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
	CA070000184	A. BUILDING _____ B. WING _____	C 05/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD	625 HILBY AVENUE SEASIDE, CA 93955

(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	Informed Medical Breach 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 information.	A 001	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 Incidents CA00306419 in CDPH letter dated June 11, 2012. **Deficiency # D071 [22 CCR 75030(a)(2) not met because of failure to ensure written policies and procedures were implemented for one patient; failure to provide supervision to ensure the policy was implemented]** **(a) Corrective actions to be accomplished for the affected patient:** As soon as the Seaside Center Manager learned about the possible breach of the patient's protected health information (PHI), a comprehensive investigation was begun. After it was determined that a breach had occurred, a PPMM representative called and spoke with Patient 1 informing her of the breach and apologizing. PPMM's Compliance Officer also sent Patient 1 a letter communicating similar information. There is no Statement of Deficiency concerning PPMM's communication with the patient.	(a) 4/10/12
D 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of an entity reported incident conducted on 5/29/12. Entity Reported Incident CA00306419 regarding a breach of patient health information by the primary care clinic was substantiated. A deficiency was identified (see California Code of Regulations, Title 22, Section 75030(a)(2)). The affected patient was notified by the clinic of the privacy on 4/9/12. Inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the clinic.	D 000	**(b) Identification of other patients potentially affected by the same deficient practice and corrective action to be taken:** This situation involved Staff B impermissibly gaining access to Patient 1's chart because Patient 1 was Staff B's relative and Staff B had no business reason to gain that access. The breach was reported to PPMM's Compliance Officer by another employee (Staff A). PPMM has repeatedly emphasized the importance of employees reporting possible PHI breaches to their supervisor, as Staff A did. None of the people to whom employees are directed to report this conduct (Compliance Officer, CEO, General Counsel, Seaside Center Manager) has received such reports or reports from any other sources about such PHI breaches. PPMM is also not aware of Staff B having any other relatives receiving care at PPMM nor of Staff B impermissibly gaining access to any other patient charts. When Staff B was approached following the breach, she said that she had never accessed a friend's or another relative's chart, except her mother's chart.	(b) 4/9/12

POC accepted 6/25/12 by S. Nolan

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
	CA070000184	A. BUILDING _____ B. WING _____	C 05/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD	625 HILBY AVENUE SEASIDE, CA 93955

(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	Continued From page 1 Representing the California Department of Public Health: 11442, Health Facilities Evaluator Nurse.	D 000	**(c) Immediate measures and systemic changes that will be put in place to ensure that deficient practice does not recur.** 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. 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).	(c) 5/9/12
D 071	T22 DIV5 CH7 ART4-75030(a)(2) Basic Services--Policies and Procedures (2) Policies relating to patient care. 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 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 Provision of Services to Relatives and Others Known to Staff. The policy indicated."...Personnel shall not provide medical-related services to their relatives,...services shall include...access to	D 071	**(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 Manager, working with the PPMM Compliance Officer, will take appropriate steps to address the situation.	(d) 6/25/12

California Department of Public Health

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	CA070000184	A. BUILDING _____ B. WING _____	C 05/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD	625 HILBY AVENUE SEASIDE, CA 93955

(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 071	Continued From page 2 medical files/records..." The clinic failed to provide supervision to ensure the policy was implemented to protect patient health information.	D 071	After July 31, 2012, the Seaside Center Manager, in consultation with the PPMM Compliance Officer and other appropriate PPMM staff, will review the results of this supervision/monitoring. If there are no instances of EMR access, they will re-evaluate the need for daily visual supervisions. 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.	

