHO CRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY CACHO CRECTIVE ACTION SHOULD BE CROSS-REFER	
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by a pad count and the documented estimate on the progress note was approximate. 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. Action Plan will be signed by the Medical Director and Chief Administrative Officer once completed.	
On 5///13. Review of the Progress Notes dated	8
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).	2013 S
An interview with the Medical Director was initiated on 7/11/13 at 1000 hours. The Medical	
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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 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **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) 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

Pat Velting Fat Velles
LABORATORY DIRECTOR'S OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Operations Manager for CQ

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California Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING

CA060001620

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

700 S TUSTIN STREET

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A 017	Continued From page 1	A 017	a) Corrective Actions Continued	
A 017	1280.15(a) Health & Safety Code 1280 (a) A clinic, health facility, home health agency,	A 017	2. Costa Mesa Health Center Letter sent to Patient H notifying them of	6/21/12
	hospice licensed pursuant to Section 1204, 1250, 1725, or 1745 shall prevent unlawful or unauthorized access to, and use or disclosure patients' medical information, as defined in	of,	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	ro.
	subdivision (g) of Section 56.05 of the Civil Coc and consistent with Section 130203. The	le	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 accesses		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	10/19/12
	used, or disclosed, and up to seventeen thousand five hundred dollars (\$17,500) per subsequent occurrence of unlawful or		contact our office for additional assistance.	
	unauthorized access, use, or disclosure of that patients' medical information. For purposes of tinvestigation, 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 regulation the extent to which the facility detected violation and took preventative action to immediately correct and prevent past violations from recurring	r ns, is	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 conside 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
icensing an	This Statute is not met as evidenced by: Based on interview and hospital document review, the facility failed to prevent the disclosu of 11 patients' protected health information (PH to unauthorized individuals (Patients A, B, C, D, E, F, G, H, I, J and K).	I)	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.	N/9/12 icans
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PRINTED: 01/10/2013 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) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE 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 what corrective actions will be taken. Findings: 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

The disclosed PHI belonging to Patients A. B. C. D, E and F are as follows:

were found on top of the paper towel dispenser in

Patients A, B, and F's name, date of last menstrual period, size of family, income and the internal medical record number were disclosed.

Patient C's name was disclosed.

the bathroom.

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

situation, talks to our compliance office

and we work on solutions so these types of errors will not happen in the future.

When required, new policies are written

Employees we were able to identify as

violators of HIPAA incidents receive

Corrective Action Warning Notices.

and communicated with staff.

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 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **700 S TUSTIN STREET** PLANNED PARENTHOOD/ORANGE & SAN BEI ORANGE, CA 92863 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (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

Further review of the Health Center's investigation showed staff neglected to follow the policy on verifying patient identity on labeled supplies and/or documents before distribution.

3. On 8/14/12, the Anaheim Health Center discovered staff inadvertently handed a patient a urine cup labeled with Patient J's PHI. The patient went to the bathroom and noticed the urine cup with Patient J's name and returned it to a staff member.

The PHI disclosed included first initial, last name and date of birth of Patient J.

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 intended recipient on 4/25/12.

Through investigation the health center discovered staff had inadvertently switched the last two numbers of the fax number.

Patient G's PHI disclosed included name, date of birth, the health center's internal medical record number, income and phone number.

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

incident occurred we moved our call center representatives from each health center location to one location. They now have their own secure area with shred bins and no patients have access to the documents or the paperwork on their desks.

We remind staff and include in our new hire training that staff should always confirm the patient's full name and date of birth before handing a patient anything that has patient information written on it. This includes urine cups, Family Pact cards, prescriptions, test results, supplies etc.

We continue to remind staff to be familiar with our new FAX policy and to preprogram those FAX numbers that are used repeatedly. One must always verify the numbers they have entered before transmitting a FAX.

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(X5) COMPLETE

Ongoing

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A 017	Continued From pa	age 4		A 017	d) Description of the monitoring	process.	
	health center disco 7/29/2012.	pelonging to Patient I wered the inadverten	t act on		Monitoring process includes Management overseeing the op of our health centers including t distribution of supplies and pres	he criptions.	Ongoi
	The PHI belonging to Patient I that was disclosed included name, date of birth, and the Family Pact card identification number.				Newly hired staff receive HIPAA on their first day of work before their worksite. Health Center Massistants receive additional HI	going to ledical	
	discovered staff ha	Westminster Health (d inadvertently given nging to Patient K on	another		training during their weeklong o training within 30 days of new h also have quarterly Medical Ass	rientation ire. We sistant	
	The PHI disclosed	on the form showed	Patient		trainings where we train and rei		*

The above breaches of PHI were confirmed during a telephone interview with the health centers' Operations Manager for Compliance, Quality and Risk Management and the Senior Vice President of Compliance and Privacy on 12/6/12 at 1400 hours.

K's name and a test result.

on 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 portance of following HIPAA guidelines at each of their Monthly Health Center staff meetings. At quarterly Quality & Risk Management Meetings, HIPAA Breaches are discussed and monitored by management. We also have spot checking audits conducted by the Compliance Office throughout the year. The importance of this function has been communicated to staff and they

e) Date when corrective action will be completed.

understand the importance of following

our policies.

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: ____ B. WING CA220001034 11/17/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAN ANTONIO ROAD PLANNED PARENTHOOD **MOUNTAIN VIEW, CA 94040** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 000 Initial Comments D 000 The following reflects the findings of the California Department of Public Health during a complaint visit. The inspection was limited to the specific complaint investigated, and does not represent the findings of a full inspection of the facility. For Complaint no. CA460155 regarding Quality of Care/ Treatment, the Department was unable to identify a violation of Federal regulations. Representing the California Department of Public Health: 29956, Health Facilities Evaluator Nurse Licensing and Certification Division LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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PRINTED: 03/26/2015 FORM APPROVED

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D 000	Department of Pulinvestigation of a spatient's medical in Complaint number. The investigation of the investigation of the Inspection of the Representing the Realth: Health Factorians and the Inspection of the	r: CA00420907 was limited to the spe not represent the fin	an of a ecific event dings of a t of Public	D 000	a. The deficiency occurred with anded an enrollment letter whow to set up a patient portal that was intended for Patient assistant involved in the error normal process for confirming prior to handing over the enrollment of the immediately dis-enrolled Patient B further access to Patient A's plan addition, we apologized to her next visit three days later updated enrollment letter with to set up her patient portal acc A follow up breach notification to Patient A the day after her	A. The med failed to fo g the patient letter error, we ent A from a was unable portal. Patient A in and she reconstruction count and patient was un letter was on letter was un letter w	I password ical I password ical Illow the t's identity r. the patient to gain a person at cived an as for how assword.	11-14-14 11-17-14 11-18-14
A 001	" A clinic, health fa also report any uni- to, or use or disclo- information to the representative at t later than five busi unauthorized acce- been detected by tagency, or hospical The CDPH verified affected patient(s) representative(s) of	Code Section 1280.1 cility, agency, or hosplawful or unauthorized sure of, a patient's maffected patient or the he last known addressness days after the uss, use, or disclosure the clinic, health facility."	plice shall d access ledical e patient's is, no nlawful or e has ty, med the uthorized	A 001	The plan is to ensure that medestablish correct patient ident enrollment letter to a patient, occurred, a third identifier has patient portal enrollment proc a patient portal account, the patient patient patient and their the date of birth is not listed of letter, a patient would not be access another patient's portal additional identifier. b. The procedure will include staff our established process a correct patient receives the confect patient receives the confect patient identity and (b) asking the name and email address of belong to them. c. Monitoring procedures will training at routine center staff the mandatory process for estimation in the patient identity prior to handi	ity prior to be Since this in a been added the sees. In order attent must to the token email addron the enroll able to inad all without know the reviewing for ensuring for ensuring the patient on the enroll ablishing control abl	nanding an acident d to the r to set up now enter listed on ess. Since ment vertently nowing this with all that the ment letter, arrect to ensure ment letter lilow up egarding prirect	
D 177	Health Records	T6-75055(b) Unit Pa		D 177	portal enrollment letter to the	patient. A	meri In i	cans
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTII	IPLE CONSTRUCTION		(X3) DATE SURVEY		
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D 177	Continued From Pa	age 1		D 177	Continued From Page 1	<u> </u>		OFFICE
	This RULE: is not Based on interview failed to protect the one sampled patien Health and Safety result, the patient's (PHI) was compror Findings: The facility was ma 11/14/14. The facility he incident on 11/11. The facility reported following PHI related laboratory results, when an annual complete the during a telephone Administrative staff welcome letter control of the state of	met as evidenced by and record review, to medical record inform (Patient A) as requestion 128 private health informatised.	th federal, the facility mation for ired per 0.15. As a nation the on ment of uded the control provider acident the elived a nt A. The n how to		c. The monitoring process review of all patient privacy reports by the HIPAA Privacy Director of Quality and the Operations. We will identified and address them immediate wide errors. d. The Health Center Manaimplementing the plan of econtinuously monitoring of HIPAA privacy policies and health centers. This include patient privacy through the establishing correct patient handing over an enrollment In addition, the HIPAA Pri HIPAA training for all new part of the agency's orienta program as well as an annu Compliance Training reviecempliance audits are also a minimum of six health ce breaches are also reviewed health center leadership at e. The Health Center Manareviewed what contributing error by conducting a root determined that a medical followed our mandatory in establishing correct patient handing over a patient port. The Health Center Manage discussed the incident with staff meeting and reminded importance of ensuring that identity is always establish over a patient portal enroll. The third identifier was ad birth in order to enroll in the content of the content	y root cause acy Officer, Sr. Directo y any similisely to avoid a ger is responsed in the protect of the protec	clude a canalysis. Sr. r of Center ar errors of system- onsible for ad for co all canalysis of process of or to patient. cr conducts ter staff as a sining cannually at A privacy sed with seetings. iately l to the sis and d not can letter. and the next see tient chanding control of the canal	11-26-14
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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 B. WING CA250001778 02/19/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12900 FREDERICK STREET, SUITE C PLANNED PARENTHOOD - MORENO VALLEY **MORENO VALLEY, CA 92553** 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 TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) A 000 Initial Comments A 000 We spoke to Patient A on the phone 1-12-15 and apologized to her for the error. The following reflects the findings of the California She agreed to return the letter with Department of Public Health during the Patient B's information on it to us investigation of one entity reported incident. in a self-addressed, stamped envelope that was mailed out to her. In addition, Entity reported incident number: CA00429105 an RN in the Case Management Department called Patient A, discussed Representing the California Department of Public her lab results with her and scheduled Health: 25937 / 2122 an appointment for her to receive treatment. The inspection was limited to the specific entity reported incident investigated and does not A follow up letter was mailed to Patient 1-26-15 represent the findings of a full inspection of the A informing her that Patient B facility. had returned the letter with Patient A's information on it. This Department was able to substantiate a violation of the regulations. We apologized to Patient B in person, 1-13-15 retrieved the letter from her with Patient A 001 Informed Medical Breach A 001 A's information on it and provided her with appropriate treatment. Health and Safety Code Section 1280.15 (b)(2), " A clinic, health facility, agency, or hospice shall A follow up letter was mailed to Patient 1-26-15 also report any unlawful or unauthorized access B informing her that Patient A had agreed to, or use or disclosure of, a patient's medical to return the letter to us with information to the affected patient or the patient's Patient B's information on it. representative at the last known address, no later than five business days after the unlawful or We have determined that this is unauthorized access, use, or disclosure has been not a system error; it is a one-off detected by the clinic, health facility, agency, or error by an employee. hospice." The RN Manager of Case Management 1-20-15 The CDPH verified that the facility informed the immediately discussed the incident affected patient(s) or the patient's with the Case Management Specialist representative(s) of the unlawful or unauthorized involved in the error and reminded her access, use or disclosure of the patient's medical that our process includes the mandatory information. double checking of the patient name and address on a lab results letter against the patient name and address on the

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envelope label, prior to placing the



If continuation sheet 1 of 4

PRINTED: 02/25/2015 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 CA250001778 02/19/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12900 FREDERICK STREET, SUITE C PLANNED PARENTHOOD - MORENO VALLEY MORENO VALLEY, CA 92553 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) Continued From page 1 A 017 A 017 1280.15(a) Health & Safety Code 1280 in the envelope. The Case Management A 017 Manager also reinforced with the employee (a) A clinic, health facility, home health agency, or the need to handle only one patient letter hospice licensed pursuant to Section 1204, and envelope at a time. 1250, 1725, or 1745 shall prevent unlawful or unauthorized access to, and use or disclosure of, Every new Case Management RN patients' medical information, as defined in receives training which includes subdivision (g) of Section 56.05 of the Civil Code mandatory double checking of and consistent with Section 130203. The patient name and address on a lab department, after investigation, may assess an results letter against the patient administrative penalty for a violation of this name and address on the envelope section of up to twenty-five thousand dollars label prior to placing the letter in (\$25,000) per patient whose medical information the envelope. was unlawfully or without authorization accessed, used, or disclosed, and up to seventeen The RN Case Management Manager thousand five hundred dollars (\$17,500) per is responsible for continuously subsequent occurrence of unlawful or monitoring compliance to all HIPAA unauthorized access, use, or disclosure of that privacy policies including our process patients' medical information. For purposes of the of mandatory double checking of investigation, the department shall consider the patient name and address on a lab clinic's, health facility's, agency's, or hospice's results letter against the patient name history of compliance with this section and other and address on the envelope label related state and federal statutes and regulations, prior to placing the letter in the envelope. the extent to which the facility detected violations It is part of the annual performance and took preventative action to immediately evaluation, which is conducted by the correct and prevent past violations from recurring. RN Case Management Manager. and factors outside its control that restricted the facility's ability to comply with this section. The HIPAA training for all new staff is department shall have full discretion to consider conducted by the HIPAA Privacy all factors when determining the amount of an Officer as part of the agency's administrative penalty pursuant to this section. orientation and training program in addition to an annual HIPAA Compliance Training review.

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This Statute is not met as evidenced by:

Based on interview and facility document review,

the facility failed to prevent unauthorized access and/or disclosure of two patients (Patient 1 and

Patient 2) medical information, when Patient A's

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1-26-15

HIPAA compliance

audits are also conducted on an annual

All corrective actions were completed

basis by the HIPAA Privacy Officer



PRINTED: 02/25/2015 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 CA250001778 02/19/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12900 FREDERICK STREET, SUITE C PLANNED PARENTHOOD - MORENO VALLEY MORENO VALLEY, CA 92553 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) A 017 Continued From page 2 A 017 laboratory results were sent to Patient B, and Patient B's lab results were sent to Patient A. This failure had the potential to result in misuse of private/protected information. Findings: 1. On February 19, 2015, at 2 p.m.., the Privacy officer (PO) was interviewed. The PO stated Patient A notified the facility on January 12, 2015. that she had received a letter in the mail that was intended for Patient B. The PO stated Patient A's name and address was on the outside envelope. but the letter inside was addressed to Patient B. and contained protected health information (PHI). The PO stated the letter contained Patient B's positive Chlamydia results (a sexually transmitted disease). The PO stated Patient A returned the letter to the facility. The letter sent to Patient A was reviewed. The letter contained Patient B's name, address, and positive test results for Chlamydia (a sexually transmitted disease). 2. On February 19, 2015, at 2 p.m.., the Privacy officer (PO) was interviewed. The PO stated Patient B notified the facility on January 13, 2015, that she had received a letter in the mail that was intended for Patient A. The PO stated Patient B's name and address was on the outside envelope, but the letter inside was addressed to Patient A. and contained protected health information (PHI). The PO stated the letter contained Patient A's

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positive Chlamydia results (a sexually

returned the letter to the facility.

transmitted disease). The PO stated Patient B

The letter sent to Patient B was reviewed. The letter contained Patient A's name, address, and

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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 B. WING CA250001778 02/19/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12900 FREDERICK STREET, SUITE C PLANNED PARENTHOOD - MORENO VALLEY MORENO VALLEY, CA 92553 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) A 017 Continued From page 3 A 017 positive test results for Chlamydia (a sexually transmitted disease). The PO stated, the employee stuffing the envelopes, and then addressing them, should have verified the correct address label was going on the correct envelope. In addition, The PO stated the employee should have only handled one envelope/letter at a time. The information contained in the facility employee handbook, under Health Insurance Portability and Accountability Act (HIPAA) Privacy Statement. The information indicated the following: 1. Make sure all medical records are secure from unauthorized use. 2. Never allow an unauthorized person access to any medical records or PHI. 3. As a general matter, An individual's PHI may not be used or disclosed without proper permission.

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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 PLAI' OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 240001766 01/12/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1873 COMMERCENTER WEST** PLANNED PARENTHOOD/ORANGE & SAN BEI SAN BERNARDINO, CA 92408 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) RE: CMS 2567 01.23.15 D 000 Initial Comments D 000 Entity Reported Incident Number CA00421439 The following reflects the findings of the California PPOSBC submits that to PPOSBC's knowledge, no PHI Department of Public Health during an may have been actually been breached in this matter, abbreviated standard survey to investigate an as the receiving entity was a covered and treating entity reported incident. entity that recognized based on patient name that the document at issue was not the intended patient Entity Reported Incident Number: CA00421439 record; and furthermore, that covered/treating entity expeditiously contacted PPOSBC and expeditiously Representing the California Department of Public returned the PHI to PPOSBC via certified mail. Health: 34388-HFEN However, as reported in PPOSBC's initial report to The inspection was limited to the specific entity your facility, PPOSBC nevertheless reported this reported incident investigated and does not matter in good faith; thereby, PPOSBC respectfully represent the findings of a full inspection of the submits that this form may be inapplicable to PPOSBC facility. for this matter. However, PPOSBC respectfully submits its plan of correction to your form 2567 as follows. One deficiency was issued for entity reported incident number: CA00421439 Your CMS 2567 correspondence dated January 14, 2015 states in pertinent part: D 177 T22 DIV5 CH7 ART6-75055(b) Unit Patient D 177 The Plan of Correction for each deficiency must contain the following: Health Records a) What corrective action(s) will be accomplished for the patient(s) identified to (b) Information contained in the health records have been affected by the deficient practice. shall be confidential and shall be disclosed only b) How other patients having the potential to be affected by the same deficient to authorized persons in accordance with federal, practice be identified, and what corrective action will be taken. state and local laws. c) What immediate measures and systemic changes will be put into place to ensure that the deficient practice does not recur. d) A description of the monitoring process and positions of persons responsible for monitoring (i.e., Administrator, Director of Nursing, or other responsible supervisory personnel). How the facility plans to monitor its performance to This Statute is not met as evidenced by: ensure corrections are achieved and sustained. The plan of correction must be Based on interview and record review, the facility implemented, corrective action evaluated for its effectiveness, and it must be failed to ensure the confidential treatment of integrated into the quality assurance system. protected health information (PHI) for Patient B. Dates when corrective action will be completed. The corrective action when a medical assistant (MA 1) inadvertently completion date must be acceptable to the Department. The deficient practice should be corrected immediately. This date shall be no more than 30 calendar scanned a release form into the medical record of days from the date the facility was notified of the non-compliance. Patient B instead of Patient A. A medical records clerk (MRC 1) then processed the release of records and mailed the medical records for Per your request, please find the following per inent Patient B to an outside entity. This failure resulted Plan of Correction. in an unauthorized release of PHI for Patient B. Licensing and Certification Division LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE JVID11 STATE FORM 6899 If continuation sheet 1 of 2

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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD/ORANGE & SAN BEI SITREET ADDRESS, CITY, STATE, ZIP CODE 1873 COMMERCENTER WEST SAN BERNARDINO, CA 92408 DIPONDER'S PLAN OF CORRECTION (EACH OGRRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG TO Continued From page 1 D 177 On December 30, 2014 at 11:50 AM, a phone interview was conducted with the Privacy and Compliance Officer (PCO) regarding an entity reported incident of a breach of PHI for Patient B, detected by the facility on November 5, 2014. The PCO stated it was an "unfortunate human error". She stated staff are trained to check the name and medical record number to make sure it is the right patient. She further stated there are policies and procedures in place to prevent this from happening, but they were not followed. During a record review it was determined Patient B, was notified via mail of the breach on November 10, 2014 of their individual PHI. During a review of the documentation contained Patient B's name, address, phone number, date of birth, age, account number, provider name and aspects of their health history. A review of the facility policy and procedure titled, "Medical Records Release," dated August, 2013, indicated, "All information contained within a patient's EMRwill be maintained in a confidential manner to protect the patient's right to confidentia		[18] [18] [18] [18] [18] [18] [18] [18]						
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PRÉFIX TAG D 177 Continued From page 1 D 177 D 177 Continued From page 1 D 177 D 177 Continued From page 1 D 177 D 177 D 177 D 177 Continued From page 1 D 177 D 178 D 177 D 17	PLANNED PARENTHOOD/ORANGE & SAN BELL							
well as mailed a written correspondence Notice to the patient at issue, said correspondence included identifying the incident at issue, said correspondence included identifying procedure of a bready and Compliance Officer (PCO) regarding an entity reported incident of a breach of PHI for Patient B, detected by the facility on November 5, 2014. The PCO stated it was an "unfortunate human error". She stated staff are trained to check the name and medical record number to make sure it is the right patient. She further stated there are policies and procedures in place to prevent this from happening, but they were not followed. During a record review it was determined Patient B, was notified via mail of the breach on November 10, 2014 of their individual PHI. During a review of the documentation mailed to the outside entity in error, the documentation contained Patient B's name, address, phone number, date of birth, age, account number, provider name and aspects of their health history. A review of the facility policy and procedure titled, "Medical Records Release," dated August, 2013, indicated, "All information contained within a patient's EMR. will be maintained in a confidential manner to protect the patient's right to confidentiality" The failure to verify the correct patient and their medical records prior to mailing resulted in the unauthorized release and breach of PHI for	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE	
trained/retrained on security and privacy of PHI, and PHI process(es). Specific trainings to specific staff are	D 177	Finding: On December 30, 2 interview was cond Compliance Officer reported incident of detected by the fact. The PCO stated it verror". She stated is name and medical is the right patient. policies and proced from happening, but During a record rev. B, was notified via a November 10, 2014. During a review of the outside entity in contained Patient Enumber, date of bir provider name and A review of the facil "Medical Records Findicated, "All inform patient's EMRwill confidential manne to confidentiality" The failure to verify medical records pri	2014 at 11:50 AM, a phone ucted with the Privacy and (PCO) regarding an entity f a breach of PHI for Patient B, ility on November 5, 2014. was an "unfortunate human staff are trained to check the record number to make sure it She further stated there are dures in place to prevent this at they were not followed. View it was determined Patient mail of the breach on 4 of their individual PHI. Ithe documentation mailed to a error, the documentation B's name, address, phone th, age, account number, aspects of their health history. Ility policy and procedure titled, Release," dated August, 2013, mation contained within a be maintained in a r to protect the patient's right of the correct patient and their for to mailing resulted in the		well as mailed a written correspondence N patient at issue; said correspondence inclufying the incident at issue, identifying PP mitment to patient privacy and security PPOSBC"s commitment to retraining and of staff at issue; as well as contact informatic credit reporting agencies, and contact infor PPOSBC's Privacy Officer in the event patito further communicate regarding this recorrespondence to patient was previously your facility and is again attached. (b), (c), (d), and (e): PPOSBC takes this matter very seriously be matter at issue and regarding other patient PPOSBC continues with quality assurance retrain and re-train all staff on manage protection of protected health informate PPOSBC conducts on-going quality assurance. PHI trainings, with both patient services PPOSBC other staff. PHI training includes in-depth training at convention of protected and risk matter in the specific matter. PPOSBC also complete ongoing PHI compliance and risk materials, including the annual all-state completed during October 2014; and further during July 29, 2014, and July 30, 2014 services staff. Please find previously enclosed copies of agendas for ongo services, and all-staff PPOSBC compliance, PHI training. PPOSBC has a proactive programment of the process of seen and privacy by clinical, and non-clinical staff are trained/retrained on security and privacy	otice to the uded identi-OSBC com- as well as counseling on for three mation for ient wished natter. Said provided to both for the ats. Thereby, measures to ement and ation (PHI). Ince focused as staff, and conset of hire as; as well as involved in as pro-active nanagement aff training ner trainings for patient y-submitted ing patient privacy and train vehere- proactively of PHI, and	S	

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California Department of Public Health

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D 177 Continued From page 2	2		on-going training as well as any applicable as warranted. Also attached are relepreviously submitted policies regarding coprivacy, PHI, and records release process. In reviewing the matter at issue, PPOSBC good faith that applicable robust training tinent policies were implemented proacconsistently irrespective of this matter; and at issue was an inadvertent, human-errequiring retraining and counseling of specissue as described. Nevertheless, as state has further retrained and counseled stainport of the privacy and security of PHI a processes (please kindly again note by taining agendas and programs copies hereto). Both the PPOSBC medical record the PPOSBC MA at issue have also receiv retraining and counseling on agency propolicies required for release of records verifying correct patient data and identificach stage of said process Also as part of PPOSBC's commitment assurance processes, PPOSBC will continuon on-going robust trainings at all applications includes not only a full compliance training at inception of employment, and at departmental levels, but also, ongoing all-staff trainings as exemplified by implemented annual PPOSBC Complian Management All-Staff training program cowith the 2014 annual program (a paper coporgram is also attached hereto). Applicable supervisory staff for ongoing training of compliance include PPOSBC management staff, PPOSBC Administrative in staff, PPOSBC Information Technology mastaff, and PPOSBC Patient Services management staff, and	evant and ompliance, ing. submits in son pertively and the matter or matter iffic staff at d., PPOSBC iff on the individual related the several attached is clerk and including fication at to quality to to focus able levels. It is applicable "Annual," the newly ce & Risk in mencing by of which compliance in an agement in an agement in a submit an agement in a submit an agement in a submit an a s

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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: A. BUILDING: COMPLETED C B. WING 240001766 10/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1873 COMMERCENTER WEST PLANNED PARENTHOOD/ORANGE & SAN BEI SAN BERNARDINO, CA 92408 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 TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 000 Initial Comments RE: CDPH Intake File Number: CA00460847 10/12/15 D 000 The following reflects the findings of the California "The Plan of Correction for each deficiency must Department of Public Health during an contain the following: investigation of a Community Clinic reported incident. a) What corrective action(s) will be accomplished for the patient(s) identified to Entity Reported Incident number: CA00460847 have been affected by the deficient practice." Representing the California Department of Public Health: HFEN 35290 a): The patient at issue was contacted by PPOSBC informing patient of the incident, that PPOSBC The inspection was limited to the specific incident would investigate said incident and remediate reported, and does not represent the findings of a (please see copy of PPOSBC written full inspection of the facility. correspondence to (1 patient at issue attached hereto and incorporated herein One deficiency was issued as a result of entity reported event: CA00460847 (Name and Address of patient redacted four privacy; a non-redacted copy of said letter was D 177 T22 DIV5 CH7 ART6-75055(b) Unit Patient D 177 provided to at CDPH or about Health Records October 12, 2015). Patient was provided full contact information at PPOSBC for any additional (b) Information contained in the health records questions or concerns at patient's discretion. To shall be confidential and shall be disclosed only concretely ensure ongoing safety and privacy of to authorized persons in accordance with federal. patient's protected health information, PPOSBC state and local laws. R.N. staff member at issue was also promptly counseled and retrained by the agency Compliance Officer and by the agency Director of This Statute is not met as evidenced by: Quality Management on or about September 28. Based on interview and record review, the facility 2015 and September 29, 2015. Said PPOSBC R.N. failed to ensure the confidential treatment of staff member at issue also re-completed the protected health information (PHI) for Patient A, when a progress note for Patient A that contained agency compliance annual training on or about PHI, was faxed to an incorrect FAX number. This October 2, 2015 (please see copy of proof of resulted in the unauthorized release of Patient A's training of R.N. for both 2014, and 2015 PHI to an unauthorized entity. PPOSBC annual Compliance Training or protected health information/HIPAA, attached Findings: hereto and incorporated herein). Moreove con or about September 29, 2015, PPO During a phone interview with the Compliance Licensing and Certification Division LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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PRINTED: 10/22/2015 **FORM APPROVED** California Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING: 240001766 10/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1873 COMMERCENTER WEST PLANNED PARENTHOOD/ORANGE & SAN BEI SAN BERNARDINO, CA 92408 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 REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) thoroughly evaluated said facsimile machine D 177 Continued From page 1 D 177 10/12/15 functions for performance improvement; Officer (CO) on October 7, 2015 at 3:55 PM, the PPOSBC was able to expeditiously devise CO stated that the breach was discovered on bolstered quality assurance for said facsimile September 21, 2015, when Registered Nurse machine wherein the machine is now (RN 1) noticed the fax confirmation sheet indicated the documents were faxed to two fax programmed to prompt a user to affirmatively numbers instead of just the one for which it was approve any fax number(s) to which a user intended. intends to submit authorized facsimile transmissions. Additionally, PPOSBC case RN 1 contacted the agency where the fax was management staff members were promptly sent in error, and employees of the agency counseled and retrained on or about September advised her that the faxed documents would be 29, 2015 regarding protected health information destroyed. privacy and security, as well as use of said The documentation contained Patient A's name. updated facsimile process (please see copy of account number, date of birth, address, phone September 29, 2015 PPOSBC Case Management number, past medical history, past surgical Training Agenda, attached hereto and history, vital signs (blood pressure, heart rate, incorporated herein). height, weight, and temperature) current medication, medication/treatment prescribed, "b) How other patients having the potential negative Human Immune Deficiency Virus Antibody (HIV) test results, recent sexual history, to be affected by the same deficient practice drug use history, and family medical history. be identified, and what corrective action will be taken." A concurrent interview was conducted on October 09, 2015 at 9:45 AM with the CO and RN 1. (b): PPOSBC has a robust series of policies that When asked how the incident occurred, RN 1 staff must adhere to for optimum security and stated, "We have numbers (fax numbers) that are already pre-populated (entered previously). I pick privacy of patient protected health information. from the drop-down menu and press send The Staff is also regularly trained on said policies. confirmation sheet noted it was sent to (agency I. Pertinent said policies include: name where it was intended to be faxed) and another fax number ... There was another fax (1) Compliance Policy 200-301 PPOSBC Confidentiality number somewhere in fax machine history ... The of PHI. other fax number did not appear anywhere when I (2) Compliance Policy 200-307 PPOSBC PHI

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sent the fax."

The CO was asked about what facility or

CO stated, "Information Technology (IT)

departmental measures have been established to prevent an occurrence like this in the future. The

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Minimum Necessary Rule,

Unauthorized Access PHI,

Management 6.24

(3) Compliance Policy 200-308 PPOSBC Sanctions

(4) Patient Services Policy HIV Testing and Results



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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: A. BUILDING: COMPLETED 240001766 B. WING 10/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1873 COMMERCENTER WEST PLANNED PARENTHOOD/ORANGE & SAN BEI SAN BERNARDINO, CA 92408 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 REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 177 please see copy of September 29, 2015 PPOSBC Continued From page 3 D 177 10/12/15 Case Management Training Agenda, attached hereto and incorporated herein). An agency culture that invites reporting any suspected compliance and/or privacy matter to supervisors in any department, including but not limited to PPOSBC Human Resources Department, Patient Services Department, Administration and the Compliance Department. III. Moreover, PPOSBC supports/implements: A dedicated agency Compliance Hotline 24 hours a day 7 days a week, 365 days a year (please see a copy of said Hotline program communication to staff, attached hereto and incorporated herein). Suspension of Employment, Separation of Employment, other disciplinary processes and/or retraining and counseling for any staff that fails to follow policies and processes described herein. Accordingly, PPOSBC submits in good faith, that it implements and continues to implement robust, consistent and good faith efforts towards optimum protection of protected health information for all patients including any other patients having any potential to be affected. "c) What immediate measures and systemic changes will be put into place to ensure that the deficient practice does not recur." c): As described herein, PPOSBC has a robust series of policies that staff must adhere to for optimum security and privacy of patient

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protected health information. Staff'



California Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING 240001766 10/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1873 COMMERCENTER WEST PLANNED PARENTHOOD/ORANGE & SAN BEI SAN BERNARDINO, CA 92408 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 TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 177 regularly trained on said policies. Continued From page 4 D 177 10/12/15 . Pertinent said policies include: (1) Compliance Policy 200-301 PPOSBC Confidentiality of PHI, (2) Compliance Policy 200-307 PPOSBC PHI Minimum Necessary Rule, (3) Compliance Policy 200-308 PPOSBC Sanctions Unauthorized Access PHI, (4) Patient Services Policy HIV Testing and Results Management 6.24 (Please see copies of said policies attached hereto and incorporated herein) II. In addition to the promulgation of said policies at PPOSBC, PPOSBC also regularly trains and educates staff for optimum privacy and security of protected health information. Ongoing training is accomplished for (i) any applicable re-training. (ii) for proactive training at inception of staff hire, and (iii) for proactive annual training, including as follows: Protected Health Information (PHI)/HIPAA in-person training at staff orientation day/hire. additional An Protected Health Information/HIPAA Online training for new staff to be additionally completed within 30 days of hire (please see copy of outline of LawRoom training module for new hires, attached hereto and incorporated herein). Proactive Patient Services staff training on Protected Health Information(PHI)/HIPAA (please see copy of July 2015 protected health information/HIPAA training agenda for patient services staff, attached hereto and incorporated herein).

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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 240001766 10/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1873 COMMERCENTER WEST PLANNED PARENTHOOD/ORANGE & SAN BEI SAN BERNARDINO, CA 92408 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) Proactively calendared Annual All-Staff Training D 177 Continued From page 5 D 177 10/12/15 on Compliance Policies and Procedures that include protected health information (PHI)/HIPAA (please see copies of excerpts of 2014 and 2015 Annual PPOSBC Compliance Trainings, attached hereto and incorporated herein). Expeditious evaluation and remediation of the functionality of the facsimile machine at issue as described herein. Further expeditious retraining to case management staff on protected health information privacy and security, as well as updated training on facsimile use as described herein (please see copy of September 29, 2015) PPOSBC Case Management Training Agenda, attached hereto and incorporated herein). An agency culture that invites reporting any suspected compliance and/or privacy matter to supervisors in any department, including but not limited to PPOSBC Human Resources Department, Patient Services Department, Administration and the Compliance Department. III. Moreover, PPOSBC supports/implements: A dedicated agency Compliance Hotline 24 hours a day 7 days a week, 365 days a year (please see a copy of said Hotline program communication to staff, attached hereto and incorporated herein). Suspension of Employment, Separation of Employment, other disciplinary processes and/or retraining and counseling for any staff that ails to follow policies and processes described herein. IV. As further, additional measures: PPOSBC employs a chief Compliance Officer, chief HIPAA Privacy Officer, and chi

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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: A. BUILDING: COMPLETED C 240001766 B. WING 10/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1873 COMMERCENTER WEST PLANNED PARENTHOOD/ORANGE & SAN BEI SAN BERNARDINO, CA 92408 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 177 Continued From page 6 D 177 Security Officer to review PPOSBC systems for 10/12/15 additional compliance and quality improvement as applicable. (i) One immediate result herein is the updating of applicable agency process (es) to include an agency enterprise-wide Compliance, Quality & 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) Also resulting is bolstered agency HIPAA Security processes including software programs designed to detect potential systems intrusions and/or unauthorized attempted access. (iv) PPOSBC has also installed a Chief Operating Officer who regularly collaborates with the Compliance Officer, HIPAA Privacy Officer, HIPAA Security Officer, VP of HR. PPOSBC Medical Director, Patient Services Management Staff, and the Office of the CEO, to directly oversee ongoing training of agency health center staff, both licensed and non-licensed. • PPOSBC also commits to a long-term plan to continue to review applicable agency policies and training for optimum quality and compliance. PPOSBC also commits to optimum protection of patient privacy and security, and compliance with regulatory and agency standards. Accordingly, PPOSBC submits in good faith, habit implements and continues to implement robust consistent and good faith efforts towards optimum protection of protected health information for all patients including any other patients having potential to be affected.

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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: A. BUILDING: COMPLETED C B. WING 240001766 10/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1873 COMMERCENTER WEST PLANNED PARENTHOOD/ORANGE & SAN BEI SAN BERNARDINO, CA 92408 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Thereby, PPOSBC further submits in good faith D 177 Continued From page 7 D 177 10/12/15 that it is taking, and has taken notable measures to ensure that the CDPH described deficiencies that CPDH sets forth for Complaint Number CA00460847, do not recur. "d) A description of the monitoring process and positions of persons responsible for monitoring (i.e., Administrator, Director of Nursing, or other responsible supervisory personnel). How the facility plans to monitor its performance to ensure corrections are achieved and sustained. The plan of correction must be implemented, corrective action evaluated for its effectiveness, and it must be integrated into the quality assurance system. e)Dates when corrective action will be completed. The corrective action completion date must be acceptable to the Department. The deficient practice should be corrected immediately. This date shall be no more than 30 calendar days from the date the facility was notified of the non-compliance." d) and e): As noted in above-referenced section (c) in detail, PPOSBC has a robust series of policies that staff must adhere to for optimum security and privacy of patient protected health information. Staff is also regularly trained on said policies. I. Pertinent said policies include: (1) Compliance Policy 200-301 Confidentiality of PHI, (2) Compliance Policy 200-307 PPOSBC PHI Minimum Necessary Rule, (3) Compliance Policy 200-308 PPO

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D 000	Initial Comments		D 000	a) What corrective action(s) will be accomplished for the patient(s) identified to	10/1/16	
	Department of Pub	ets the findings of the California lic Health during an ommunity Clinic reported		have been affected by the deficient practice. PPOSBC respectfully submits it was not deficient in practice but rather, was required to		
		ident number: CA00488868		mitigate, remediate and address behavior by then-staff that was fully noncompliant with established PPOSBC policies. PPOSBC previously	4	
	Representing the C Health: 34959	California Department of Public		had and continues to have established policies and training on protected health information security and privacy, effective both prior to the		
ì		s limited to the specific incident not represent the findings of a e facility.		incident at issue and continuing after the incident at issue. Nevertheless, and in good faith, PPOSBC corrective action plans include (1)		
	One deficiency was reported event: CA	s issued as a result of entity 00488868	20	investigating and verifying the limited nature of the information at issue and establishing the patient information at issue was illegible and did not contain or set forth detailed medical or		
D 177	T22 DIV5 CH7 AR Health Records	T6-75055(b) Unit Patient	DAR	protected heatlh information, (2) notifying the patients at issues by individual phone calls by PPOSBC (3) notifying the patients by individual	i	
	shall be confidentia	Italined in the health records at and shall be disclosed only ons in accordance with federal,	Medi	written notifications by PPOSBC, (4) by expeditiously separating the noncompliant staff at issue from employment with PPOSBC (5) by		
	State and local law	5.	The state of the s	contacting Upland police department to request additional law enforcement measures against the noncompliant staff at issue (6) by completing		
	Based on interview failed to protect the	met as evidenced by: y and record review, the facility e confidential medical	M. Carrier	additional training with staff for optimum mitigation of future noncompliance by any remaining staff.		
	C, D, E, F, G, H, I, S), when the Medi assists a qualified clinical settings) se	for 19 patients (Patients A, B, J, K, L, M, N, O, P, Q, R, and cal Assistant (MA) (one who physician in an office or other ent a text message to her hrough the phone that		(b) How other patients having the potential to be affected by the same deficient practice by identified, and what corrective action will be taken.		
	contained Patients L, M, N, O, P, Q, F information (CMI),	A, B, C, D, E, F, G, H, I, J, K, and S confidential medical resulting in a breach of		PPOSBC respectfully submits it was no deficient in practice but rather, was required to mitigate, remediate and address sehavior by the	gcans	
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PRINTED: 09/28/2016 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 240001766 09/21/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1873 COMMERCENTER WEST PLANNED PARENTHOOD/ORANGE & SAN BEI SAN BERNARDINO, CA 92408 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) staff at issue who was fully noncompliant with D 177 Continued From page 1 D 177 10/1/16 established PPOSBC policies. PPOSBC previously Patients A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, had and continues to have established policies P, Q, R, and S's CMI. and training on protected health information security and privacy, effective both prior to the During a phone interview on June 2, 2016 at 9:48 incident at issue and continuing after the AM, with the Assistant Manager (AM), when incident at issue. Additionally, the information at asked if she knew MA's boyfriend since she said issue was limited, illegible and did not contain it came from an anonymous source, but the text detailed medical or protected health information. had been sent to her phone number, she denied Moreover, this was a limited set of patients at issue. Therefore, there is no current potential for any other patients to be identified as potentially During a phone interview on June 2, 2016 at affected by the practice at issue. However, and 11:00 AM, with the AM, she stated that she nevertheless, as described in subsection (a), received an anonymous text screen shot to her PPOSBC corrective action plans included (1) cell phone that showed the scheduled investigating and verifying the limited nature of appointments for the 19 patients that included: the information at issue (2) notifying the Patients first and last name, medical record patients at issues by individual phone calls by number and the reason for the visit. The screen shot included the name and phone number of the PPOSBC (3) notifying the patients by individual written notifications by PPOSBC, (4) by MA as it appeared when the MA sent it to the person who reported it to the AM. expeditiously separating the noncompliant staff at issue from employment with PPOSBC (5) by During a phone interview on September 15, 2016 contacting Upland police department to request at 5:22 PM, with the General Counsel (GC), she additional law enforcement measures against stated that the MA sent a text to her boyfriend to the noncompliant staff at issue (6) by completing

first she lost her phone, then stated she left her phone behind with her partner." A review of the copies of the letters provided by the facility that were sent to patients to notify them that their medical information was breached was conducted. The letter were individually addressed to Patients A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, and S, and informed each

of them that their personal information to include

show him what her schedule was for the day. The

text was a snap shot of the white board sent from

MA's cell phone which included: patients names,

date, and the reason the patients had an

appointment at the facility, for example: a headache. "When I interviewed MA she stated at

> PPOSBC respectfully submits it was not deficient in practice but rather, was required to mitigate, remediate and address behavior by the staff at issue who was fully noncompliant with established PPOSBC policies. PPOSBC previously had and continues to have established policies

> additional training with staff at the center site at

issue for optimum mitigation of future

noncompliance by any remaining staff at the

C) What immediate measures and systemic

changes will be put into place ensure that the

PPOSBC center at issue.

deficient practice does not recur.