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
	CA140000238	A. BUILDING: _____ B. WING _____	C 05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF CONTRA COSTA	2185 PACHECO STREET CONCORD, CA 94520

(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 records for a follow-up visit at the clinic. Employee 1 made a list of telephone calls to complete including Hospital 1 and Hospital 2. Employee 1 called and disclosed the information on Patient 1 to Hospital 1 instead of Hospital 2 in error. On 05/03/2013 at 3:06 p.m., Employee 2 informed the Vice President of Client Services and Compliance Officer (Employee 3) of the interaction between Employee 1 and the clerk at Hospital 1. Employee 3 stated that she received communication regarding the incident from Employee 2 late Friday, 05/03/2013. Employee 3 stated that she would call Employee 2 on Monday for further details. There was communication by email from Employee 2 to Employee 3 explaining the incident on 05/08/2013. Review of the clinic's Annual HIPPA Policy and Procedure: Agreement and Acknowledgement dated 03/01/02, did not include provisions on how an employee would request a medical record from another facility by phone in a manner that would protect the patient's identity.	D 177	The Annual HIPAA Policy and Procedure Agreement has been revised to include the following statement' " I will double check that I am calling the correct provider/patient before I disclose any protected health information including patient's name." All staff will be retrained in this addition to the policy and procedures. Adherence to this procedure will be monitored by the Director of the Medical Results Department, All Health Center Directors and VP of Client Services and Compliance Officer.	6/21/2013 7/5/2013

PRINTED: 06/11/2013
FORM APPROVED

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
	CA140000238	A. BUILDING: _____ B. WING _____	C 05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF CONTRA COSTA	2185 PACHECO STREET CONCORD, CA 94520

(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 California Department of Public Health during the investigation of an entity reported incident on medical breach. Entity Reported Incident Intake Number: CA00354156. Representing the Department: 31387. The findings reflect the specific component of the entity reported incident investigated and do not represent a complete inspection of the facility.	D 000	Patient 1 was notified that we inadvertently contacted the wrong hospital to obtain her medical records and disclosed her name and birth date. We apologized for the incident and gave the patient the opportunity to contact the HIPAA Privacy Officer is she had any concerns. She declined to do so. No other patients were identified to have the potential of being affected by this same deficient practice.	5/9/2012 5/8/2013
D 177	T22 DIV5 CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws. This Statute is not met as evidenced by: Based on staff interview and document review, the clinic failed to ensure the confidentialityof Patient 1's information when Employee 1 disclosed the information to Hospital 1 when there was no need for the hospital to know. Findings: During a phone interview on 05/22/2013 at 5:48 p.m., Employee 3 said that on 05/03/2013 Employee 1 had two hospitals to call concerning two different patients including Patient 1. Patient 1 was seen the emergency room of Hospital 2. Employee 1 had to request the emergency room	D 177	Employee 1 received a corrective action notice from her Supervisor Employee 2 about the incident All Employees in Medical Results dept received retraining on the importance of double checking that they are calling the right provider before disclosing any PHI	5/8/2013 5/9/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Andrea Rumph TITLE VP Client Services (X6) DATE 6/24/13

Accepted & compliance office 6/25/13 ph

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA090000256	A. BUILDING _____ B. WING _____	04/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - EL CAJON CLINIC	1685 EAST MAIN STREET, SUITE 301 EL CAJON, CA 92020

(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 following an investigation of a self-reported breach of a patient's medical information. Complaint number: CA00348529 The investigation was limited to the specific event 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 State ID: 27941.	D 000	We apologized to Patient B in person and reassured her that Planned Parenthood is committed to protecting patient privacy. We also thanked her for returning the empty bottle of medication with Patient A's name on it. An apology letter was mailed to Patient A regarding the privacy breach. (Please see attached.) The Health Center Manager discussed the incident with the staff person involved and reviewed the 5 Rights of Medication Administration with all health center staff at their staff meeting. She also reviewed with staff the importance of handling one patient's chart at a time.	3/22/13 3/25/13 3/29/13
A 001	Informed Medical Breach 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 information.	A 001	A streamlined process has been put into place whereby charts are maintained with the patient until health center staff is ready to complete the orders for the patient. This will prevent errors form occurring and supports the staff in managing one patient chart at a time. The Health Center Manager will perform a root cause analysis with the Director of Quality Management to determine what contributing factors led to the error. Results will determine if additional measures should be put into place and/or what systemic changes may need to be made.	3/29/13 4/18/13
D 177	T22 DIV5 CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records	D 177		

RECEIVED
CA DEPT OF PUBLIC HEALTH
MAY 13 2013
LICENSING & CERTIFICATION
SAN DIEGO NORTH DISTRICT OFFICE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane R. DeMille — TITLE: HIPAA Privacy Officer — (X6) DATE: 4/30/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA090000256	A. BUILDING _____ B. WING _____	04/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - EL CAJON CLINIC	1685 EAST MAIN STREET, SUITE 301 EL CAJON, CA 92020

(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 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 health 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 was compromised. Findings: The facility was made aware of a medical information breach on 3/22/13. The facility notified the Department of the incident on 3/25/13. The facility reported a breach of the following private health information (PHI) of Patient A: Name and medication. On 3/28/13 at 10:50 AM, Medical Assistant (MA) 1 stated, she accidently gave Patient B a bottle of medication meant for Patient A.	D 177	Monitoring of compliance to the 5 Rights of Medication Administration 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 consistently adhering to the 5 Rights of Medication Administration with every patient and with every transition of patient care. 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 4-18-13.	05/25/12 (Date assessment form implemented)

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
	CA090001041	A. BUILDING: _____ B. WING _____	12/11/2013

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 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	D 000		

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane R. DeKille TITLE: HIPAA Privacy Officer (X6) DATE: 1/3/2014

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
	CA090001041	A. BUILDING: _____ B. WING _____	12/10/2013

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 investigation of an entity reported incident. Entity reported incident: CA00368794 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.	D 000	We apologized to Patient 2 on the phone, reassured that Planned Parenthood is committed to protecting patient privacy and asked that return the receipt intended for Patient 1. Patient 2 returned Patient 1's receipt within 30 minutes of visit and was provided with a correct receipt. An apology letter was mailed to Patient 1 regarding the privacy breach and reassuring that Planned Parenthood is committed to protecting patient privacy. Patient 1 was also informed in the letter that Patient 2 had returned the receipt to us within 30 minutes.	9-3-13 9-4-13
D 177	T22 DIV5 CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws. This Statute is not met as evidenced by: Based on interview and record review, the clinic failed to ensure the information contained in the patient's health record be disclosed only to the patient or authorized person. The health information of 1 of 2 sampled Patients (1) was inadvertently disclosed to another person without the Patient 1's authorization. Findings: Patient 1 and Patient 2 with identical first names were seen and examined at the facility on the same day and around the same time. An interview with the health center manager	D 177	The Health Center Manager immediately discussed the incident with front office staff, reviewed the policy and procedure for verifying patient identity and emphasized the importance of handling one patient's paperwork at a time. The Health Center Manager performed a 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 whereby the FOS will ask the patient to confirm the information on the receipt and to then initial the receipt. The Health Center Manager reviewed the incident with all health center staff at their next staff meeting, reminded staff about the policy and procedure for verifying patient identity and the importance of handling one patient's paperwork at a time.	9-3-13 9-10-13 9-27-13

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane R. DeKille TITLE: HIPAA Privacy Officer (X6) DATE: 1-3-14

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
	CA090001041	A. BUILDING: _____ B. WING _____	12/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - CHULA VISTA CEN	1295 BROADWAY, #201 & #202 CHULA VISTA, CA 91911

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D 177	Continued From page 1 (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 2 received the receipt that contained Patient 1's personal information.	D 177	Continued from page 1 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 assessment form implemented)*