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION	(X3) DATE	
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D 177	Continued From page 2	D 177	and training on protected health information security and privacy, effective both prior to the	10/1/16
	their reason for their appointment at the facility,		incident at issue and continuing after the	
	had been breached.		incident at issue. Additionally, the information at	
	A B B B B B		issue was limited, illegible and did not contain or	
İ	During a review of the copy of the Separation		set forth any level of detailed medical or	
	Notice dated May 4, 2016, provided by the facility		protected health information. Moreover, this	
	that was given to the MA indicated: "Termination		was a limited set of patients at issue. Therefore,	
ı	notice pursuant to the provisions of 22 Code of		there is no current potential for any recurrence.	
	Regulations Section 1089-1 of the California		However, and nevertheless, as described in	
	Unemployment of Insurance Code. This will notify		subsection (a), PPOSBC institued quality	
	you a change in you employment status due to		assurance and quality improvement measures,	
	discharge."		and corrective action plans that included (1)	
-	During a review of the copy of the HIPAA/Privacy		investigating and verifying the limited nature of	
	and Security Recap. Training dated March 23,		the information at issue (2) notifying the	
	2016, provided by the facility indicated by the		patients at issues by individual phone calls by	
	MA's signature that she was aware of maintaining		PPOSBC (3) notifying the patients by individual	
	confidentiality of patient information.		written notifications by PPOSBC, (4) by	
			expeditiously separating the noncompliant staff	
	The facility's policy and procedure entitled [Name		at issue from employement with PPOSBC (5) by	
	of Facility] Sanctions for Unauthorized Access,	8	contacting Upland police department to request	
	Use and /or Disclosures of Protected Health		additional law enforcement measures against	
	Information, dated February 4, 2015, indicated,		the noncompliant staff at issue (6) by completing	
	"Accessing a patient's medical record/Personal		additional training with staff at the center site at	
	health information for any purpose outside of		issue for optimum mitigation of future	
	treatment, payment, health care operations, job/service duties and/or Health Insurance		noncompliance by any remaning staff at the	
	Portability and Accountability Act (HIPAA) (a 1996		PPOSBC center at issue. Moreover (7) PPOSBC	. 1
	Federal law that restricts access to individuals		has expanded its policies on cell	
	private medical information) (minimum necessary		phone/electronic device use to require	
	standards. Accessing, using and / or disclosing		non-clinician staff to secure any such personal	
	personal health information out of curiosity or for		devices in containers and lockers during work	83.5
	any purpose outside of treatment, payment,		time periods. Additionally, (8) PPOSBC provided	
	health care operations, job/service duties and / or		multiple trainings on its policies on protected	
	Health Insurance Portability and Accountability		health information privacy and security both pre	
	Act minimum necessary standards."		and post the incident date of February 14, 2016	
	*		including on or about July 22, 2015, November	
	7		10, 2015, January 5, 2016, March 23, 2016, April	
			27, 2016, May 12, 2016, June 21, 2016 and currently again in October 2016 FFOS30	
			thereby respectfully submits it implemented	Tu

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further administer and monitor this plan for any core compliance, added training and any required disciplinary process measures. As described above, the fully implemented plan includes (1) investigating and verifying the limited nature of the information at issue to better assess any root cause and better plan an appropriate corrective action plan (2) monitoring

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER PLANNED PREVIDER OR SUPPLIER STREET ADDRESS CITY, STATE, JP CODE 1873 COMMERCENTER WEST SAN BERNARDINO, CA 92408 PREVIDENCIES OF THE WEST AND ENANT STATEMENT OF DEFICIENCIES PAGE DEFICIENCY WAST SEP PRECEDED BY PLUL PREVIDENCIES OF THE WEST AND ENANT OF CORRECTION THE CONTINUED PREVIDENCIES OF THE WEST AND ENANTHORN OF CORRECTION PREVIDENCIES OF THE WEST AND ENANTHORN OF CORRECTION BY COMMERCENTER WEST AND ENANTHORN OF CORRECTION PREVIDENCIES OF THE WEST AND ENANTHORN OF CORRECTION BY COMMERCENTER	Californi	a Department of Put	olic Health				
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individual phone calls by PPOSBC (3) monitoring and ensuring notice to the patients at issue by individual written notifications by PPOSBC, (4) by effectively expeditiously separating the noncompilant staff at issue from employment with PPOSBC (5) by coordinating with Upland police department to request additional law enforcement measures against the noncompilant staff at issue (6) by completing additional training with staff at the center site at issue for optimum mitigation of future noncompilance by any remaining staff at the PPOSBC center at issue. Moreover (7) PPOSBC has expanded it is policies on cell phone/electronic device use to require non-clinician staff to secure any such personal devices in containers and lockers during work time periods. Additionally, (8) PPOSBC provides multiple trainings on its policies on protected health information privacy and security both pre and post the incident dated of February 14, 2016, including on or about July 22, 2015, November 10, 2015, January 5, 2016, March 23, 2016, April 27, 2016, May 12, 2015, March 23, 2016, April 27, 2016, May 12, 2015, and June 21, 2016. PPOSBC will continue to monitor, train on, and address compliance and quality assurance for agency guidelines on privacy and security of protected health information including agency training also in October 2016. Compliance trainings are also scheduled for all staff at hire, and again annually each October. By this plan and these processes, PPOSBC respectfully submits that is has and continues to monitor; this plan and these processes, PPOSBC respectfully submits that is has and continues to monitor; be implemented, and the corrective actions are evaluated for effectiveness, and integrated into	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	
I line quality assurance and compliance dy force 110 of 100	D 177	Continued From pa	ge 4	D 177	and ensuring notice to the patients a individual phone calls by PPOSBC (3) nand ensuring notice to the patients a individual written notifications by PPO effectively expeditiously separated noncompliant staff at issue from enwith PPOSBC (5) by coordinating with police department to request additenforcement measures again noncompliant staff at issue (6) by additional training with staff at the certissue for optimum mitigation noncompliance by any remaining st PPOSBC center at issue. Moreover (1) has expanded its policies phone/electronic device use to non-clinician staff to secure any suc devices in containers and lockers detime periods. Additionally, (8) PPOSB multiple trainings on its policies on health information privacy and securitand post the incident dated of Fe 2016, including on or about July November 10, 2015, January 5, 2016, 2016, April 27, 2016, May 12, 2016, at 2016. PPOSBC will continue to monitor and address compliance and quality for agency guidelines on privacy and protected health information including training also in October 2016. Outrainings are also scheduled for all stand again annually each October. Be and these processes, PPOSBC submits that is has and continues to performance to ensure corrections a and sustained its plan of continuely entered the corrective stands and sustained its plan of continuely entered the corrective stands and sustained its plan of continuely entered the corrective stands and sustained its plan of continuely entered the corrective stands and sustained its plan of continuely entered the corrective stands and sustained its plan of continuely entered the corrective stands and sustained its plan of continuely entered the corrective stands and sustained its plan of continuely entered the corrective stands and sustained its plan of continuely entered the corrective stands.	nonitoring it issue by SBC, (4) by ing the aployment the Upland it the completing intersite at the completing work on cell in require the personal uring work or protected the personal uring assurance security of ing agency of compliance taff at hire, by this plan respectfully monitorities actions are grated into a personal uring a plan respectfully monitorities actions are grated into a personal uring a plan respectfully monitorities actions are grated into a personal uring a plan respectfully monitorities actions are grated into a personal uring a plan respectfully monitorities actions are grated into a personal uring a plan respectfully monitorities actions are grated into a personal uring a plan respectfully monitorities actions are grated into a plan respectfully monitorities are actions are grated into a plan respectfully monitorities actions are grated into a plan respectfully monitorities.	

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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: A. BUILDING: COMPLETED C B. WING 240001766 09/21/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1873 COMMERCENTER WEST PLANNED PARENTHOOD/ORANGE & SAN BEI SAN BERNARDINO, CA 92408 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) Dates when corrective action will be Continued From page 5 D 177 D 177 10/1/16 completed. The corrective action completion date must be acceptable to the Department. The deficient practice should be corrected immediately. This date shall be no more than 30 calendar days from the date the facility was notified of the non-compliance. The incident at issue was reported in May 2016. The date of this notice form 2567 is September 28, 2016. PPOSBC recieved said notice on or about October 5, 2016. 30 calendar days from the date listed on the written notice is on or about October 27, 2016. Since PPOSBC self-reported the incident to CDPH on or about May 16, 2016 and commenced its correction action plan at that time, PPOSBC has since completed that action plan completed October 1, 2016. Therefore, PPOSBC has timely and compliantly completed implementation of the corrective action plan described in this response. Thank you.

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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: A. BUILDING: COMPLETED C B. WING 240001766 10/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1873 COMMERCENTER WEST PLANNED PARENTHOOD/ORANGE & SAN BEI SAN BERNARDINO, CA 92408 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 TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 000 Initial Comments RE: CDPH Intake File Number: CA00460847 10/12/15 D 000 The following reflects the findings of the California "The Plan of Correction for each deficiency must Department of Public Health during an contain the following: investigation of a Community Clinic reported incident. a) What corrective action(s) will be accomplished for the patient(s) identified to Entity Reported Incident number: CA00460847 have been affected by the deficient practice." Representing the California Department of Public Health: HFEN 35290 a): The patient at issue was contacted by PPOSBC informing patient of the incident, that PPOSBC The inspection was limited to the specific incident would investigate said incident and remediate reported, and does not represent the findings of a (please see copy of PPOSBC written full inspection of the facility. correspondence to (1 patient at issue attached hereto and incorporated herein One deficiency was issued as a result of entity reported event: CA00460847 (Name and Address of patient redacted four privacy; a non-redacted copy of said letter was D 177 T22 DIV5 CH7 ART6-75055(b) Unit Patient D 177 provided to at CDPH or about Health Records October 12, 2015). Patient was provided full contact information at PPOSBC for any additional (b) Information contained in the health records questions or concerns at patient's discretion. To shall be confidential and shall be disclosed only concretely ensure ongoing safety and privacy of to authorized persons in accordance with federal. patient's protected health information, PPOSBC state and local laws. R.N. staff member at issue was also promptly counseled and retrained by the agency Compliance Officer and by the agency Director of This Statute is not met as evidenced by: Quality Management on or about September 28. Based on interview and record review, the facility 2015 and September 29, 2015. Said PPOSBC R.N. failed to ensure the confidential treatment of staff member at issue also re-completed the protected health information (PHI) for Patient A, when a progress note for Patient A that contained agency compliance annual training on or about PHI, was faxed to an incorrect FAX number. This October 2, 2015 (please see copy of proof of resulted in the unauthorized release of Patient A's training of R.N. for both 2014, and 2015 PHI to an unauthorized entity. PPOSBC annual Compliance Training or protected health information/HIPAA, attached Findings: hereto and incorporated herein). Moreove con or about September 29, 2015, PPO During a phone interview with the Compliance Licensing and Certification Division LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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PRINTED: 02/04/2016

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 CA070000691 01/21/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 398 S GREEN VALLEY ROAD **PLANNED PARENTHOOD** WATSONVILLE, CA 95076 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 001 Informed Medical Breach A 001 Health and Safety Code Section 1280.15 (b)(2), " A clinic, health facility, agency, or hospice shall also report any unlawful or unauthorized access to, or use or disclosure of, a patient's medical information to the affected patient or the patient's representative at the last known address, no later than five business days after the unlawful or unauthorized access, use, or disclosure has been detected by the clinic, health facility, agency, or hospice." The CDPH verified that the facility informed the affected patient(s) or the patient's representative(s) of the unlawful or unauthorized access, use or disclosure of the patient's medical CALIFORNIA DEPARTMENT information. OF PUBLIC HEALTH FEB 2 6 2016 D 000 Initial Comments D 000 L& C DIVISION The following reflects the findings of the California SAN JOSE Department of Public Health during an abbreviated survey for Entity Reported Incident CA00457933 regarding Breach to Person/Entity Outside Facility/Healthcare System. Inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: 32398, Health Facilities Evaluator Nurse. The Department was unable to substantiate a violation of Federal or State regulations.

Licensing and Certification Division

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

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PRINTED: 02/20/2014

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 CA070000691 B. WING C 02/18/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 398 S GREEN VALLEY ROAD **PLANNED PARENTHOOD** WATSONVILLE, CA 95076 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE (X5) TAG COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) A 000 Initial Comments A 000 all dates refer to 2014. The following reflects the findings of the California Department of Public Health during an investigation of Entity Reported Incident CA00387919 regarding an alleged breach of CALIFORNIA DEPARTMENT patient information on 2/18/14. OF PUBLIC HEALTH Inspection was limited to the specific entity MAR 6 - 2014 reported incident investigated and does not represent the findings of a full inspection of the L & C DIVISION SAN JOSE Representing the California Department of Public Health: 29328, Health Facilities Evaluator Supervisor. The following is Planned Parenthood Mar Monte's (PPMM's) response to the Department's request for a Facility detected the breach of patient health Plan of Correction with respect to Entity Reported information on 2/7/14. Facility reported the breach Incident CA00387919 (CMS 2567) enclosed in CDPH of patient health information to the Department on letter dated February 20, 2014 concerning an incident 2/14/14. Facility notified patient of the breach of at PPMM's Watsonville Health Center (Watsonville) that was reported to CDPH on February 13, 2014 patient health information on 2/11/14. (CDPH Report). A 001 Informed Medical Breach Deficiency cited as not complying with Cal Health & A 001 Safety Code 1280.15(6) (facility failed to prevent Health and Safety Code Section 1280.15 (b)(2), unauthorized disclosure of Patient 2's protected health information (PHI) because Staff A mistakenly put " A clinic, health facility, agency, or hospice shall Patient 2's label on a prescription intended for Patient also report any unlawful or unauthorized access 1, Staff B gave that prescription to Patient 1's mother, to, or use or disclosure of, a patient's medical and neither staff member followed PPMM's information to the affected patient or the patient's procedures for checking the PHI matched the patient). representative at the last known address, no later than five business days after the unlawful or (a) Corrective actions to be accomplished for the 2/11, 2/13 unauthorized access, use, or disclosure has been affected patient: detected by the clinic, health facility, agency, or One of Watsonville's supervisors called Patient 2 on hospice." February 11, 2014, explaining the mistake and apologizing for the error. On February 13, 2014, The CDPH verified that the facility informed the PPMM's Compliance Officer also sent Patient 2 the letter required by 1280.15. CMS 2567 does not note affected patient(s) or the patient's any deficiency concerning PPMM's com nincton representative(s) of the unlawful or unauthorized with Patient 2. access, use or disclosure of the patient's medical information. Licensing and Certification Division LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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PRINTED: 02/20/2014 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: A. BUILDING: COMPLETED C CA070000691 B. WING 02/18/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 398 S GREEN VALLEY ROAD PLANNED PARENTHOOD WATSONVILLE, CA 95076 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) all dates refer to 2014 A 001 Continued From page 1 A 001 A 017 | 1280.15(a) Health & Safety Code 1280 A 017 (b) Identification of other patients potentially affected by the same deficient practice and corrective NIA (a) A clinic, health facility, home health agency, or action to be taken: hospice licensed pursuant to Section 1204. PPMM has not identified other patients potentially 1250, 1725, or 1745 shall prevent unlawful or affected in this instance. unauthorized access to, and use or disclosure of, patients' medical information, as defined in (c) Immediate measures and systemic changes that subdivision (g) of Section 56.05 of the Civil Code 2/14, 2/18, will be put in place to ensure that deficient practice and consistent with Section 130203. The does not recur: . 2/27 department, after investigation, may assess an Staff B no longer works at PPMM as of February 14, administrative penalty for a violation of this 2014. On February 18, 2014, the Watsonville center section of up to twenty-five thousand dollars manager reviewed at the center-wide staff meeting (\$25,000) per patient whose medical information the PHI-checking procedures and forms when the was unlawfully or without authorization accessed. electronic system is not working (since disclosure used, or disclosed, and up to seventeen occurred because the standard prescription-writing thousand five hundred dollars (\$17,500) per process was not working). On February 27, 2014, the center manager also gave Staff A a copy of PPMM's subsequent occurrence of unlawful or policy about reasonable safeguards to protect PHI unauthorized access, use, or disclosure of that (Privacy Manual Policy 4) and the most recent version patients' medical information. For purposes of the of PPMM's New Hire Orientation privacy presentation, investigation, the department shall consider the which she acknowledged in writing on that date that clinic's, health facility's, agency's, or hospice's she read, understood, and would follow. history of compliance with this section and other related state and federal statutes and regulations, (d) Monitoring Process/Quality Assurance 3/28 the extent to which the facility detected violations On February 24, 2014, Watsonville center manager (or and took preventative action to immediately designee) began randomly spot-checking Staff A for correct and prevent past violations from recurring, consistent use of PPMM's PHI-checking procedure and and factors outside its control that restricted the will conclude on March 28, 2014, which point the facility's ability to comply with this section. The center manager will determine whether additional department shall have full discretion to consider monitoring is necessary. all factors when determining the amount of an administrative penalty pursuant to this section.

Licensing and Certification Division

This Statute is not met as evidenced by:

Based on interview and facility document review,

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STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE	SURVEY
		CA070000691	B. WING		I	C 19/204 #
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	1 02/	18/2014
PLANNE	D PARENTHOOD	398 S GR	EEN VALLEY VILLE, CA 9:	'ROAD		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF COR	DECTION	
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A 017	Continued From pa	ge 2	A 017			
	or patients' medical	revent unauthorized disclosure information when Patient 2's PHI) was mistakenly given to				
	Findings:					
	Patient 1's family me prescription with Pat	reived a self-reported incident ort revealed that on 2/5/14, ember mistakenly received a cient 2's PHI. Patient 1's ned the prescription to the				
	the self-reported inciprescription had Pati insurance and medic stated the clinic repo Department on 2/14/	cal record number. She rted the incident to the 14. The clinic called Patient at him a written notification				
2	2/13/14 indicated the	s letter to Patient 2 dated facility called Patient 2 on ident and explained how his given to Patient 1.				
					S	2
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Licensing and Certification Division

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	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AIŞDELAN	OF CONNECTION	IDENTIFICATION NUMBER.	A. BUILDING:	EPARTMENT	OOIWII EETED
			D. WINO	C HEALTH	C
		CA070000691	B. WING	MAD & ARES	12/04/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	STATE, ZIP CODEMAR 0 6 2015	
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A 001	Informed Medical E	Breach	A 001	The following is Planned Parenthood	
,,,,,,	inionino iniodiodi i	3104011		Monte's PPMM's response to the Department	
		Code Section 1280.15 (b)(2),		request for a Plan of Correction with a	-
		cility, agency, or hospice shall		Entity Reported incident CA0041957	1
		awful or unauthorized access		in CDPH letter dated December 15, 2	
		sure of, a patient's medical affected patient or the patient's		received by by PPMM's AVP of HR &	·
		ne last known address, no later		Officer on February 20, 2015 concern	1
•	than five business	days after the unlawful or		incident at the Watsonville Health Ce	
		ss, use, or disclosure has been		October 31, 2014, that was reported to	l .
	hospice."	nic, health facility, agency, or		on November 7, 2014. Deficiency cite	
	nospice.	•		complying with Cal. Health and Safet	*
		I that the facility informed the		1280.15(b)(2) clinic failed to prevent unauthorized disclosure of patient hea	
	affected patient(s)			information (PHI) for one of two sam	
		of the unlawful or unauthorized closure of the patient's medical		patients (1) when Patient 1's PHI was	- I
	information.	closure or the patients medical		inadvertently mailed to another patien	
				made of the manual seasons pursues	
A 000			A 000	(a) Corrective actions to be accomplis	hed for the
A 000	Initial Comment		A 000	affected patient:	
	The following refle	ects the findings of the California		On October 31/2014, CASX observe	d employee
		blic Health during the		twice at separate times during the after	HIOOII
	conducted on 12/4	entity reported incident		demonstrating the checks she does to	make sure
	Conducted on 12/2	,		that the name and address on the enve	clope matches
		ed Incident CA00419571,		the name and address on the contents	
		onitoring, Privacy Breach to		times she performed the checks corre	ctly.
		ealthcare System, one State entified (see California Health			
	1	Section 1280.15(a)).		(b) Identification of other patients pot	entially
				affected by the same deficient practice	and
		nited to the specific entity		corrective action to be taken:	
		investigated and does not ings of a full inspection of the			
	hospital.	ingo o, a ran mopronen er ere		PPMM has not identified other patien	ts potentially
				affected in this instance.	
		California Department of Public ealth Facilities Evaluator Nurse.			Imorioons
	пеанн. 52390, П	tailis i aciiilies Evalualoi muise.		<u> </u>	Americans
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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
	CA070000691	B. WING	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

398 S GREEN VALLEY ROAD

	D PARENTHOOD WATSONV	ILLE, CA 9	95076	
(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 000	Continued From page 1	A 000	(c) Immediate measures and systemic changes	
	The clinic detected the Breach of Patient's Health Information (PHI) on 10/31/14. The clinic reported the Breach of PHI to the Department on 11/7/14. The clinic notified Patient 1 of the Breach of PHI on 11/4/14 via telephone and on 11/7/14 via mail. 1280.15(a) Health & Safety Code 1280 (a) A clinic, health facility, home health agency, or hospice licensed pursuant to Section 1204, 1250, 1725, or 1745 shall prevent unlawful or unauthorized access to, and use or disclosure of, patients' medical information, as defined in subdivision (g) of Section 56.05 of the Civil Code and consistent with Section 130203. The department, after investigation, may assess an administrative penalty for a violation of this section of up to twenty-five thousand dollars (\$25,000) per patient whose medical information was unlawfully or without authorization accessed, used, or disclosed, and up to seventeen thousand five hundred dollars (\$17,500) per subsequent occurrence of unlawful or unauthorized access, use, or disclosure of that patients' medical information. For purposes of the investigation, the department shall consider the clinic's, health facility's, agency's, or hospice's history of compliance with this section and other related state and federal statutes and regulations, the extent to which the facility detected violations and took preventative action to immediately correct and prevent past violations from recurring, and 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.	A 017	that will be put in place to ensure that deficient practice does not recur: Beginning November 7, 2014, CM or designee will conduct random audits of outgoing results via mail before envelopes are sealed for a period of 30 days. CM or designee will ensure that there will be additional training/monitoring for any staff who fail the random audits. (d) Monitoring Process/Quality Assurance CM or designee will conduct the same audit as described in (c) above during the following 3 months. (e) Date corrective action will be completed. February 28, 2015	Sican
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ATE FOR	RM	6899	for I	ation sheet 2

PRINTED: 12/15/2014 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 CA070000691 12/04/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 398 S GREEN VALLEY ROAD **PLANNED PARENTHOOD** WATSONVILLE, CA 95076 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A 017 A 017 Continued From page 2 This Statute is not met as evidenced by: Based on interview and record review, the clinic failed to prevent the unauthorized disclosure of patient health information (PHI) for one of two sampled patients (1), when Patient 1's PHI was inadvertently mailed to another patient. The failure resulted in the disclosure of Patient 1's PHI to an unauthorized individual. Findings: The California Department of Public Health received a faxed report on 11/7/14, which indicated on 10/21/14. Patient 1's laboratory test results which disclosed Patient 1's name, date of birth, address, sex, and person number (similar to a medical record number, a patient identifier), had been inadvertently mailed to Patient 2 who then brought it back to the clinic. A clinic internal investigation revealed Patient 2 received a letter from the clinic and opened it on 10/31/14. Patient 2 looked at the name on the laboratory test result documents, and saw the test results did not belong to her. She placed the test results back into the envelope, brought it back to the clinic, as she wanted her own information. The clinic staff took the letter and envelope and gave Patient 2 her own information. The internal investigation also revealed the primary care coordinator (PCC) had been using the clinic's electronic medical record system (EMR), and had been toggling back and forth between information for Patient 1 and Patient 2. PCC sent the information about Patient 1 to the printer but must have toggled back to Patient 2 to address the envelope.

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During a telephone interview on 12/4/14 at 11:30 a.m., the privacy and compliance officer (PCO) stated a staff member was working on two things

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(prior to being translated from English) indicated Patient 1's laboratory test results were sent to another person by clinic staff, which had disclosed Patient 1's name, date of birth, address, sex, and person number. The letter also indicated a staff member inadvertently inserted Patient 1's laboratory test results into an envelope which had been addressed to Patient 2.

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PRINTED: 12/15/2014 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 CA070000691 B. WING 12/04/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 398 S GREEN VALLEY ROAD PLANNED PARENTHOOD WATSONVILLE, CA 95076 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) A 017 A 017 Continued From page 4 The letter further indicated the clinic required staff to check the name and address on the information being sent matched the name and address on the envelope, but the staff member did not match them. Review of a copy of the laboratory results for Patient 1 indicated Patient 1's name, date of birth, sex, address, person number (medical record number), name and address of clinic, liver test, blood components test, electrolytes test, blood protein test, white and red blood cell counts. and cholesterol tests. Review of a copy of the clinic's 09/2013 "Reasonable Safeguards Against Privacy Breaches" policy indicated staff who prepare patient mailings should double-check that the name and address on the documents to be sent match the name and address on the envelope.

Licensing and Certification Division STATE FORM

California Department of Public Health					FORM.	APPROVED
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		sents the finding of the ent of Public Health during the emplaint.				
	Complaint Number:	CA00425037				
	Representing the D HFES 25205.	epartment: HFEN 25206 and				
	complaint investigat	limited to the specific ted and does not represent inspection of the facility.				
	Three deficiencies vinvestigation.	were written as a result of the				
	The following definit	tions are included for clarity.				
	used by doctors to e	ound: a type of ultrasound examine female reproductive a probe into the vagina.				
	extraction from its m	the complete expulsion or nother of a fetus or embryo; of any other product of				
	successful. The pre- will develop, but the	: an abortion that was partially gnancy has ended-no fetus body has only expelled part oducts of pregnancy.				
	surgical procedure of first-trimester misca	s dilation and curettage, is a often performed after a rriage. In a D&C, dilation e cervix; curettage refers to ofte of the uterus.			S	S

Licensing and Certification Division

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

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	needle, tube, devic invasive procedure test, inserting a tub Medical Board of C agency that license	california (MBC): the state es medical doctors, aints, and disciplines those				
	medication which b	n: Use of a synthetic steroid clocks a hormone essary for pregnancy to				
	MA is defined unde California Medical F Professions Code s Assistants means a unlicensed who per clerical, and technic functions under the physician and physician and physician and physician and physician clinic setting. "Me allowed to perform placing the needle of disconnectingan I line]administering	V[intravenous medications or injections into g a urine catheterusing				
	routine medical task be safely performed has limited training. Code §2069.) Unlicensed Assistive	we services means simple ks and procedures that may d by a medical assistant who" (Business a Professions e Personnel:"Refers to torkers who are not licensed to			\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	S

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D 001	perform nursing tas health care workers certified, but are no require a substantia knowledge and tecl assigned to unlicen (The California Boa	sks; it also refers to those who may be trained and tilcensedTasks which all amount of scientific notical skill may not be sed assistive personnel." In the provided Heritage of the second of the	D 001	On March 3, 2017, we reviewed standardized procedures (SPs) and deterr	1900/03/0
D 046	appliances shall be		D 046	that the following changes need to be made a. Our standardized procedures minclude, or reference specifically, information PPNorCal's existing protocols and procedures (1) how the SPs were developed approved in collaboration by the nurse practice (NPs), the supervising physicians, and the administrator of the health center; (2) the to which physician supervision is required	ust either on from ures that and uctitioners extent for
	Based on staff inter facility (Clinic 1) fails clinician, nurse pracestandardized process California laws government when ordering medifailure resulted in the law not being for potential to comprose (Standardized process mechanism for regist practitioners to perfect the rwise be considered.)	met as evidenced by: view and record review, the ed to ensure that the lead cititioner (NP 2), followed a dure, in accordance with erning nurse practitioners, ications for Patient 1. This e safety elements inherent in llowed and therefore had the mise the safety of Patient 1. edures are the legal stered nurses and nurse form functions which would lered the practice of medicine. ered Nursing on Nurse e: NPR-B-23 04/1999 and		specific functions; (3) the method of period review of the NP's competence, including review and review of the provisions of the (4) the entire regimen of medication the N administer/dispense; and (5) the supervisor relationships between the NPs and the suphysician, provided that a physician shall supervise more than 4 full time equivalent at one time. b. As mentioned in the Statement Deficiencies, PPNorCal's clinicians practic accordance with written medical protocols and procedures contained in its Manual of Standards and Guidelines (MS&Gs) and soperating procedures. The MS&Gs and soperating procedures (collectively, Protocol based on the evidence-based protocols is the Planned Parenthood national office, P Parenthood Federation of America. These are adapted for use by each affiliate, inclu PPNorCal.	peer SPs; P can ory pervising not NPs of see in , policies, Medical standard tanding ols) are sued by lanned e protocols

Licensing and Certification Division

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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: B. WING CA140000241 12/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1104 BUCHANAN ROAD, SUITE C10 PLANNED PARENTHOOD - ANTIOCH ANTIOCH, CA 94509 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) PPNorCal's Protocols are written by the Continued From page 3 D 046 Director of Quality Management and Vice President of Medical Services, who are both Review of Patient 1's Office Visit record, dated nurse practitioners, in collaboration with the 10/28/14, showed NP 2 was the "provider." Medical Director and the administrator before Under the heading of, "Meds Prescribed during the Protocols are approved and implemented this visit," for Patient 1 were: agency-wide. After the March 3, 2017 review, we * Micrhogam Ultra-Filtered Plus 250 unit (50 determined that all of the missing components mcg), intramuscular injection given to Patient 1 in identified in the Statement of Deficiencies were the clinic, (Micrhogam is an antibody that Patient actually included in the Protocols or not 1 did not have in her blood. Prescribed to prevent deficiencies at all (e.g., we adhere to the a reaction in case the fetus was positive for the physician oversight ratio requirement of 4:1). RH antibodies.) However, because these components were not * Zithromax 500 mg, one tablet, oral medication included or referenced in the Mifepristone (antibiotic) Medication Abortion document reviewed by the *Misoprostol 200 mcg (Quantity: 4), 4 tabs po (by inspector, they were identified as deficiencies mouth) for 30 minutes: swallow remainder (Used in our SPs. with another drug Mifeprex to end a pregnancy.) The revised SPs will serve as a model *Mifeprex 200 mg, administered to Patient 1 in for all process-specific or disease-specific SPs the clinic (Mifeprex or Mifepristone is an abortion used by PPNorCal, which will all be revised as pill used to terminate an early pregnancy and soon as practicable to ensure they include all causes cramping and bleeding from the uterus.) of the required elements outlined in 16 CCR 1474. *Acetaminophen-Codeine 300 mg-30 mg Our revised SPs will be distributed to (Quantity: 10), 1 to 2 tablets by mouth every four all NPs providing services for PPNorCal no later to six hours as needed for pain (narcotic pain than March 27, 2017. Director of Quality medication) Management will incorporate compliance with *Promethazine HCL 25 mg, one tablet by mouth standardized procedures into the ongoing before Misoprostol, then every six hours as monthly audits performed at PPNorCal to ensure needed. (Used to treat nausea and vomiting.) that all NPs and supervising physicians are aware of and are following the current SPs. In a phone interview on 12/30/14 at 11:25 a.m., We note that the last "deficiency" cited on page 7 of the Statement of Deficiencies Patient 1 said she received abortion pills from the is not actually a deficiency. Specifically, while the facility on 10/28/14, and then she took another inspector correctly noted that the Associate set of abortion pills on 10/29/14. She returned to Medical Director (AMD) had oversight over 20 Clinic 1 for a follow-up appointment on 11/4/14. clinics, it should not be inferred from that Patient 1 said clinic staff informed her the vaginal statement that the AMD is the supervising ultrasound showed a "complete abortion." On physician for all NPs located at all 20 clinics 11/15/14 around 1:30 a.m., Patient 1 said she at all times. bled heavily and passed clots. On 11/16/14,

died."

Licensing and Certification Division

Patient 1 said she went to the hospital because she "passed out." Patient 1 said, "...I could have

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INAME OF PROVIDER OR SUPPLIES CA140000241 NAME OF PROVIDER OR SUPPLIES CA140000241 SUMMARY STATEMENT OF DEFICIENCES 1104 BUCHANAR ROAD, SUITE C10 ANTIOCH, CA 94509 PREFORM EACH INSPICENCY SUIST BE PRECIDED BY PLLI. PRIEST IN SUBJECT BY PROVIDER OR SUPPLIES 17AO REACH INSPICE CONTROL OF SUMMARY STATEMENT OF DEFICIENCES 1D PRIEST IN SUBJECT BY PRECIDED BY PLLI. PRIEST IN SUMMARY STATEMENT OF DEFICIENCES 1D PRIEST IN SUMMARY STATEMENT OF DEFICIENCES 2D PRIEST IN SUMMARY STA	Californi	a Department of Pub	olic Health			FUNIVI	AFFROVED
NAME OF PROVIDER OR SUPPLER STREET ADDRESS. CITY, STATE, ZIP CODE 1104 BUCHANAN ROAD, SUITE C10 ANTIOCH CA 94509 PRETA SUMMANY STATEMENT OF PREPASSAGES PRETA PREPARA REACH DEPROPEDATION MUST REPRESCADE BY PILLY RECULATORY OR LSC DENTIFYING INFORMATION) PREPARA Review of the hospital's Discharge Summany, dated 11/18/14 at 1:46 p.m., showed Patient 1 was admitted for treatment of " profound vaginal bleeding due to incomplete abortion from medical abortion" In a staff interview on 11/8/16 at 11:59 a.m., Associate Medical Director (AMD) said that she worked for the facility since 2011. AMD said she had oversight of the nurse practitioners who did the clinical work in the twenty clinics. On 11/8/16 at 12:25 p.m., AMD looked at the document, entitled, "Miferpistone Medication Abortion," implemented, 9/1/14, and agreed it was the standardized procedure for nurse practitioners to perform medication abortions. AMD said in the document "MD" meant physicians; "clinicains" meant nurse practitioners on perform medication abortions. AMD said in the document "MD" meant physicians; "clinicains" meant nurse practitioners on perform medication abortions. AMD said in the document "MD" meant physicians; "clinicains" meant nurse practitioners on perform medication abortions. AMD said in the document "MD" meant physicians; "clinicains" meant nurse practitioners on perform medication abortions. AMD said in the document "MD" meant physicians; "clinicains" meant nurse practitioners to perform medication abortions. AMD said in the document "MD" meant physicians; "clinicains" meant nurse practitioners to perform medication to abortions. AMD said in the document "MD" meant physicians; "clinicains" meant nurse practitioners to perform medication abortions. AMD said in the document "MD" meant physicians; "clinicains" meant nurse practitioners to perform medication abortions. AMD said in the document "MD" meant physicians; "clinicains" meant nurse practitioners, midwises and physician supervisor or assigned no more suppres	STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	CONTRACTOR OF THE PROPERTY OF			
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PREFIX TAG TAG Continued From page 4 Peview of the hospital's Discharge Summary, dated 11/18/14 at 1:46 p.m., showed Patient 1 was admitted for treatment of ".m.profound vaginal bleeding due to incomplete abortion." In a staff interview on 11/8/16 at 11:59 a.m., Associate Medical Director (AMD) said that she worked for the facility since 2011. AMD said she had oversight of twenty clinics. The hard oversight when she standardized procedures on the the twenty clinics. On 11/8/16 at 12:25 p.m., AMD looked at the document, entitled, "Mifepristone Medication Abortion," implemented, 9/1/14, and agreed it was the standardized procedure for nurse practitioners to perform medication abortions. AMD said in the document, entitled, "Mifepristone Medication Abortion," implemented, 9/1/14, and agreed it was the standardized procedure for nurse practitioners to perform medication abortions. AMD said in the document, entitled, "Mifepristone Medication Abortion," implemented, 9/1/14, and agreed it was the standardized procedure for nurse practitioners to perform medication abortions. AMD said in the document, entitled, "Mifepristone Medication Abortion," implemented, 9/1/14, and agreed it was the standardized procedure for nurse practitioners to perform medication abortions. AMD said in the document, "MD" meant physicians, "clinicians" meant nurse practitioners, midwives and physician assistants. On 11/10/16 at 1:20 p.m., during an interview, the Administrator, (Director) said, "We follow	PLANNE	D PARENTHOOD - AN	VIIOCH				
Review of the hospital's Discharge Summary, dated 11/18/14 at 1:46 p.m., showed Patient 1 was admitted for treatment of "profound vaginal bleeding due to incomplete abortion from medical abortion" In a staff interview on 11/8/16 at 11:59 a.m., Associate Medical Director (AMD) said that she worked for the facility since 2011. AMD said she had oversight of twenty clinics in a network that provided similar services and had the same policies and procedures. AMD had oversight of the nurse practitioners who did the clinical work in the twenty clinics. On 11/8/16 at 12:25 p.m., AMD looked at the document, entitled, "Mitlepristone Medication Abortion," implemented, 9/1/14, and agreed it was the standardized procedure for nurse practitioners to perform medication abortions. AMD said in the document "MD" meant physicians; "clinicians" meant nurse practitioners, midwives and physician assistants. On 11/10/16 at 1:20 p.m., during an interview, the Administrator, (Director) said, "We follow	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
censing and Certification Division		Review of the hospidated 11/18/14 at 1: was admitted for trevaginal bleeding due medical abortion" In a staff interview of Associate Medical Eworked for the facilithad oversight of twe provided similar sempolicies and procedute nurse practitiones the twenty clinics. On 11/8/16 at 12:25 document, entitled, 'Abortion," implement was the standardize practitioners to perform AMD said in the doce physicians; "clinician midwives and physic On 11/10/16 at 1:20 Administrator, (Direct follow	tal's Discharge Summary, 146 p.m., showed Patient 1 satment of "profound e to incomplete abortion from on 11/8/16 at 11:59 a.m., Director (AMD) said that she by since 2011. AMD said she enty clinics in a network that vices and had the same ares. AMD had oversight of ers who did the clinical work in p.m., AMD looked at the "Mifepristone Medication and, 9/1/14, and agreed it d procedure for nurse form medication abortions. The amount of the complete in the	D 046	supervision and oversight: agency-wide NP-specific. The agency-wide level of s is performed by either the Medical Direct AMD, or another contracted OB/GYN, at of whom is available (either in person, over phone, or via electronic communication) a day, seven days a week (any time serve being provided and after hours) for constand guidance. The AMD was referring to of oversight when she stated on 11/08/16 had oversight over 20 clinics. However, we believe the inspector was at to determine who the assigned supervisor NP in question was, which relates to the level of review. All PPNorCal NPs are as an individual physician supervisor. The purpervisor conducts chart reviews, discuscases, and reviews the results of medical Each physician supervisor is assigned not than 4 full-time equivalent NPs. The guid for physician supervision are documented PPNorCal's Protocols, and as discussed will be incorporated either directly into the SPs or referenced by name and page numbers.	and upervision or, the least one ver the 24 hours rices are ultation to this level 5 that she attempting or for the second ssigned oblysician sses I audits. To more delines d in above, e revised mber.	rican