California Department of Public He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA090001041	A. BUILDING _____ 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 investigation on an entity reported incident. Entity reported incident: CA00329880 Category: State Monitoring: Non-Breach Patient Medical Information Incident Representing the Department: Nanette Bizzarro, 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.	D 000	We apologized to Patient 1 in person and reassured her that Planned Parenthood is committed to protecting patient privacy. A follow up apology letter was mailed to Patient 1. 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 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. See above regarding immediate measures that were put into place to ensure deficient practice does not recur. 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. 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.	10/11/12 10/15/12 10/16/12 12/14/12 12/14/12 05/25/12
D 071	T22 DIV5 CH7 ART4-75030(a)(2) Basic Services--Policies and Procedures (2) Policies relating to patient care. 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: 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	D 071		

Licensing and Certification Division

Diane R. DeFilla, HIPAA Privacy Officer TITLE 1-8-13 (X6) DATE
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

California Department of Public He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA090001041	A. BUILDING _____ 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 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 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.)."	D 071	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. A HIPAA Privacy audit of the front office processes at this health center was conducted by the HIPAA Privacy Officer. All corrective actions were completed by 12/14/12.	11/26/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA090000256	A. BUILDING _____ B. WING _____	01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - EL CAJON CLINIC	1685 EAST MAIN STREET, SUITE 301 EL CAJON, CA 92020

(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 following an investigation of a self-reported breach of a patient's medical information. Complaint number: CA00336712 The investigation was limited to the specific event 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 State ID: 15932.	D 000	We apologized to Patient B on the phone and reassured her that Planned Parenthood is committed to protecting patient privacy. An apology letter was mailed to Patient A regarding the privacy breach. (Please see attached.) The Health Center Manager spoke to Patient B and asked that she return the birth control pill packet (correct prescription) with Patient A's name on it and receive a correctly labeled birth control pill packet with her own name on it. The Health Center Manager reviewed with all health center staff at their staff meeting, the policy for Verifying Client Identification and the 5 Rights of Medication Administration. She also reviewed with staff the importance of handling one patient's chart at a time. The Health Center Manager performed a root cause analysis with the Director of Quality Management to determine what contributing factors led to the error. This resulted in a streamlined process whereby charts are maintained with the patient until health center staff is ready to complete the orders for the patient. This will prevent errors from occurring due to the staff in managing one patient chart at a time.	12/11/12 12/17/12 12/17/12 12/19/12 1/09/13
A 001	Informed Medical Breach 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 information.	A 001		
D 177	T22 DIV5 CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records	D 177		

RECEIVED
CA DEPT OF PUBLIC HEALTH
APR 17 2013
LICENSING & CERTIFICATION
SAN DIEGO NORTH DISTRICT OFFICE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane R. DeMille, HIPAA Privacy officer — TITLE — (X6) DATE: 4-16-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA090000256	A. BUILDING _____ B. WING _____	01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - EL CAJON CLINIC	1685 EAST MAIN STREET, SUITE 301 EL CAJON, CA 92020

(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 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 12/11/12. The facility notified the Department of the incident on 12/17/12. The facility reported that the breach included the following PHI related to Patient A: Name, birth control information. The Administrative staff confirmed the incident during a telephone interview on 1/23/13. The Administrative staff stated that Patient B informed the facility that she received birth control medications that were meant for Patient A.	D 177	Monitoring of compliance to the policy for Verifying Client Identification and the 5 Rights of Medication Administration 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 and the new process for handling one patient chart at a time. 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 1-9-13.	05/25/12 (Date assessment form implemented)

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CA DEPT OF PUBLIC HEALTH
JUL 31 2013
LICENSING & CERTIFICATION
SAN DIEGO NORTH DISTRICT OFFICE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA080000255	A. BUILDING _____ B. WING _____	07/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD-ESCONDIDO CENTER	347 W MISSION AVENUE ESCONDIDO, CA 92025