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	devices by a nurse physician and surge surgeon supervision require the physical but does include (1) development of the approval of the standavailability by telephypatient examination "(e) For purposes of and surgeon shall su					
	with standardized pin the above law in t	a," showed it did not comply procedure elements described that: ence of collaboration on the opproval of the standardized urse practitioner, the an, and administrator. ician and surgeon supervision iodic review of the nurse etence, including peer review, rovisions of the standardized specified in the document. a "IX. Medication Regimens" ded Mifepristone and ation abortion pills) and hycin.) The regimen did not edications prescribed: tinophen-codeine, and				
	*The physician had practitioners in twen	oversight of nurse ity clinics as stated in an			Ame	rican
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D 046	Continued From page 7	D 046				
	interview on 11/8/16 at 11:59 a.m. as reported above.					
D 068	T22 DIV5 CH7 ART4-75029(b) Basic ServicesOther Health Personnel (b) The professional director shall ensure that, in addition to meeting the licensing, certification or other legal requirements, all health personnel are qualified by training and experience to perform those services they are assigned to provide.	D 068	On March 3, 2017, PPNorCal reviewed its entire clinical operations system and policies and made the following changes: 1. Transvaginal ultrasounds. a. As of Friday March 3, 2017, unlicensed Reproductive Health Specialists (RHS) no longer perform transvaginal ultrasounds (TVUs). All PPNorCal policies and procedures, training materials, and forms related to TVUs have been updated to reflect this change. b. On Thursday March 2, 2017, this			
	This Statute is not met as evidenced by: Based on staff interview and record review, the professional directors: Associate Medical Director, Vice President of Medical Services, and the Regional Director of Clinic 1: 1. Failed to provide qualified staff to perform transvaginal ultrasounds for Patient 1, who had a medication abortion. A "Reproductive Health Specialist" (RHS 1), with a high school diploma and a medical assistant class, was trained by the clinic's staff to perform transvaginal ultrasounds. The performance of a transvaginal ultrasound is an invasive procedure and outside the scope of service of a medical assistant. (See Business and Profession Code §2069 - §2070.) This failure resulted in staff, without the required educational background and certification performing an invasive procedure which could potentially result in patient injury and poor quality, ultrasound images.		change was communicated via teleconference to all health center managers and Senior Regional Directors. On Thursday March 2, 2017, PPNorCal also distributed a memorandum about this change to all health center staff, including all RHS staff. c. No later than Friday, March 17, 2017, a chart audit of all TVUs performed after March 3, 2017, will be completed by Director of Quality Management to ensure that all health personnel are performing only those services they are authorized and assigned to provide. If any TVU is found to be not in compliance with PPNorCal's revised policies and procedures, the Director of Quality Management will inform the health center manager who oversees the staff member who performed the procedure, and specific corrective action will be taken as needed, under the direction of the health center manager, the Director of Quality Management and the Senior Regional Director.			
	2. Failed to ensure the RHS' job description complied with the laws of California when the job description included giving advice, and providing comprehensive education and options counseling. The listed clinic responsibilities		Ameri	S		

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D 068	failure had the pote would rely on the jo of the limitations of Findings: 1. Review of Patien 11/4/14, showed that medication abortion 10/28/14 and Misop with the Vice Presid and also a nurse printerpreted the ultra Patient 1 had an emabortion. In a phone interview Patient 1 said she refollow-up appointmed showed a complete released. Patient 1 sa.m., she bled heav 11/16/14, she went because she passes she was hospitalized the contents from in blood transfusion. Pher the uterus' open	e of service of the RHS. This ntial RHS' and other staff b description and be unaware	D 068	d. The PPNorCal Medical Quality Assurance Committee reviews all medical incidents on a quarterly basis. At Monda March 6, 2017 meeting, a retrospective re all abortion-related incidents was perform determine whether any incidents from 20' date may have been related to an RHS' performance of a TVU. No incidents were determined to have been the result of RH performance of a TVU. The Medical Quali Assurance Committee will continue to mo and discuss all incidents on a quarterly ba 2. RHS job descriptions. a. The current job description for RHS por will be reviewed no later than Thursday, N 2017 by legal counsel and the VP of Med Services to ascertain compliance with all rules and regulations, including but not lin California Business and Professions Code §§ 2069-2070. Any needed revisions to t description will be completed no later than Monday, March 13, 2017. Health center managers will review with all RHS staff th scope of their work and limitations of their using the revised job description as a guit b. The revised job description as a guit existing PPNorCal policy with respect to I which includes the direction that unlicens may not give advice or provide recommen to patients. Rather, RHS staff provide pa information and instruction, as authorized 16 CCR 1366. This includes reviewing w	y, eview of ed to 14 to e S itty initor asis. sition March 9, ical relevant nited to e he job n ee r scope, de. reflect RHS staff, ed staff indations tient I under rritten	

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On 12/9/16 at 1:05 p.m., during a phone

interview, Patient 1 said NP 2 did not check

whether her cervix (opening of the uterus) in the

follow-up appointment on 11/4/14. Patient 1 said

and felt a huge blood clot, the size of a baseball.

Review of the hospital's Emergency Department Physician Notes, dated 11/16/14 at 2:09 p.m.,

she did a manual check herself later at home,



any patient questions to a licensed clinician or

observations will be conducted on an ongoing

basis by both health center managers and lead

clinicians to ensure that all health personnel are

performing only those services they are authorized

physician. To ensure compliance, staff

and assigned to provide.



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING: ___ B. WING CA140000241 12/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

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D 068	showed Patient 1: "Presents with vaginal bleedingpatient had a tab [therapeutic abortion] about 2 weeks ago, had large amount of spotting and clots. Saturday [11/15/14] started heavy vaginal bleedinghad a syncopal [fainting] episode" Review of the hospital's Discharge Summary, dated 11/18/14 at 1:46 p.m., showed that Patient 1: "Was admitted to the hospital for treatment of profound vaginal bleeding due to incomplete abortion from medical abortion 10/29/14. She had acute blood, symptomatic blood loss that required 2 units of PRBC [packed red blood cells] to be transfused and D and C by a gynecology [women health] physician." Patient 1's post-operative diagnosis indicated incomplete abortion. In staff interviews on 10/25/16 at 2:58 p.m 4 p.m., the Vice President of Medical Services (VP) said the staff person who performed the transvaginal ultrasound was a Reproductive Health Specialist (RHS 1.) VP said RHS 1 performed the ultrasound scans of Patient 1, before and after the medication abortion, on 10/28/14 and 11/4/14. RHS 1 loaded the images into the computer and NP 2 interpreted the images at a computer outside the exam room. VP said RHS' were unlicensed staff, trained by clinic staff to perform ultrasounds.	D 068	3. Informed consent. a. RHS staff will no longer witness informed consent documents. As of Monday, March 27, 2017, PPNorCal's policy with respect to obtaining informed consent from a patient in advance of a complex procedure will include asking a licensed clinician to obtain a patient's signature on a written informed consent form and to have that licensed clinician witness the signature. This practice will better document PPNorCal's existing policy of ensuring that a patient has the ability to ask questions about obtain information from a licensed clinician before consenting to a complex procedure. b. All PPNorCal policies and procedures, training materials, and forms will be updated no later than Monday, March 27, 2017 to reflect this change. c. To ensure compliance, staff observations will be conducted on an ongoing basis by both health center managers and lead clinicians to ensure that all health personnel are performing only those services they are authorized and assigned to provide.	
	On 10/25/16 at 2:59 p.m., during an interview, Director said she "pretty much runs the clinic." Director said that some RHS' had medical assistant certificates, and some had college degrees and all had extensive in-house training. Director said a physician initially signed off on the RHS' skill and annually audited their skills to			S
	perform transvaginal ultrasounds. Director also said she did not know Title 22 (California		Ame	rica

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PRINTED: 02/14/2017 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 CA140000241 B. WING 12/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1104 BUCHANAN ROAD, SUITE C10 PLANNED PARENTHOOD - ANTIOCH ANTIOCH, CA 94509 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE. PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 068 D 068 Continued From page 10 regulations which pertain to legal operations of health care facilities including primary care clinics): "I can't say I heard of it." Director said she followed OSHA guidelines (Occupational Safety and Health Administration: federal and state organizations which protects and improves the health and safety of working men and women), the policies and procedures of Clinic 1. and HIPAA (Health Insurance Portability and Accountability Act of 1996, federal legislation that provides privacy and security provisions for safeguarding medical information) to guide her in running the clinic. On 11/8/16 at 11:59 a.m., during an interview, the Associate Medical Director (AMD) said she had oversight of Clinic 1 and 19 other clinics in a network of clinics providing similar services. AMD said the network of 20 clinics were run the same and had the same policies and procedures. AMD said she had clinical oversight of the nurse practitioners but did not supervise RHS'. AMD said to ask the Director about policies related to the RHS'. On 11/8/16 at 12:35 p.m., AMD said the head of ultrasound trainers was also trained in-house and was not a certified ultrasound technician. AMD said performing a transvaginal ultrasound was not outside the scope of a medical assistant/RHS. AMD said many other health care settings had medical assistants performing ultrasounds. AMD was unable to name another health care setting, outside the clinic network for whom she worked,

Licensing and Certification Division

RHS.

which allowed medical assistants to perform ultrasounds. AMD then said it was her medical opinion that performing ultrasounds was within the scope of service of a medical assistant and

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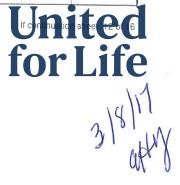
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D 068	Continued From pa	ge 11	D 068			
D 066	On 11/10/16 at 1:20 Director said she di Board of California can do: "We follow organization's] prote who wrote the prote process of policy de only implement the she was the RHS' s RHS' had to submit ultrasound views to and they were evaluated the physicians. Clin who performed the Director said that a minimum qualification. In a staff interview, 2 said she was the supervisor of RHS transvaginal ultraso a probe into the vag during the procedur Clinic 1's policies ar medical assistants of p.m., RHS 1 said shinto Patient 1's vagin uterus in different pl different views. RHS swipe, but the swipe views. RHS 1 said the did the swipe. RHS	o p.m., during an interview, d not contact the Medical to determine what MAs/RHS'[national cools." Director could not say bools, and didn't know the evelopment. Director said: "I protocols." Director said that supervisor. Director said that a certain number of the clinic's medical services, yated and signed off by one of ic 1 had three to four RHS' transvaginal ultrasounds. high school diploma was the on to become an RHS. On 11/10/16 at 2:45 p.m., NP lead clinician and clinical I, who performed the und on Patient 1 by inserting lina. NP 2 was not in the room the procedures about what	D 088			
	vaginal ultrasounds	since 2004, and the former ned her off to do ultrasounds.			8	200
	RHS 1 also said she	submitted various			7)J
		to a physician for annual ncy renewal. The physician			Ame	rican
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victor per th 2. joint son the son into the	emputer drive and efformance of the emember if the clire e limitations of he Review of the "Rebed be description, und esponsibilities inclusive by the control, give a could birth control, formed decision" In 11/8/16 at 9:32 are above job description" In 11/8/16 at 9:32 are above job description" In 11/8/16 at 9:32 are above job description" In 11/8/16 at 9:32 are above job description re medical as at the mining are above job description. A magnitude to counse do description. A magnitude to examinate to examinate to examinate are single are above In 11/10/16 at 1:20 are above In 11/10/16 at 1:20 are above	off site, through a shared did not observe the ultrasound. RHS 1 did not nic had any policy regarding r job classification. eproductive Health Specialist" ated, included a list of clinic ading: "Answer questions health, and pregnancy. dviceAbortion services: sive education and options allowing client to make answer questions regarding ure, possible complications, tionsPrimary Care/Well vide health education about a.m., after an inquiry regarding iption, an e-mail from the ing: "This position would num the training required by esistant; however, many of the ob description do not fall bractice for a medical only be performed by a veA medical assistant is not a patients or give medical intioned several times in the edical assistant is not e the patient or to obtain om a patientA medical de only technical supportive inple, routine medical tasks p.m., Director said the RHS'-they relay advice." Director ormation sheets and explain	D 068		Ame	S rican
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D 068	choices/options cousituation. "The RHS questions to get the decision." Director's was in the job describere was a written Director said there written: "They follow In a staff interview, p.m., NP 2 said she Clinic 1 and the clinic 1 and the clinic 3 and could not do involved in policy-mithe California Medic medical assistants' On 11/10/16 at 3:54 give advice. She remainly about birth considered and could not record control or another. RHS 1 described he the patient's signature and on the medication presence of the NP what the consent wapatient. RHS 1 said information they decishe witnessed the services and the services of the NP what the consent wapatient. RHS 1 said information they decishe witnessed the services and the services of the NP what the consent wapatient. RHS 1 said information they decishe witnessed the services of the NP what the consent wapatient. RHS 1 said information they decishe witnessed the services of the NP what the consent wapatient. RHS 1 said information they decishe witnessed the services of the NP what the consent wapatient. RHS 1 said information they decished that RHS 2 signature. Typed in a "The patient got this "The patient got this	unseling depending on the bray ask a few clarifying em [patients] close to making a said she did not question what ription. Regarding whether guidance for RHS' limitations, was nothing specifically the protocols." on 11/10/16, beginning at 2:45 a was the lead clinician in ical supervisor of RHS'. NP 2 are clinic's policies and that medical assistants could be that medical shall not get asking and she did not contact that Board to inquire about the scope of service. In p.m., RHS 1 said she didn't wiewed educational forms, ontrol, with patients. RHS 1 side effects of birth control. In mend one type of birth regarding consent forms, are process. RHS 1 obtained are on a service consent form on abortion consent out of the or physician. RHS 1 read off as and gave a copy to the after the patients received the cided to sign or not and then ignature. Mutual review of formation For Informed Abortion Pill, dated 10/30/14, witnessed Patient 1's above RHS 2's signature was: information. She said she dit. She [Patient 1] was able	D 068		S	S rican

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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: B. WING CA140000241 12/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

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D 068	Continued From page 14	D 068		
	In a phone interview on 12/9/16 at 12:58 p.m., Patient 1 said the staff who reviewed the medication abortion informed consent and witnessed her signature, was a different person from the NP who provided the medication for the abortion.			
	Review of the AMD's job description, last revised 8/3/16, had the following: "The Associate Medical Director is responsible with the Medical Director for providing medical leadership and directionfor implementing medical protocols that are consistent with clinical standards set by[national organization] and all federal and state regulations and for assuring on-going compliance by all licensed staff in the provision of medical care"			
	Review of the job description of the Director, undated, showed: "The Regional Director is responsible for the internal systems and personnel management of the health centers, assuring compliance with regional and state regulations and standards.			
	Review of the clinic network's organizational chart, updated 11/4/16, showed the VP of Medical Services had oversight of the medical services of all 20 clinics as well as Quality Management.			
	Review of the clinic's Ultrasound Services document, implemented 6/1/14, showed that "Both licensed and non-licensed personnel may be trained in the provision of ultrasound where allowed by state and local law. Non-licensed personnel may perform ultrasound for abortion, early pregnancy evaluation."			S
	On 11/8/16 at 8:55 a.m., after an inquiry, the		Ame	rica

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D 068	Medical Board of C email with the follow the Medical Board of conducting a vagina scope of a medical procedure, and is n	alifornia's Analyst sent an wing statements: "According to of California's legal counsel, al ultrasound is outside of the assistant. This is an invasive of authorized under the tions applicable to medical	D 068			ican's
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	The following reflect Department of Publinvestigation of ent CA00538248 regard Inspection was limit reported incident in represent the finding facility. Representing the Called Health: 35302, Health	ets the findings of the California lic Health during the ity reported incident reding state monitoring (breach). Ited to the specific entity exestigated and does not high of a full inspection of the California Department of Public alth Facilities Evaluator Nurse. It does not substantiate a violation of gulations.		CACOX ON SOME OF SOME	Control of the last	
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	Department of Pub	ic Health during the callornia in the ca				
		alifornia Department of Public ealth Facility Evaluator Nurse,				
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	complaint investiga	limited to the specific ted and does not represent inspection of the facility.	:			
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FORM APPROVED 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: _ С B. WING CA630004341 01/30/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3569 ROUND BARN CIRCLE VISTA FAMILY HEALTH CENTER SANTA ROSA, CA 95403 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (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) A 000 Initial Comments A 000 The following represents the findings of the California Department of Public Health during an investigation for Complaint or Entity Reported Incident Number(s): #CA00518025. Inspection was limited to the investigation of the complaint or ERI and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Health Facility Evaluator Nurse #2533. NO DEFICIENCIES WERE ISSUED FOR COMPLAINT: #CA00518025.

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PRINTED: 12/20/2016 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 CA630004341 B. WING 11/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3569 ROUND BARN CIRCLE VISTA FAMILY HEALTH CENTER SANTA ROSA, CA 95403 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE 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 **DEFICIENCY**) A 000 Initial Comments A 000 The following reflects the findings of the California Department of Public Health during aninvestigation for Complaint or Entity Reported Incident Number(s): #CA00497665. Inspection was limited to the investigation of the complaint and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor # 2533 Health Facility Evaluator Nurse. NO DEFICIENCIES WERE ISSUED FOR COMPLAINT: #CA00497665. Licensing and Certification Division LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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FORM APPROVED 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 CA630004341 09/11/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3569 ROUND BARN CIRCLE VISTA FAMILY HEALTH CENTER SANTA ROSA, CA 95403 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1D (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) A 000 Initial Comments A 000. The following reflects the findings of the California Department of Public Health during a Complaint incident visit. Complaint Incident Intake number: CA00432128 The inspection was limited to the specific Complaint Incident investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor #2888, Health Facilities Evaluator Nurse. The Department was unable to substantiate a violation of the Regualtions. NO DEFICIENCY WAS ISSUED FOR COMPLAINT INCIDENT CA00432128.

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United for Life

PRINTED: 06/26/2015

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 CA630004341 06/16/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3569 ROUND BARN CIRCLE **VISTA FAMILY HEALTH CENTER** SANTA ROSA, CA 95403 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ΙD (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) D 000 Initial Comments D 000 The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint: CA00340683 Representing the California Department of Public Health Services: Health Facility Evaluator Nurse: # 2139 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. NO DEFICIENCIES WERE ISSUED FOR COMPLAINT: CA00340683

Licensing and Certification Division

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

TITLE

PRINTED: 01/29/2014 FORM APPROVED

If continuation sheet 1 of 1

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 CA630004341 10/18/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3569 ROUND BARN CIRCLE VISTA FAMILY HEALTH CENTER SANTA ROSA, CA 95403 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG **DEFICIENCY**) A 000 Initial Comments A 000 The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint: CA00369382 Representing the California Department of Public Health Services: Medical Consultant I: # 1781 The inspection was limited to the specific complaints/entity reported incidents investigated and does not represent the findings of a full inspection of the facility. NO DEFICIENCIES WERE ISSUED FOR COMPLAINT: CA00369382 Licensing and Certification Division LABORATORY DIBECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

PRINTED: 08/21/2017 FORM APPROVED

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDEA/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE S COMPL	
an was find the first page		CA070000182	B WING_	CALIFORNIA DEPARTMENT	C 05/24	/2017
	PROVIDER OR SUPPLIER D PARENTHOOD	STREET AD 1691 THE SAN JOS	Dress, City. Alameda E, Ca 9511	0 2017		
pcs) 10 PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLANOF CORRECTION SHOWS A CONTROL OF THE	DULD	COMPLETO DATE
0005	Department of Publinvestigation of an conducted on 10/1: For Entity Reporter regarding State M Person/Entity Outs System, a State de Title 22, Section 75 Inspection was illustrated incident is represent the findinospital. The clinic detected information (PHI) of The clinic reported Department on 4/1. The clinic notified to Breach of PHI on 3.	nited to the specific entity investigated and does not ags of a full inspection of the lithe Breach of Patient's Health on 3/22/16. If the Breach of PHI to the 1/16, the affected patients of the		The following is Planned Parenthood Mar Mo (PPMM's) response to the Department's requirement's requi	uest for a priced incident lune 21, enter first port) 12, Section buthorized the affected y the cy Officer notification ecautions to mployee who PMM. 10 be affected and what	
	Health Records (b) Information constall be confidentiate authorized personatate and local law	mation contained in the health records confidential and shall be disclosed only rized persons in accordance with federal,		(c) What immediate measures and systemat will be put into place to ensure that the deficioes not recur. 1. Immediately ensure all staff is current with HIPPA/Privacy modules through the Center Learning (CAL). 2. Review PPMM's Sanctions for Unauthoriz Disclosure of PHI (Policy #CO1020) in the Heweekly micro meeting.	cient practice h annual for Affiliated ed use and/or	CA
	on interview and re	met as evidenced by: Based ecord review, the clinic failed uthorized disclosure of	to be a critical and	3. Highlight and review "Minimum Necessary Know" policy only as necessary for duties as of PPMM's Privacy Policy #CO1030		SS.

Licensing and Certification Division

LABORATORY DIRECTOR SOPPROVIDER/SUPPLIERREPRESENTATIVE'S SIGNATURE

TITLE

VPHR/Privacy Officer

STATE FORM

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United for Life

7/10/17

Poc accepted with Rochelle Noone, VP Human Resources / Privacy Officer

STATEMENT OF DEFICIENCIES (X1) PROVIDEA/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A BUILDING CALIFORNIA DEPARTME COMPLETED OF PUBLIC HEALTH C **BWING** CA070000182 05/24/2017 13 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY. STATE ZIP CODE 1691 THEALAMEDA **PLANNED PARENTHOOD** L&C DIVISION SAN JOSE, CA 95126 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLANOFCORRECTION (X4) 10(X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) BE CROSS, REFERENCED TO THE DATE TAG APPROPRIATE DEFICIENCY) D005 **Initial Comments** D005 The following is Planned Parenthood Mar Monte's (PPMM's) response to the Department's request for a Plan of Correction with respect to Entity reported incident The following reflects the findings of the California CA00482515, enclosed in CDPH letter dated June 21, Department of Public Health during the 2017, received by PPMM's San Jose Health Center first investigation of an entity reported incident Reported to CDPH on April 1, 2016 (CDPH Report) conducted on 10/12/16, 10/14/16 and 5/24/17. Deficiency cited as not complying with Title 22, Section For Entity Reported Incident CA00482515 75055(b). (the clinic failed to prevent the unauthorized regarding State Monitoring, Breach to Disclosure of patient health information) Person/Entity Outside Facility/Health Care System, a State deficiency was identified (see (a) Corrective actions to be accomplished for the affected Title 22, Section 75055(b)). patient(s) identified to have been affected by the deficient practice. Inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the On March 22, and March 30, 2016, the Privacy Officer hospital. spoke with patient regarding this incident. A notification letter was mailed on March 22, 2016. The clinic detected the Breach of Patient's Health The Center Manager has taken additional precautions to Information (PHI) on 3/22/16. protect this patient's medical records. The employee who The clinic reported the Breach of PHI to the committed this breach no longer works for PPMM. Department on 4/1/16. The clinic notified the affected patients of the (b) How other patients having the potential to be affected Breach of PHI on 3/22/16. by the same deficient practice be identified, and what corrective action will be taken Representing the California Department of Public PPMM has not identified other patients affected in this Health: 37883, Health Facilities Evaluator Nurse. instance D1440 T22 DIVS CH7 ART6-75055(b) Unit Patient D1440 (c) What immediate measures and systematic changes will be put into place to ensure that the deficient practice Health Records does not recur. (b) Information contained in the health records 1. Immediately ensure all staff is current with annual shall be confidential and shall be disclosed only HIPPA/Privacy modules through the Center for Affiliated to authorized persons in accordance with federal. Learning (CAL). state and local laws. Review PPMM's Sanctions for Unauthorized use and/or Disclosure of PHI (Policy #C01020) in the Health Cent :r's weekly micro meeting. This Statute is not met as evidenced by: Based 3. Highlight and review "Minimum Necessary/Need to on interview and record review, the clinic failed Know" policy only as necessary for duties assigned section to prevent the unauthorized disclosure of of PPMM's Privacy Policy #CO1030

Licensing and Cert1f1eat1on Division

California Deoartment of Public Healt

LABORATORY DIRECTOR'S ORPROVIDER/SUPPLIERREPRESENTATIVE'S SIGNATURE

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STATE FORM

PHR/Privacy Officer

PRINTED: 06/21/2017 FOAM APPROVED

California Oecartment of Public Healt, STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (XJ) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A BUILDING_ C **B WING** CA070000182 05/24/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESSCITY, STATE ZIP CODE 1691 THE ALAMEDA **PLANNED PARENTHOOD** SAN JOSE, CA 95126 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLANOFCORRECTION (EACH (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** CROSS, REFERENCED TO THE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG APPROPRIATE DEFICIENCY) D1440 Continued From page 1 D1440 (d) A description of the monitoring process and positions of persons responsible for monitoring (i.e., Administrator, patient health information (PHI) for Patient 1, Director of Nursing, or other responsible supervisory when Patient 1's PHI was accessed by an personnel). How the facility plans to monitor its performance to ensure corrections are achieved and employee. The failure resulted in the disclosure of sustained. The plan of correction must be implemented, Patient 1's PHI to an unauthorized individual. corrective action evaluation for its effectiveness, and it must be integrated into the quality assurance system. Findings: Center Managers, Supervisors and staff are notified via email when employees are due for HIPAA/Privacy renewal Review of an audit trail of the electronic medical certification. This ensures HIPAA compliance for all record (EMA) indicated Employee 1 accessed employees, contractors and volunteers. Patient 1's PHI on 22 occasions from 6/24/14 to Center Managers facilitate weekly meetings for trainings, 12/14/15. reviews and immediate system changes. All staff are required to attend and sign in on the attendance log. During an interview on 10/12/16 at 10:11 a.m., the Those not in attendance are sent the meeting notes. Privacy Officer (PO) confirmed that an employee Review of privacy practices at these quarterly mandatory (Employee 1) had accessed the PHI of Patient 1 staff meetings will be a standing agenda item. Evaluation and disclosed the PHI to an unauthorized of staff knowledge will include but not limited to "pop individual. The PO confirmed that the employee quizzes", staff role play, and zero preventable privacy accessed Patient 1's PHI on approximately 22 deficiencies. occasions from 6/24/14 to 12/14/15. Random audits of the EHR System are already in place to review access and identify odd activity, such as accessing a Review of "2015 CERTIFICATION TO ADHERE chart at 2:00am. TO" the clinic's compliance program, signed and dated by Employee 1 on 6/26/15, indicated the (e) Dates when corrective action will be completed. The employee agreed and promised that at all times, Corrective action completion date must be acceptable to the Department. The deficient practice should be the employee would not use or disclose the corrected immediately. This date shall be no more than 30 confidential information except as authorized. calendar days from the date the facility was notified of the non-compliance. Meeting took place on 6/302017. Next meeting is scheduled for 7/7/2017.





PRINTED: 12/03/2019 FORM APPROVED

California	Department of Public	Health			
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	Department of Public Certification during the CA00483026 Representing Californ Health-Licensing and 31505, RN, HFEN The inspection was license complaint investigate the finding of a full instance.	the findings of the California Health-Licensing and he investigation of complaint: In Department of Public Certification: Federal ID # mited to the specific d and does not represent spection of the facility. It is issued for Complaint:			
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Licensing and Certification Division

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

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If continuation sheet 1 of 1

California Department of Public Health

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	OF CORRECTION	IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
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PRINTED: 11/20/2019

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: __ B. WING CA11000000812 07/24/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1179 MCDOWELL BLVD **PETALUMA HEALTH CENTER** PETALUMA, CA 94954 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 010 Initial Comments D 010 The following represents the findings of the California Department of Public Health during a complaint investigation. Complaint number: CA00471159 The investigation was limited to the specific complaint and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: Health Facility Evaluator Nurse, 40742 No deficiencies were cited for complaint # CA00471159

Licensing and Certification Division

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

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E E		CA11000000812	B. WING		10/15/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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÷	Representing the C	pection of the facility. California Department of Public cility Evaluator Nurse #2533.		CDPH L&C Santa Rosa D.(
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ce: Pam shaber, RN

10/24/2018

PRINTED: 12/12/2014

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 CA11000000812 10/02/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1179 MCDOWELL BLVD **PETALUMA HEALTH CENTER** PETALUMA, CA 94954 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (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**) A 000 Initial Comments A 000 The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint: CA00413027. Representing the California Department of Public Health Services: Health Facility Evaluator Nurse: # 2534 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. NO DEFICIENCIES WERE ISSUED FOR COMPLAINT: CA00413027

Licensing and Certificat of Division

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TITLE

INTERIAL CEO

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	M 201 201	E CONSTRUCTION		(X3) DATE S COMPLI	URVEY ETED
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ETALU	MA HEALTH CENTER		OWELL BLV 1A, CA 9495	No.			
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=	California Departme	sents the findings of the ent of Public Health during an ENTITY REPORTED 59789					
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8		Public Health was notified imeframe for ENTITY ENT: CA00369789					
	One deficiency was REPORTED INCIDE						
A 001	Informed Medical B	reach	A 001				
,	A clinic, health fac also report any unla to, or use or disclos information to the al representative at the than five business d unauthorized access	Code Section 1280.15 (b)(2), ility, agency, or hospice shall wful or unauthorized access ure of, a patient's medical ffected patient or the patient's e last known address, no later lays after the unlawful or s, use, or disclosure has been ic, health facility, agency, or					
	affected patient(s) of representative(s) of access, use or discl information.	that the facility informed the or the patient's the unlawful or unauthorized osure of the patient's medical			_	Ame	rica ito
	l Certification Division DIRECTOR'S OR PROVIDI	ER/SUPPLIER AEPRESENTATIVE'S SIGN	NATURE	Compliance		for	(d) DATE
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	Patlent 1 (CA00369 by mail, on 11/21/13	9789) informed of the breach, 3					
A 017	1280.15(a) Health 8	k Safety Code 1280	A 017				
	hospice licensed p 1250, 1725, or 1744 unauthorized access patients' medical ir subdivision (g) of S and consistent with department, after in administrative penal section of up to twe (\$25,000) per patien was unlawfully or w used, or disclosed, thousand five hunds subsequent occurre unauthorized access patients' medical ini investigation, the de clinic's, health facilit history of compliance related state and fee the extent to which and took preventative correct and prevent and factors outside facility's ability to co department shall ha all factors when det	acility, home health agency, or ursuant to Section 1204, 5 shall prevent unlawful or is to, and use or disclosure of, iformation, as defined in section 56.05 of the Civil Code Section 130203. The vestigation, may assess an lity for a violation of this inty-five thousand dollars into whose medical information ithout authorization accessed, and up to seventeen red dollars (\$17,500) per ince of unlawful or so unlawful or so, use, or disclosure of that formation. For purposes of the epartment shall consider the partment shall consider the deral statutes and regulations, the facility detected violations we action to immediately past violations from recurring, its control that restricted the mply with this section. The ve full discretion to consider ermining the amount of an ity pursuant to this section.					
	This Statute is not i	met as evidenced by:				erica Lito	

Licensing and Certification Division

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California Department of Public Health

•	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
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PETALU	MA HEALTH CENTER	ľ	IA, CA 949			ŀ	
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A 017	Based on interview failed to prevent un disclosure of a patihealth information medical information Family. This failure unauthorized access information. Findings: The California Depnotified on 9/16/13 Health Information During an interview Administrative Staff was handed, in errounlicensed Staff B, from a community the dates of birth formation. Administrative Staff error, on the part of both patients had the but different dates self reported the error, on the part of both patients had the but different dates self reported the error, and the error of the part of both patients had the but different dates self reported the error of the part of both patients had the but different dates self reported the error, and in subsessification of the patient 1 was not a communicated with Helpdesk Supervise Patient 1 so that she staff A in notifying is different of the polysion of the patient Division of the patient of	and record review, the facility authorized access and ent's (Patient 1) protected when some of Patient 1's in was handed to Patient 2's ellowed the unlawful or as of protected health artment of Public Health was that a, "Breach of Protected (PHI)", occurred on 9/10/13. I on 10/31/13 at 9 a.m., f A stated that Patient 1's PHI or, to Patient 2's Family by on 9/10/13 after she printed it database, without comparing or both patients. I uded her name, medical se of birth, and immunization f A also stated that it was an f Unlicensed Staff B, in that he same first and last names of birth and Unlicensed Staff B ror to Licensed Staff C, on equently called Administrative of A further stated that, as a patient of his facility, he athe Community Database or, on 9/16/13, regarding the could help Administrative Patient 1's Physician. The	A 017	• Notification: Individual whose Information accessed on from the California Immun Registry (CAIR) was not a patient at Pet Health Center and, therefore, we did not individual's contact Information to notical fected individual within 5 business date. a. Upon discovery on 9/11/2013 we CAIR Help Desk of the breach on 9 and requested that the patient be or that we receive the individual's information to complete notificat were advised that our message we forwarded to the appropriate indication can be 9/16/2013, we emailed CAIR Data (see attached email marked Exhib were advised by the CAIR specialismessage would be send to the He Supervisor for action. c. 10/31/2013, PHC telephoned CAIR that the patient was notified. d. 11/21/2013, PHC received a call firm, who inquired about the bread discussed our attempts to secure information from CAIR. The CAD contacted CAIR and verified our produced CAIR and verified our produced the address and phone of the patient's primary care provided the address and phone of the patient's primary care provided the address and phone of the patient's primary care provided the patient, leading that the Individual's provider with instructions to forw notification letter to the patient, advised of steps for recourse to gagainst harmful use of disclosed FPRNH11	ization aluma by have the five	11/21/2013 Lerica Itorica Itorica Itorica Itorica Itorica Itorica	ins d
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A 017	responded, 11/21/1: Staff A the name an physician, so that a the physician, advis breach. A review of the facil "Authorizations for United Health Inthe following: "RESI responsibility of all I identity of a patient health information.	se Helpdesk Supervisor 3, by giving Administrative d address for Patient 1' letter could be sent, in care of ing Patient 1's Family of the lity Policy and Procedure for, Jses and Disclosure of formation", (9/29/10), reveals PONSIBILITY: 1. It is the facility] staff to verify the prior to releasing protected Patient identity will be verified s the primary Indicator,	A017	h. 11/27/2013 discussed action and faxed a copy of our corr primary care provider and paletter. Medical Assistant counseled on for verify patient identity using date of second identifier prior to giving depatient. Prior to distributing paper do or highlighter the date of bir document against the patient. Have established a contact part of the partient's contact information notification. Monitoring: The Team Manager, it with the COO and Compliance Offices ponsible for monitoring the staperformance for sustained improve privacy policy. Quality and Risk Manager, it with the COO and compliance Offices ponsible for monitoring the staperformance for sustained improve privacy policy. Quality and Risk Manager, it will be considered to coordinator hipAA audits weekly. Quality Oversight: PHC's Internal Committee oversees reportable in reports trends to the Board Risk Manager. The Compliance Office privacy breaches to ensure staff is trained and that our processes are ensure privacy. Corrective actions and implemented to prevent brea	espondence to attent notification illowing policy to of birth and ocuments to a comments to a comments, circle the on the paper t's date of birth. erson at CAIR, or facilitate future attens. Help Desk rimary care a can obtain the ocomplete in conjunction icer, is ff person's rement to follow enager and conduct random. Risk Management is revaluates appropriate a effective to a re identified	09/17/2013 4/2013 11/27/2013 Ongoing Ongoing
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California Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTAUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING; B. WING CA11000000812 10/03/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1179 MCDOWELL BLVD PETALUMA HEALTH CENTER PETALUMA, CA 94954 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PAOVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG DEFICIENCY) D 000 Initial Comments D 000 The following reflects the findings of the California Department of Public Health Services during a Complaint Investigation CA00261697 and CA00216521. The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health Services: Health Facilities Evaluator Nurse (HFEN) #21156 The Department was unable to substantiate a violation of regulations for CA00216521. The Department was able to substantiate violation of regulation 75032(a) for CA-00261697. D 083 T22 DIV5 CH7 ART4-75032(a) Drug Distribution D 083 Service--General Reg (a) A clinic which provides drug distribution service shall provide such service in conformance with state, federal and local laws. This Statute is not met as evidenced by: Based on facility staff interview and review of facility document review, the facility administered an incorrect vaccine to a four month old patient, Failure to administer an incorrect medication to a four month old patient could potentially result in a severe adverse reaction. Findings: On 1/29/2010, the Department received a Licensing and Certification Division LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE POC accepted TIC to Teresa Tillman Teresa Tillman 3/12/14 #21/56 HPEN STATE FORM

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COME	SURVEY PLETED
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PETALU	MA HEALTH CENTER		OWELL BLI IA, CA 9495			
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D 083	Continued From pa	ge 1	D 083			
	complaint alleging t administered an inc old patient on 1/26/	correct vaccine to a four month				
	Assurance Director provided a facility in the four year old Pahis mother and was immunizations. Hib b, a vaccine to previous the outer lining of the and the IPV (polio video medications can be formula, Patient 1's Immunizations to be On 10/3/13 at 10:53 interviewed regardification to the immunization. She immunization to the prepared vaccine to She stated that the children the ages of was a booster whice On 10/3/13 at 11:0	D ä.m., the facilities Quality A was interviewed. He acident report indicating that attent 1 came in the facility with a due to receive the (Haemophilus influenza type yent a bacterium that can infect he brain causing meningitis), vaccine.) Although these administered in a combined mother wanted the administered separately. 5 a.m., Medial Assistant B was ng the administration of the stated she gave the child. She stated she he and showed the the of the provider for accuracy. Hib was to be given to f 2, 4, and 6 months and there h was given at 15 months. 5 a.m., Quality Assurance a copy of Patient 1's progress				
	note dated 1/26/10	which indicated that the plan attent 1 with Hib 0.5 milliliters.				
	Director A provided encounter dated 1/2 1's family member about the (HIBERIX as an initial dose, to	a.m., Quality Assurance a copy of a telephone 27/10. The caller was Patient and stated she was concerned () dose that was administered b Patient 1, Instead of the Hib. booster and should be			An	ericans
		ages of 15 months. This was			T I	
icensing an	d Certification Division	<u> </u>	!			