(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 following an investigation of a self-reported breach of a patient's medical information. Complaint number: CA00362725 The investigation was limited to the specific event 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 State ID: 15932.	D 000	We apologized to Patient B in person and reassured her that Planned Parenthood is committed to protecting patient privacy. We took the birth control pill packet with Patient A's name on it and provided Patient B with a properly labeled birth control pill packet with her name on it. The Health Center Manager called Patient B after determining that she may have also received two boxes of emergency contraception with Patient A's name on them. Patient B returned two boxes of emergency contraception with Patient A's name on them and was provided with properly labeled boxes of emergency contraception with her name on them. We again apologized to Patient B and thanked her for returning the items.	7/16/13 7/17/13
A 001	Informed Medical Breach 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 information.	A 001	The Health Center Manager also left a phone message for Patient A apologizing for the error and asked her to contact us. In addition, the Health Center Manager immediately discussed the error with medical assistant staff. An apology letter was mailed to Patient A regarding the privacy breach. (Please see attached.) The Health Center Manager performed a root cause analysis with the Director of Quality Management to determine what contributing factors led to the error. This resulted in a streamlined process whereby a pre-printed label with the patient's information on it, will be generated after the clinician has placed the order. The medical assistant will then confirm the patient's identity in the presence of the patient, prior to attaching the label to the medication (s).	7/18/13 7/19/13
D 177	T22 DIV5 CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records	D 177		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Diane R. DeBille, HIPAA Privacy Officer — 7/30/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA080000255	A. BUILDING _____ B. WING _____	07/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD-ESCONDIDO CENTER	347 W MISSION AVENUE ESCONDIDO, CA 92025

(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 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 7/17/13. 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.	D 177	Continued From Page 1 The Health Center Manager reviewed with all health center staff at their staff meeting, the policy for Verifying Client Identification and the 5 Rights of Medication Administration. She also reviewed with staff the new process for labeling medication in the presence of the patient. Monitoring of compliance to the policy for Verifying Client Identification and the 5 Rights of Medication Administration 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 and the new process for labeling medication in the presence of the patient. In addition, the HIPAA Privacy Officer conducts HIPAA training for all new health center staff as part of the agency's orientation and training program as well as an annual HIPAA Compliance Training review. HIPAA compliance audits are also conducted annually at a minimum of six health centers. All corrective actions were completed by 7-26-13.	7/26/13 5/25/12 (date Assessment form implemented)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA080000255	A. BUILDING _____ B. WING _____	08/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD-ESCONDIDO CENTER	347 W MISSION AVENUE ESCONDIDO, CA 92025

(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 following an investigation of a self-reported breach of a patient's medical information. Complaint number: CA00407428 The investigation was limited to the specific event 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 State ID: 15932.	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 email. That process involves comparing the patient's email address listed on their medical records release form against the email address on the computer, prior to sending medical records via email. Performance issues related to quality of work had also been identified with the staff person involved in the error. She had difficulty operating systematically and in a timely fashion. The staff person was acting with a sense of urgency to meet the patient's request and inappropriately ignored all procedures that were outlined.	
A 001	Informed Medical Breach 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 information.	A 001	Prior to this error, the staff person had received re-training and a detailed process for responding to medical records requests which had been developed for her to ensure timeliness and accuracy. She received this policy on 7-2-14 and was being actively monitored on a bi-weekly basis by her supervisor. As of 8-8-14, the staff person is no longer employed by the agency. b) New written procedures have been created and provided to the current medical records staff. In addition, we are developing a new onboarding process for all new medical records staff. The new onboarding process will focus on a standardized step by step procedure for fulfilling medical records requests, including responding to requests by email.	
D 177	T22 DIV5 CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records	D 177	c) This procedure will be used as the guideline for training and evaluating medical records staff on a regular basis. In addition, this procedure will be used at the four month	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane R. DiLille, HIPAA Privacy officer — TITLE — (X6) DATE: 9/3/14

9/8/14
M

Accepted 9/8/14
15932

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA080000255	A. BUILDING _____ B. WING _____	08/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD-ESCONDIDO CENTER	347 W MISSION AVENUE ESCONDIDO, CA 92025