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California Department of Public Health

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: CA11000000812 10/03/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1179 MCDOWELL BLVD PETALUMA HEALTH CENTER PETALUMA, CA 94954 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Corrective Actions: Continued From page 2 D 083 D 083 Patient identification: Identified patient's parent 1/28/2010 was notified by the provider via telephone that the confirmed by a staff member call to a staff at the HIBERIX booster was administered instead of the immunization manufacturer. HIB immunization that was ordered. On 11/13/13, the facilities Immunization Determination of Risk: Medical Director contacted 1/28/2010 Coordinator C provided an email with the Hibirix manufacturer and verified that the acknowledgment that the error occurred because booster posed minimal risk to the patient. The dose the facility dld not have the HIB immunization that of vaccine is the same in the HIBIRIX as the HIB Immunization, However, the Hiberix contains a the family member had asked for. The Hiberex small amount of lactose. The parent was informed vaccine, was the only vaccine available and the by the provider that there was not a risk of adverse facilities provider approved the vaccine for reaction to the patient and of the quantity of administration to the four month patient. She lactose in the Hibirix, Patient's mother further indicated that the error had occurred acknowledged satisfaction with the information because the vaccine order "deviated from the provided norm" and special care required to safely Immediate Measures: Medical Assistant was 01/28/2010 administer the vaccine, off schedule, was not counseled on following the Injectable Medicine. adequately done. and Administration of Medication policies, to verify drawn vile and open vile of medication against the order, and to present to a provider for approval prior to administering injection. Monitoring: The Team Manager, in conjunction Ongoing with the Team Director, Medical Director, and COO, are responsible for monitoring the staff person's performance for sustained improvement to follow the injectable Medicine--withdrawing into a syringe, Ordering and Administration of Medication, and Vaccination Policies and Procedures, Ongoing Quality Oversight: PHC's Internal Risk Management Committee oversees reportable incidents and reports trends to the Board Risk Management Committee. The Medical Director, COO, and Compliance Officer evaluate drug distribution errors to ensure staff is appropriately trained and that our processes are effective to ensure patient and staff safety. Corrective actions are identified and implemented to prevent errors. Licensing and Certification Division STATE FORM

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
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C ti	California Department Investigation of an INCIDENT: CA003	senting the California Department of Pu					
		ilities Evaluator Nurs					
	entity reported incid	ted to the investigation dent and does not reput mplete inspection of	resent		e e		
	within the required	Public Health was no timeframe for ENTIT ENT: CA00339762			Corrective And		
	One deficiency was REPORTED INCID	s issued for ENTITY ENT: CA00339762			1) 1/30/2013 Quality	As summer	430/2013
A 001	Informed Medical B	reach		A 001	to all stoll to	pu GA pro	essee
	"A clinic, health fac also report any unla to, or use or disclos information to the a representative at th than five business of unauthorized access	at Breach ty Code Section 1280.15 (b)(2), facility, agency, or hospice shall unlawful or unauthorized access closure of, a patient's medical e affected patient or the patient's t the last known address, no later as days after the unlawful or cess, use, or disclosure has been clinic, health facility, agency, or			Corrective Actions! D (30/2013 Quality Implemented multiplemented multiplemented multiplemented multiplemented for the start for release. A. Medical Assett ack documented matches into modern into modern into DOB and No	istant conservation conditions	firm and an
	affected patient(s) of representative(s) of access, use or disc information.	that the facility inform or the patient's f the unlawful or unau losure of the patient's 1762) informed of bre	ithorized s medical		B. MA intals of documents or as sonotime C. Staff secures from a soco	bottom ngg	2.5
censing and	Certification Division	in QT	Comp	liance	Officer TITLE 2/13	7206	(X6) DATE
	A COUNTY CONTROL TO CASE OF THE CONTROL OF THE CONT	ER/SUPPLIER REPRESEN	TATIVE'S SIGNA	ATURE			
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	ia Department of Pub	nic Health		,			
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A 001	Continued From page 1 phone on 1/15/13 and by mail on 1/22/13			A 001	continute potents ide	04.4	
A 017	1280.15(a) Health 8	& Safety Code 1280		A 017	and envelope model	ma ma	
	(a) A clinic, health facility, home health agency, or hospice licensed pursuant to Section 1204, 1250, 1725, or 1745 shall prevent unlawful or unauthorized access to, and use or disclosure of, patients' medical information, as defined in subdivision (g) of Section 56.05 of the Civil Code and consistent with Section 130203. The department, after investigation, may assess an administrative penalty for a violation of this section of up to twenty-five thousand dollars (\$25,000) per patient whose medical information was unlawfully or without authorization accessed, used, or disclosed, and up to seventeen thousand five hundred dollars (\$17,500) per subsequent occurrence of unlawful or unauthorized access, use, or disclosure of that patients' medical information. For purposes of the investigation, the department shall consider the				and Name or SEN. D. The sheft person providing the double-check initials the moment of the docard to the right of the individual who is completing the mailing to indicate identity has been verified.		
	history of complian- related state and fethe extent to which and took preventation correct and preventant and factors outside facility's ability to condepartment shall have all factors when de	ity's, agency's, or hose ce with this section a sederal statutes and retend the facility detected the facility detected to action to immediat past violations from the its control that restriction with this section ave full discretion to determining the amountally pursuant to this section.	nd other egulations, violations ately recurring, cted the n. The consider t of an		Tram 1-Roll play too The policy describe was walked thro by dinneal supo shaff so everyon knowled peoble as the poecess.	ining 4/3/2013 clabore repl A	
_icensing a	Based on interview failed to prevent un	met as evidenced by and record review, to authorized access a ent's (Patient 1) prote	he facility nd		the focess.	American United	



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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MUL A. BUILDI B. WING		(X3) DATE S COMPL	
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	medical information instead of Patient 1 unlawful or unauthor health Information. Findings: The California Depanotified on 1/15/13 Health Information During an interview Administrative Staff received a phone of that she had received laboratory results when many medical received to the staff received a phone of the part of facility policy and properties the following patient privacy is of organization Safe of acility that appropriate in place to reason health information from the HIPAA Prival Awareness It is the members of our wouther compliance date procedures governing information and how information and how instance in the staff received information and how instance in the staff received information and how instance in the staff received in the staff received	when some of Patier was mailed to Patier was mailed to Patier This failure allowed orized access of prote artment of Public Hea that a, "Breach of Prote (PHI)", occurred on 1 on 1/16/13 at 11:30 A stated that the clir all, on 1/11/13, from 1 ed a mailed copy of Pi chich included Patien ord number, date of b	alth was otected /9/13. a.m., nic Patient 2 Patient 1's t 1's olrth, and that lowed. dure for, /13), tion of the rds will tected r violation d that all ained by	A 017	Quality Assurance / Monitoring: Petaluma Health Center's Risk Management Committee of the oversees all reportable incidents occur within the health center. Management committee meets to evaluate health center risk are mitigate risk through corrective a Our policy is for privacy incidents documented and submitted to ti Compliance Officer for evaluatio investigation, reporting, follow-u Privacy breaches are evaluated t staff is appropriate trained to ou and that our processes are effect protect privacy of PHI. Correctiv will be identified and implement prevent privacy breach recurrence Monitoring performance to ensu corrections are achieved and sus the responsibility of department managers, Chief Clinical Operatio Officer, and Compliance Officer i conjunction PHC's Risk Managem Committee.	that The Risk monthly eas and action. It to be ne n, It paction. It policies tive to e actions ed to te. The Risk In action. In acti	Ongoing Sold
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. California Department of Public Health

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	•	3	j				
	Rules".						
	"Notice of Privacy F the following: "THIS MEDICAL INFORM USED AND DISCLA GET ACCESS TO understand that hea the health care you committed to protec informationWe an sure that health info kept private in acco A review of the facil "Authorizations for to Protected Health In the following: "RES responsibility of all f Identity of a patient health Information.	e required by law to: primation that identified identified redance with relevant lity Policy and Proceduses and disclosure of formation", (4/14/03). PONS(BILITY: 1. It is facility staff to verify the prior to releasing propatient identity will bus the primary indicate.	reveals ES HOW I MAY BE DU CAN IWe I you and We are Make Is you is law". Iure for, of , reveals s the he tected e verified				
	A review of the facil employee point of h (1/16/13), reveals the HIPAA? Protecting to maintaining our p in healthcare and put HIPAA "privacy Rule of medical records, protecting health inf is in electronic, oral, information or record or oral), about an in-	ity Privacy Training a ire and annual there are following: "Why co confidentiality of (sic atlent's trust and conublic health systems. "requires the confid Specifically it:applormation no matter vor paper formAny d (including electronic dividual's mental or patent of treatment (wether parts).	after imply with critical critical ifidenceThe fentiality ies to vether it			A ma	SS erican
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	Representing the California Department of Public Health: Health Facilities Evaluator Nurse 2139/26290. Inspection was limited to the investigation of the entity reported incident and does not represent the findings of a complete inspection of the facility.						
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	unable to determine	erified that the facility e the identity of the pay the Unauthorized dis information.	atient				
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	"A clinic, health factorial also report any unlate, or use or disclosinformation to the a representative at the than five business cunauthorized access."	Code Section 1280.15 cility, agency, or hosp ewful or unauthorized sure of, a patient's me offected patient or the le last known address days after the unlawfus, use, or disclosure ic, health facility, age	ice shall access edical patient's s, no later ul or has been	æ			
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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4-18-13 The Jeren Julyan, Compliance Potates Rolling Por accepted. HERN 3139/36390

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ABER:	(X2) MULTI A, BUILDIN B. WING _	PLE CONSTRUCTION	(X3) DATE SI	TED	
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	MA HEALTH CENTER		1179 NORT	H MCDOV	VELL BLVD		
			PETALUMA	, CA 9490	 		
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, A 000	Initial Comment			A 000			
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		alifornia Department ilities Evaluator Nurs					
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·	hospice licensed p 1250, 1725, or 174t unauthorized acces patients' medical ir subdivision (g) of S and consistent with department, after in administrative pena section of up to twe	acility, home health a ursuant to Section 125 shall prevent unlaw is to, and use or disciplination, as define ection 56.05 of the C Section 130203. The overtigation, may assuit of a violation of the control of the co	204, ful or losure of, d in aivil Code ess an this				•
icaneina an	was unlawfully or w used, or disclosed, thousand five hunds subsequent occurre unauthorized access patients' medical in	nt whose medical info ithout authorization a and up to seventeen red dollars (\$17,500) ence of unlawful or is, use, or disclosure formation. For purpose epartment shall cons	per of that	·		Ame	ricans
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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUMBER 11000000081	MBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DAYE SURVEY COMPLETED C 03/15/2012		
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A 017	clinic's, health facil history of compliar related state and fithe extent to which and took prevental correct and prever and factors outside facility's ability to o department shall hall factors when deadministrative pen	ity's, agency's, or hosice with this section are deral statutes and retented the facility detected vive action to immediat past violations from a its control that restrict omply with this section ave full discretion to determining the amount alty pursuant to this section.	nd other gulations, yiolations tely recurring, cted the n. The consider to f an ection.	A 017	Corrective Actions:	'and	3/2/2012	
icensing an	failed to prevent upatient's protected 1. Patient 1 found medical information medical records; a facility's policy and authorization for re Findings: The Department wounauthorized discled PHI to Patient 1. facility was notified 3/2/12, and the fact Department on 3/5 business days. During interview of Administrative Sta at the facility on 2/1 her medical record her care to a new	and record review, to authorized access to health information (P copies of another pain included with a copy of 2. Staff did not follow procedure regarding blease of PHI. Tas notified via fax of posure of an unknown The Department verification the privacy breachility then notified the privacy breachility then notified the privacy breachility then the required 13/15/12 at 12:20 p.m. of A stated Patient 1 we 22/12 and requested a because she was traphysician in another of A stated Staff B, where the privacy of the privacy of the privacy breaching the privacy breaching the privacy of the privacy breaching the privacy of the privacy breaching the privacy of the	a HI) when: tient's y of her low the proper cossible patient's ed the n on ed five n., ras seen a copy of ansferring sity.		Corrective Actions: 1) Medical assistant 108 superisur coun andretrained to 10 linguisments protection 10 linguisment health in 10 trained on ident 1	s and privacy renty the patrice		
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NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY,	STATE, ZIP CODE		
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	attempts, she spok obtained the new p was still unable to r patient or what type inadvertently received. Administrative Stafnew provider's offic been information the included in the cop staff had shredded of the patient or who destroyed. Admining the patient of the patient of the patient or who destroyed. Admining the patient of the p	f A stated she contacte, and was told that the belonged to another of Patient 1's record it and did not recall the tinformation had be strative Staff A stated the name of the pate to provide notificate	5/12 and Patient 1 cother ad ted the there had er patient is, but the name een she was tient who of PHI and	•	All staff comples annual HIPAA training MA 154	feel ing.	6/36/2- 3 1-1 7(36-72-
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Provider Identification Number: CA 11000000812

Complaint Number: CA00302434

Name of Provider:

Petaluma Health Center 1179 North McDowell 8lvd

Petaluma CA

Provider Plan of Correction - ID Prefix Tag A017 (continuation from State	Date
Form A9l311)	Complete
7) Quality Assurance Monitoring	Ongoing
Petaluma Health Center's Risk Management Committee of the Board	
oversees all reportable incidents that occur within the health center.	
This committee meets monthly to evaluate health center risk areas and	
mitigate risk through corrective action. Our policy is for privacy	
incidents to be documented and submitted to the Compliance Officer	
for evaluation, investigation, reporting, follow-up action. Privacy	
breaches are evaluated to ensure staff is appropriate trained to our	
policies and that our processes are effective to protect privacy of PHI.	
Corrective actions will be identified and implemented to prevent	
privacy breach recurrence.	
8) Mitigate Risk of Harm to the Individual as a result of Disclosure:	3/8/2012
Patient 1 stated to the Compliance Officer that she "did not look" at the	
documents that were provided after she saw they were for another	
patient. Patient 1 stated to Compliance Officer that she could not	
i ·	:
Identify the name of Patient 2 and that she provided the envelope from	:
Identify the name of Patient 2 and that she provided the envelope from Petaluma Health Center and its contents to her new OB/Gyn practice.	
Identify the name of Patient 2 and that she provided the envelope from Petaluma Health Center and its contents to her new OB/Gyn practice. Compliance Officer spoke with the new OB/Gyn office staff who	:
Identify the name of Patient 2 and that she provided the envelope from Petaluma Health Center and its contents to her new OB/Gyn practice. Compliance Officer spoke with the new OB/Gyn office staff who confirmed receipt of the contents, including the documents for another	:
Identify the name of Patient 2 and that she provided the envelope from Petaluma Health Center and its contents to her new OB/Gyn practice. Compliance Officer spoke with the new OB/Gyn office staff who confirmed receipt of the contents, including the documents for another patient, and had shredded the contents. Risk to Patient 2 as a result of	;
Identify the name of Patient 2 and that she provided the envelope from Petaluma Health Center and its contents to her new OB/Gyn practice. Compliance Officer spoke with the new OB/Gyn office staff who confirmed receipt of the contents, including the documents for another	
Identify the name of Patient 2 and that she provided the envelope from Petaluma Health Center and its contents to her new OB/Gyn practice. Compliance Officer spoke with the new OB/Gyn office staff who confirmed receipt of the contents, including the documents for another patient, and had shredded the contents. Risk to Patient 2 as a result of this breach was not significant to financial, reputational or other harm.	7
Identify the name of Patient 2 and that she provided the envelope from Petaluma Health Center and its contents to her new OB/Gyn practice. Compliance Officer spoke with the new OB/Gyn office staff who confirmed receipt of the contents, including the documents for another patient, and had shredded the contents. Risk to Patient 2 as a result of) 2 27 3



Californi	ia Department of Pu	blic Health		"		
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		CA070000183	B. WING .			22/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
PLANNE	ED PARENTHOOD		DRNWOOD DI SE, CA 95123	RIVE, SUITE G		
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a	Department of Pub of an Entity Report	cts the findings of the California blic Health during investigation ed Incident CA00627620 Rights; Patient's Privacy Not	3			
	Reported Incident	ited to the specific Entity investigated and does not ngs of a full inspection of the				
		California Department of Public alth Facilities Evaluator Nurse.				
		ras unable to substantiate a l or State regulations.				
				CALIFORNIA OF PUBLI	DEPARTMENT C HEALTH	
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Licensing a	nd Certification Division RY DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	Un	ited
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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: A. BUILDING: COMPLETED CA050000118 B. WING 09/10/2019 NAME OF FROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 518 GARDEN ST PLANNED PARENTHOOD OF SANTA BARBAR SANTA BARBARA, CA 93101 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) J 000 a. What corrective action(s) will be Initial Comments J 000 accomplished for the patient(s) The following reflects the findings of the California identified to have been affected by the Department of Public Health, Licensing and deficient practice. Certification, during an investigation of one The patient was informed of the breach Facility Reported Incident (FRI). including the action we took to terminate 8/6/19 employment with the employee involved FRI: CA00649646--Substantiated in the incident. The patient was reassured that the copy of the identification and Representing the Department: medical cards retrieved from her medical HFEN 39106 record would not impact her current employment or ability to be employed in The inspection was limited to the specific facility reported incident investigated and does not another department. In fact, they were represent the findings of a full inspection of the deleted. The patient verbalized facility. appreciation for the swift action taken. b. How other patients having the J 099 - CCR TITLE 22 DIV5 CH7 ART6 -75055(b) Unit J 099 potential to be affected by the same Patient Health Records deficient practice will be identified, and what corrective action will be taken. (b) Information contained in the health records This was a unique situation with an action shall be confidential and shall be disclosed only to authorized persons in accordance with federal, taken by one employee. We do not state and local laws. believe this will happen again. This Statute is not met as evidenced by: c. What immediate measures and Based on interview and record review, the facility systemic changes will be put into place failed to protect the privacy of a patient (Patient 1) to ensure that the deficient practice when an employee intentionally accessed the does not recur. patient's electronic health record. The employee involved in this incident 8/2/19 was the Director of Revenue Cycle This fallure resulted in disclosure of information to (DOR). In their role, they have access to another employee and the potential for misuse of patient medical records. However, they the patient's information. violated HIPAA policy when they used that access to retrieve information for the Findings: purpose of employment. The patient was The facility policy and procedure titled "General concurrently an employee seeking a Security Compliance" dated 12/01/2018, indicates position in a different department. The in part "As a covered entity under the Security DOR's employment was terminated for Regulations, the facility works to protect against violating policy and using poor any reasonably anticipated uses or disclosures of judgement. Licensing and Certification Division LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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California Department of Public Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED CA050000118 B. WING 09/10/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 518 GARDEN ST PLANNED PARENTHOOD OF SANTA BARBAR. SANTA BARBARA, CA 93101 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE. REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) J 099 Continued From page 1 J 099 d. A description of the monitoring process and positions of persons such information that are not permitted or responsible for monitoring (i.e., required by the Privacy Regulations". Administrator, Director of Nursing, or The facility policy and procedure titled "Uses and other responsible supervisory Disclosure of PHI based on an Authorization" personnel). How the facility plans to dated 01/01/2019, Indicates in part "A use or monitor its performance to ensure disclosure of PHI for purposes other than corrections are achieved and sustained. treatment, payment or healthcare operations The plan of correction must be must be accompanied by an Authorization signed implemented, corrective action by the patient..". evaluated for its effectiveness, and it must be integrated into quality During an interview on 8/14/19, at 11:30 a.m., the assurance system. chief financial officer (CFO) Indicated the director of revenue cycle (DRC) communicated on 8/1/19 We do not believe this was a systemic that she needed clarification of the spelling of a problem. All employees go through prospective employee's first name. The DRC was intensive HIPAA training within the 1st directed to the human resources director (HRD) week of employment and participate in an for assistance with this matter. The CFO further annual review. We believe this was a explained that later that same day, the DRC one-time occurrence involving one emailed the prospective employee's driver's employee who used poor judgement. As license and insurance card to the CFO. The CFO a result, they are no longer employed with Indicated the DRC acknowledged accessing the prospective employee's (who had been a patient the agency. e. Dates when corrective action will be of the facility in the past) medical record to obtain a copy of the driver's Ilcense and health completed. The corrective action insurance card. completion must be acceptable to the Department. The deficient practice Euring an interview on 8/14/19, at 1150 a.m., the should be corrected immediately. This chief operating officer (COO) confirmed the date shall be no more than 30 calendar unauthorized access of Patient 1's electronic days from the date the facility was health record by the DRC on 8/1/19. The COO notified of the non-compliance. further confirmed there was not a legitimate Coincidently, we were due for our annual reason for the DRC to have accessed the health HIPAA training. The HIPAA Privacy record. Officer and HIPAA Security Officer provided their training at all of our administrative and health center locations between the dates of August 20 - August 23, 2019. Attached are the sign in sheets for each of those trainings and name Licensing and Certification Division participants along with the STATE FORM

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: _ B. WING CA630003541 07/24/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 W HILLCREST DR STE 100 PLANNED PARENTHOOD OF THOUSAND OAK THOUSAND OAKS, CA 91360 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) A 000 Initial Comment A 000 The following reflects the findings of the California Department of Public Health, Licensing and Certifiacation, during the investigation of an Entity Reported Incident (ERI). ERI CA00595373 - Substantiated Representing the Department: 2675 - HFES The investigation was limited to the investigation a. What corrective action(s) will be of the ERI and does not reflect the findings of a accomplished for the patient(s) full inspection of the facility. identified to have been affected by the deficient practice. A 170 A 170 1280.15(a) Health & Safety Code 1280 We were informed that Patient A's letter 7/6/18 was received by a person who was not the a) A clinic, health facility, home health agency, or hospice licensed pursuant to Section 1204, 1250, intended recipient. We apologized for the 1725, or 1745 shall prevent unlawful or error and she agreed to return the letter. unauthorized access to, and use or disclosure of, Several phone calls were made to patients' medical information, as defined in Patient A with the attempt to inform her Section 56.05 of the Civil Code and consistent of the breach. The patient did not reply. with Section 1280.18. For purposes of this section, internal paper records, electronic mail, or facsimile transmissions inadvertently misdirected A letter was mailed informing patient of 7/13/18 within the same facility or health care system the breach. In addition, we have been within the course of coordinating care or working with Ventura's Public Health delivering services shall not constitute Department to locate the patient given unauthorized access to, or use or disclosure of, a that treatment for STD has not been patient's medical information. The department, attained. They have attempted phone after investigation, may assess an administrative calls and field visits without success. penalty for a violation of this section of up to twenty-five thousand dollars (\$25,000) per patient whose medical information was unlawfully or b. How other patients having the without authorization accessed, used, or potential to be affected by the same disclosed, and up to seventeen thousand five deficient practice will be identified, and hundred dollars (\$17,500) per subsequent what corrective action will be taken. occurrence of unlawful or unauthorized access, A report was run identifying use, or disclosure of that patient's medical Licensing and Certification Division LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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If continuation sheet 1 of 3

PRINTED: 07/25/2018 **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:** A. BUILDING: _ COMPLETED B. WING CA630003541 07/24/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 W HILLCREST DR STE 100 PLANNED PARENTHOOD OF THOUSAND OAK THOUSAND OAKS, CA 91360 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) A 170 Continued From page 1 A 170 patients who had letters mailed out information. For purposes of the investigation, the regarding lab follow-up on the same day. department shall consider the clinic's, health Each patient was contacted to ensure they facility's, agency's, or hospice's history of received letters intended for them. compliance with this section and other related state and federal statutes and regulations, the c. What immediate measures and extent to which the facility detected violations and systemic changes will be put into place took preventative action to immediately correct to ensure that the deficient practice and prevent past violations from recurring, and factors outside its control that restricted the does not recur. facility's ability to comply with this section. The Call Center Director did an immediate 7/9/18 department shall have full discretion to consider review of procedures regarding abnormal all factors when determining whether to lab follow up. He spoke with the investigate and the amount of an administrative Abnormal Lab Coordinator involved and penalty, if any, pursuant to this section. reminded her that the process includes the mandatory double checking of the patient name and address on the envelope label. prior to placing the letter in the envelope. He also reinforced with the employee the need to handle only one patient letter and envelope at a time. This process was This Statute is not met as evidenced by: reviewed with all of the case management Based on interview and record review, the facility failed to ensure a patients' (Patient A) protected team. health information (PHI) was kept private, when Patient A's confidential information was sent by d. A description of the monitoring US postal service to the wrong recipient. process and positions of persons responsible for monitoring (i.e., This failure resulted in the unauthorized Administrator, Director of Nursing, or disclosure of Patient A's PHI and the potential for other responsible supervisory misuse of the information. personnel). How the facility plans to

Licensing and Certification Division

Findings:

During a telephone interview with the chief

operating officer (COO) on 7/24/18, at 8:10 a.m.,

the COO stated, on 7/06/18 the facility received a

phone call from an individual who stated she had

received a letter addressed to her in the mail but

the information inside had another patients name

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monitor its performance to ensurcorrections are achieved and sustained

implemented, corrective action

evaluated for its effectiveness, hillit

The plan of correction must be

must be integrated into qua

assurance system.

California Department of Public Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	E	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		CA630003541	B. WING		C 07/24/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	
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A 170	and lab results (Pair The letter and lab retransmissible disea case management enclosed a letter ar Patient A into the was According to the factorized Patient A by inform her of the urangement and According to the factorized Patient A by inform her of the urangement and According to the facility policy and Health Information 11/2016, indicated is security provisions Portability and According to the facility provisions Portability and According to the facility policy and Management and According to the facility policy and Procedure" revicase management	esult were related to a sexually se. The COO explained that personnel had accidentally and lab result intended for rong envelope. cility they were unable to phone but sent a letter to intentional disclosure. Ind procedure entitled "Notice on Privacy Practices" revised in part "The privacy and of the Health Insurance puntability Act ("HIPAA") e sure that health information is kept private." Ind procedure entitled "Case shormal Follow-Up Policies rised 2/2016, indicated in part at staff will handle medical dimedical record release	A 170	The Call Center Director and Services Director are responsion monitoring and supervision of management team. They will additional review of entire C Management and Abnormal Policies and Procedures on 8 training could not be scheduled due to a few team members' vacations. The Risk and Quality Managedoing a quality follow up aurand quarterly thereafter. The will be incorporated into the Compliance, Quality and Rism Management 2018-2019 Worden to the Completion must be accepted. The correct completion must be accepted and the shall be no more than days from the date the form the date	sible for of the case an ase Follow-Up 1/24/18. The led earlier scheduled ger will be dit on 8/24/18 is new audit affiliate's sk ork Plan. Action will be tive action otable to the ent practice diately. This is 30 calendar facility was impliance. The completed
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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: A. BUILDING: COMPLETED CA630003541 12/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 W HILLCREST DR STE 100 PLANNED PARENTHOOD OF THOUSAND OAK THOUSAND OAKS, CA 91360 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 000 Initial Comments D 000 The following represents the findings of the California Department of Health during a entity reported incident investigation. Complaint No.CA00420949 Representing the Department of Public Health Surveyor ID 2780 The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. D 070 T22 DIV5 CH7 ART4-75030(a)(1) Basic D 070 Services-Policies and Procedures (1) Description of the types and scope of services which the clinic will provide. This Statute is not met as evidenced by: The majority of corrective actions outlined Based on interview and record review the facility in this document occurred immediately following the incident. This was shared failed to implement it's written policy and procedure for scope of services when an abortion with the DPH surveyor when on site. procedure was initiated on Client A whose pregnancy was beyond the gestational age of the Safeguards are now in place to ensure the deficient practice does not recur. clinics established limits. Findings: PPSBVSLO's medical standards and Review of the clinic's policy in the "Manual of guidelines are being updated (performed Medical Standards and Guidelines", dated on an annual basis). The policy and 12/14/12, revised 6/12, page 5 subhead "Client procedure portion regarding our ability to Selection" #2 indicates "...is pregnant and is not more than the gestational age limit of the affiliate perform procedures to 16 weeks program". This clinic was approved for abortion gestational age remains unchanged services up to 16 weeks gestation. Licensing, and Certification Division LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE edical Director

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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***************************************		CA630003541	B. WING	,		0/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	·····	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
D 070	Povious of alignst Ala	ge 1 medical record on 12/18/14,	D 070	The following corrective actions too immediately following this incident:	k place	
Date is 11/18 not 11/11	revealed the following the following the started and the gestational age was stopped the proced	ng: Client A was seen on cal abortion. The procedure physician, realizing the greater than 16 weeks, ure. Client A was transported for completion of the	٠	A debriefing with the clinic staff to place immediately following the incident as agenda time on a staff meeting that already been scheduled to take pladay after clinic.	dent. the first had	11/18/14
	(PA) on 12/18/14, at she had performed prior to the procedu was her first time us machine (Brand S), other ultrasound matwo associated clini (Brand G). Further investigation	with the physician assistant to 1:45 p.m., the PA indicated the ultrasound on Client A re. The PA also indicated this sing this particular ultrasound According to the PA, all of the techines in this and the other cs were a different brand in revealed prior to the		2) Three days later, a clinical debrie took place with the staff and was le the medical Director (also the surge During this meeting the incident wa reviewed, outcomes discussed and Attachment II outlines the corrective actions to be implemented which w prevent a similar incident from occuagain. The emergency was handle appropriately with all staff carrying or roles effectively.	ad by eon). s eould irring d	11/21/14
	ultrasound being perepresentative routing last menstrual period ultrasound machine ultrasound machine first line date is the according to the patential period. The second ultrasound calculated to the ultrasound important the G brand ultrasound calculated which with the actual ultrasound calculated actual ultrasound calculated to the ultrasound calculated to the ultrasound calculated which with the actual ultrasound calculated to the ultrasound cal	rformed, the patient services nely enters the clients stated d date, into the (Brand S). This results in the Brand S e printing out two dates. The calculated gestational age ients stated last menstrual line date is the actual age according age. However, when using and there is only the first line G brand ultrasound is the alculated gestational age.		3) On December 2, 2014 a Root Ca Analysis was performed by our Mar Quality and Risk. Attachment III ou the analysis followed by corrective to to be taken. Follow up on the recommendations were made on Ja 2, 2015 with most tasks completed remaining action item is the purcha ultrasound machine (same as Bran which was ordered on 2/19/15. We anticipate arrival within the next 2-3 Brand S machine was removed from abortion services on 11/21/14.	nager of itlines action anuary The se of an d G)	1/2/15
icensing and	the nurse practitione because "She wasn During an interview 5:10 p.m., the NP in	e requested assistance from er (NP) with the ultrasound 't getting a clear picture", with the NP on 12/18/14, at dicated she took another reviewing the image she		-	Am I I	ericans
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Californ	ia Department of Put	olic Health			FORM	APPROVED	
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		CA630003541	B. WING		•	C 30/2014	
NAME: OF	PROVIDER OR SUPPLIER	STREET AL	DORESS, CITY,	STATE, ZIP CODE	111		1
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D 070	for the gestational a MD to ask "If the in the NP when she we	ge 2 seeing the classic landmarks ge". The NP approached the nage was OK ?" According to as discussing the ultrasound she relayed to the MD,in	D 070	4) As part of this incident review, determined that the PA appropriations consulted with the more experient clinician. Both appropriately consult the physician.	tely ced	11/18/14	
	error, the gestational printed on the ultras (which was actually clients stated last multrasound calculate on the second line withis case the actual	she relayed to the MD,In all age was the first line age round image, 13 weeks 1 day the age calculated by the enstrual period). The actual age prints out when using the Brand S. In ultrasound calculated actually 21 weeks and 1 day.		5) On the day of the incident, the Director (surgeon) appropriately vocammunication with the receiving physician before the patient arrive Follow up with the same local phytook place the following day to obinformation on the patient outcom current patient status.	vas in hospital ed. ⁄sician tain	11/18/14	
•	results and an intervat 6 p.m., The MD in procedure, when as she was "only lookin responding as to wh "clear". The MD cor showed up on the ul and the Brand S ma machine used which	ked to look at the ultrasound, ag at the image" and was ether or not the image was afirmed that two dates trasound Brand S machine chine is the only ultrasound has a different system of		6) In an effort to ensure that no opatients were effected by this incident audit was conducted on all patient receiving abortion service that sat All tissue examinations matched gestational age obtained on ultrastand were appropriately document EHR. As stated above, the ultrastern S was removed service. Attachment IV.	dent, an ts me day. sound ted in	2/20/15	
	printing out the gest	ational age.	24.	Quarterly gestational age audit ad QM Plan effective January 2015.	lded to		
				ZENTURA DES	2015 HAS -	55	
inapole as i	Contillection Dide			MARIE CHORE	Am	erica	ns
icensing and TATE FORM	Certification Division		6999 (7	Cont.	UI	IILE	u
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AND PLAN	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
12	17/13	CA050000445	B. WING _		C 12/09/2013
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY	, STATE, ZIP CODE	12/09/2013
PLANNE	D PARENTHOOD OF		STON ST	, , <u> </u>	
		VENTURA	A, CA 9300	3	
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D 000	Initial Comments		D 000		
	California Departme and Certification dur Complaint No. CA00 Representing the De	sents the findings of the ent of Public Health-Licensing ing a complaint investigation. 2372073- Substantiated epartment of Public Health		VENTUR A	PUBL 2013 DEC
D 172	Surveyor ID # 22363 The inspection was I event investigated artindings of a full insp T22 DIV5 CH7 ARTE	imited to the specific facility and does not represent the ection of the facility.	D 172	DISTRICT OFFICE	LICHEALTH
t t t t t t t t t t t t t t t t t t t	Unusual Occurrence epidemic outbreaks, accidents, deaths fro catastrophes and unutbreaten the welfare, personnel or visitors accility within 24 hours confirmed in writing) on ealth officer and the eport shall be retained one year. The facility pertinent information as the local health officer in the premises shall to the local fire authors accident to the local fire authors.	s. Occurrences such as poisonings, fires, major m unnatural causes or other usual occurrences which safety or health of patients, shall be reported by the seither by telephone (and or by telegraph to the local Department. An incident ed on file by the facility for shall furnish such other related to such occurrences idea or the Department may explosion which occurs in or be reported within 24 hours ity or in areas not having an to the State Fire Marshal.	1/1/2/ - 1/2/2/2	Upon notification from DPH, of the requirement hem of Unusual Occurrences within 24 hours solicy and procedure was updated. We have hared these expectations with all health central summary: When there is an Unusual Occurrence, heat taff must immediately notify Clinical Services and instration. Clinical Services Administration (specifically of Clinical Services) will send DPH a fax outling vent with specific dates/times. Clinical Services will follow up on Unusual occurrences as we normally do with notification ubmission of documentation to our insurance and Planned Parenthood Federation of Americal All occurrences are monitored by our international program. This is not a change, this type of DPH reporting does not change hurrently handle occurrences nor does it affect utcome of patient care.	our since ers. Ith center y, the VP ing the on/ carrier ca. al quality
B (C	Slinic A) failed to repo	et as evidenced by: d record review, the facility ort an unusual event which		A	America
sing and C RATORY DI	ertification Division	SUPPLIER REPRESENTATIVE'S SIGNA		W	
E FORM	ASSI	bynt.		VP Clinical Sus	(X6) DATE
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	Californ	ia Department of Pul	olic Health			FORM	APPROVED	
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	D 172	Continued From pa	ge 1	D 172				
		the California Depar	th of one Patient (Patient A) to rtment of Public Health purs of the occurrence.					
		Findings:						
		facility (Clinic A) on at approximately 15	old female, was seen in the 9/18/13 for a planned abortion weeks gestation (date per ound performed on 9/12/13).					
		record Patient A can surgical abortion wh physician (Physician noted the following: during procedure Ble According to Physiciattempted to control suspecting uterine a uterine musculature, uterine muscle compreduces flow. This in coagulation and prevuterine muscle contrhemorrhage). Patien medication and the f	on 10/8/13. According to the ne to the facility for a planned ich began at 11:32 a.m. The X) performing the abortion "complication occurred eeding-Amount 1000 cc" an X's notes, the facility the bleeding with medication tony (a loss of tone in the Normally, contraction of the presses the vessels and icreases the likelihood of vents bleeds. Thus, lack of action can cause an acute t A failed to respond to accility called 911.		E CERTIFICA DISTRICT OF	2013 DEC 19 AM II: 05	CA DEPT OF	
		was reviewed. Accor upon arrival Patient A 73/48 was confused, and cool to touch. Pa Hospital (Hospital B) (ED) by paramedics,	ospital Ambulance Report ding to the Paramedic notes, A had a blood pressure of with slurred speech, pale attent A was taken to a local Emergency Department arriving at 12:15 p.m., nospital Ambulance Report.			8		
		Upon arrival to Hospi	tal B at 12:15 p.m., the ED		· A	4m	ericai	1

Physician noted Patient A to be in "Severe sensing and Certification Division ATE FORM

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Californ	ia Department of Pub	olic Health			FORM APPROVED
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLI		PLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	3:	COMPLETED
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12	11/115	CA050000445	B. WING		C 42/00/2042
	 				12/09/2013
NAME OF	PROVIDER OR SUPPLIER		EET ADDRESS, CITY,	STATE, ZIP CODE	
PLANNE	D PARENTHOOD OF	VENTURA	0 RALSTON ST		
		VEN	ITURA, CA 9300	3	350mH 5000g (20)
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D 172	Continued From pa	ge 2	D 172		
	distress, cool, pale.	and in hemorrhagic		127	
	shock"(resulting fro	m acute hemorrhage and			
		potension, tachycardia,			
	oliguria, and by pale	e, cold, and clammy skin.)			
	Patient A was rapidl	y transfused with 6 units	of		
	blood and taken to	surgery at 1:23 p.m.			
	(according to the El				
	The operative repor	t from the surgeon (Physi	cian		
	C) was reviewed. A	ccording to the report, "	After		
	the procedure (Patie	ent A) began having heav	у		
	vaginal bleeding and	d was transferred emerge	ently	<=	
	to (Hospital B). Upo	n arrival (Patient A) was in	n	m C	2
	hemorrhagic shock	and had profuse vaginal		VENTUR	C A PUBL
	bleedingWassive t	ransfusion protocol was		RR	C A PUBL
		nt was taken emergently		دن هو	G ₩ >
		examination of the uteru			19 IC DE
	revealed a perioration	on (a hole made by boring	gor	EF CERTIFICATION DISTRICT OFFICE	T TO
		e passing through or into		22	A C
	uterus because of t	ft lateral lower portion of t he volume of bleeding an	ne	17	AMII:
	the location of the lo	ncerationthe decision wa	u	000	· =
		th hysterectomy (a surgic		<u> </u>	0
		all or part of the uterus).	ai	Sec.	c,
	The California Dena	rtment of Public Health		_	
	(CDPH) was notified	of the above unusual			
	occurrence through	an anonymous complaina	ant		
	on 10/4/13. CDPH e	ntered Clinic A on 10/8/13	3.		
		e date of occurrence	1		
	(9/18/13).				
		terviewed on 10/8/13 and		*	
	stated they recogniz	ed the occurrence as unu		~	
	for their facility, man	agement staff stated			
	administrative staff v	were aware of the inciden	t		
		ative staff that reported ar	ny		88
	occurrences to the o				イン
		at Clinic A were interviewe	ed		
	on 10/30/13 by telep		7755		Ambrican
		they were unaware unusu			American
		s this should be reported t	to		T In it a
rate FORM	Certification Division				
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STATEMENT AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SI IDENTIFICATION	ON NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	LETED
NAME OF	PROVIDER OR SUPPLIER	CA050000		B. WING			9/2013
	D PARENTHOOD OF	VENTURA	5400 RA	ADDRESS, CITY, S ALSTON ST RA, CA 93003	STATE, ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INF	ENCIES ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	V SHOULD BE	(X5) COMPLETE DATE
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