(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 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 notified the Department of the incident on 7/28/14. 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	performance evaluation to ensure that this person is meeting the requirements of the job. The Sr. Director of Quality is responsible for conducting performance evaluations for medical records staff which includes ensuring policies and procedures are followed regarding the appropriate release of patient records by email. The performance review process is part of our quality assurance program. d) The Sr. Director of Quality is also responsible for continuously monitoring compliance to all HIPAA privacy policies and procedures in the Medical Records Department. e) The Sr. Director of Quality oversees the Medical Records Department and is responsible for implementing the plan of correction. The Sr. Director of Quality immediately reviewed what contributing factors led to the error and determined that a medical records staff person had not followed the policy and procedure for responding to a patient's request to receive records by email. A written procedure was created and all medical records staff have been trained on this. The Sr. Director of Quality also met with the staff person involved to discuss the error and corrective actions. In addition, the HIPAA Privacy Officer conducts training for all new staff (including medical records staff) as part of the agency's orientation and training program. An annual HIPAA Compliance Training is also required of all staff. HIPAA compliance audits are also conducted on an annual basis by the HIPAA Privacy Officer All corrective actions were completed by 8-8-14.	

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
	CA070000181	A. BUILDING: _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD	760 RENZ LANE GILROY, CA 95020

(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	Informed Medical Breach 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 information.	A 001		
D 001	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of Entity Reported Incident CA00420349 regarding Breach to Person/Entity Outside Facility/HC 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.	D 001		

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

AMENDED

California Department of Public Health

PRINTED: 03/27/2012
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA070000181	A. BUILDING _____ B. WING _____	C 03/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD	760 RENZ LANE GILROY, CA 95020

(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	Informed Medical Breach 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 information.	A 001	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 CA00300096 in CDPH letter dated March 27, 2012. **Deficiency # D069, D071** [policies relating to patient care not implemented] **(a) Corrective actions to be accomplished for the affected patient:** As soon as the Gilroy Center Manager learned about the possible breach of the patient's protected health information (PHI), a comprehensive investigation was begun. After it was determined that a breach had occurred, a PPMM representative called and spoke with the patient informing her of the breach and apologizing. PPMM's Compliance Officer also sent the patient a letter communicating similar information. There is no Statement of Deficiency concerning reporting to the patient. The patient has not requested any further action from PPMM concerning the breach. This portion of the POC is the same as proposed in the POC dated March 20, 2012. **(b) Identification of other patients potentially affected by the same deficient practice and corrective action to be taken:** This situation involved an employee (Staff A) telling another employee (Staff C) about Staff C's relative's PHI. PPMM has repeatedly emphasized the importance of employees reporting possible PHI breaches to their supervisor, as Staff A did. None of the people to whom employees are directed to report this conduct (Compliance Officer, CEO, General Counsel, Gilroy Center Manager) has received such reports or reports from any other sources about such PHI breaches.	
D 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of an entity reported incident conducted 3/5/12. Entity Reported Incident CA00300096 was in regards to breach of patient health information by the primary care clinic. A deficiency was identified (see California Code of Regulations, Title 22, Section 75030(a)(2)). The affected patient was notified by the clinic of the privacy breach on 2/16/12. Inspection was limited to the specific entity reported incidents investigated and does not represent the findings of a full inspection of the primary care clinic.	D 000		

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
APR 10 2012
L & C DIVISION
SAN JOSE

Licensing and Certification Division

Ellina Cohen — Compliance Officer — 4/9/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

STATE FORM 6899 9T6J11 If continuation sheet 1 of 3

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA070000181	A. BUILDING _____ B. WING _____	C 03/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD	760 RENZ LANE GILROY, CA 95020

(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	Continued From page 1 Representing the California Department of Public Health: 11442, Health Facilities Evaluator Nurse.	D 000	In addition, PPMM has taken appropriate disciplinary action concerning the person who committed the intentional breach. In addition, PPMM will be engaging in the following proactive corrective actions concerning intentional breaches: 1) mandatory In-Services for all PPMM Health Center, Response Center, and Education staff; 2) PPMM intranet privacy FAQs; and 3) revisions to PPMM New Hire Orientation material. (see (c) below). **(c) Immediate measures and systemic changes that will be put in place to ensure that deficient practice does not recur:** 1. **Mandatory Intentional Breach Training In-Service** for all PPMM Health Centers, Response Center, and Education staff that will include: a) discussion of PPMM's privacy breach policies, highlighting and affirming that confirmed intentional breaches result in termination of the employment relationship and that suspensions may occur during investigation, consistent with PPMM's Human Resources policy; b) role playing of hypothetical scenarios and discussion of appropriate responses; and c) acknowledgement of participation in the in-service will be signed by all staff members who participate at the completion of the In-Service. The PPMM Compliance Officer will prepare the written materials, with input from PPMM staff as appropriate. The Regional Area Service Directors (ASDs) will disseminate the materials to all Center Managers and Regional Program Managers (RPMs). The Director of Operations for the Response Center will also receive the same materials. The Health Center managers or individuals with similar supervisory responsibility will review the materials and conduct the In-Service training. The highlights of this In-Service will be reinforced at the annual privacy site In-Service (material prepared by Compliance Officer, presented by same people who presented the intentional breach In-Service unless PPMM management designates otherwise).	
D 069	T22 DIV5 CH7 ART4-75030(a) Basic Services--Policies and Procedures (a) Written policies and procedures which the clinic shall implement shall include, but not be limited to: This Statute is not met as evidenced by:	D 069		
D 071	T22 DIV5 CH7 ART4-75030(a)(2) Basic Services--Policies and Procedures (2) Policies relating to patient care. 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 3/5/12, Patient 1's clinical record indicated the patient had an appointment at the clinic on 2/7/12 and 2/10/12, for test procedures. On 2/7/12, the patient received assistance for the procedure from Staff A. On 3/5/12, during an interview, Staff C stated she was related to Patient 1 and she was not aware	D 071		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA070000181	A. BUILDING _____ B. WING _____	C 03/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD	760 RENZ LANE GILROY, CA 95020

(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 071	Continued From page 2 the patient had an appointment at the clinic. On 2/8/12 at approximately 7 p.m. Staff A told her Patient 1's test results. Patient 1 did not want Staff C to know she was at the clinic. On 2/10/12, Staff C stated she was working in the back of the clinic and Staff A told her Patient 1 was in the clinic. On 3/5/12, review of Staff A's employee file indicated on 12/21/11, Staff A signed a statement she would comply with the clinic's requirements for Confidentially and Nondisclosure Agreement. The Privacy Policy indicated, the clinic, "...is committed to the protection of the confidential information, documents and proprietary information of which it is responsible." On 12/16/11, Staff A signed and dated the clinic's Policy Regarding Provision of Services to Relatives and Others Known to Staff. The policy indicated,"...Staff may encounter Others when this occurs, staff should inform them that all services are strictly confidential and that the privacy of their health information, including patient status, will be protected.." The clinic failed to ensure policies were implemented to respect patient's rights for confidentiality of health information.	D 071	2. **Privacy FAQS on the intranet: PPMM will prepare Privacy FAQs to be posted on the internal Intranet site.** The initial batch of questions posted will address intentional breaches. The Compliance Officer will work with the Information Technology Department and other PPMM staff to publicize the new feature. 3. **New Hire Orientation (NHO):** NHO materials will be revised to reflect the In-Service materials noted above. These materials will be prepared by the Compliance Officer and the Director Training and discussed at NHO. **(d) Monitoring/Quality Assurance:** PPMM plans to undertake the following monitoring and quality assurance activities: 1. **Sign-ins, acknowledgments:** see (a). The sign-ins will be maintained by the people conducting the In-Services. Heath CTR man SM 2. **"Huddles:"** The people conducting the In-Service (or their designees) will conduct daily "huddles" covering possible privacy breach examples and debriefing from previous day for three weeks after the In-Service. 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 follow-up as appropriate. These quizzes will serve as weekly reinforcement of knowledge to increase understanding of the range of intentional privacy breaches. Health Ctr man SM	4/23/12

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
	CA070000181	A. BUILDING _____ B. WING _____	C 03/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD	760 RENZ LANE GILROY, CA 95020

(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 071	Continued From page 3	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 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 quizzes 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.	4/23/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA080000260	A. BUILDING _____ B. WING _____	03/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - ISABELLA CENTER	1820 MARRON ROAD SUITE 110 CARLSBAD, CA 92008

(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 following an investigation of a self-reported breach of a patient's medical information. Complaint number: CA00343719 The investigation was limited to the specific event 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 State ID: 15932.	D 000	We apologized to Patient B in person, reassured her that Planned Parenthood is committed to protecting patient privacy and thanked her for returning the Health Access Card with Patient A's information on it. We provided Patient B with a new Health Access Card with her correct information on it. The Health Center Manager called Patient A, explained the privacy breach, apologized for the error and reassured her that Planned Parenthood is committed to protecting patient privacy. Patient A was also informed that the Health Access Card with her information on it was returned to us and that a new Health Access Card would be mailed out to her.	2/12/13 2/13/13
A 001	Informed Medical Breach 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 information.	A 001	A follow up apology letter was sent to Patient A. (See Attached.) The Health Center Manager immediately discussed the incident with front office staff, and implemented a new check-in process. The process involves the patient completing a check in form, the Front Office Specialist writing down the Health Access Card number on the form and then immediately returning the patient's Health Access Card to them. The Health Center Manager reviewed the new check-in process with all health center staff at their next staff meeting. She also reviewed the agency policy for Verifying Client Identification.	2/15/13 2/12/13 2/22/13
D 177	T22 DIV5 CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records	D 177		

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CA DEPT OF PUBLIC HEALTH
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LICENSING & CERTIFICATION
SAN DIEGO NORTH DISTRICT OFFICE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE: Diane R. DeKille, HIPAA Privacy Officer — TITLE — (X6) DATE: 4-16-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA080000260	A. BUILDING _____ B. WING _____	03/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - ISABELLA CENTER	1820 MARRON ROAD SUITE 110 CARLSBAD, CA 92008

(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 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 2/12/13. The facility notified the Department of the incident on 2/15/13. The facility reported that the breach included the following PHI related to Patient A: Name, .date of birth and medical record number. The Administrative staff confirmed the incident during a telephone interview on 3/4/13. The Administrative staff stated that Patient B informed the facility she was given a Health Acces Program card that contained the PHI of Patient A.	D 177		

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
	CA250001816	A. BUILDING: _____ B. WING _____	C 01/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD-COACHELLA VALLE	49-111 HIGHWAY 111, UNIT 6 COACHELLA, CA 92236

(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	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of one entity reported incident. Entity reported incident number: CA00365335 Representing the California Department of Public Health: 25937 / 2122 The inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility. This Department was able to substantiate a violation of the regulations.	A 000	We apologized to Patient B on the phone, reassured her that Planned Parenthood is committed to protecting patient privacy and asked that she return the letter intended for Patient A. Patient B returned the letter to us the same day. An apology letter was mailed to Patient A regarding the privacy breach and reassuring her that Planned Parenthood is committed to protecting patient privacy. Patient A was also informed that Patient B had returned the letter to us. The Case Management Supervisor reviewed 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. See above regarding immediate measures that were put into place to ensure deficient practice does not recur. Printers installed shortly after solution determined.	07/30/13 07/31/13 07/31/13
A 001	Informed Medical Breach 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 information.	A 001	APOC 2-24-14 KC	

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane R. DeRille — TITLE: HIPAA Privacy Officer — (X6) DATE: 2-19-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA250001816	A. BUILDING: _____ B. WING _____	C 01/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD-COACHELLA VALLE	49-111 HIGHWAY 111, UNIT 6 COACHELLA, CA 92236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 017	Continued From page 1	A 017	Continued from page 1	
A 017	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. 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	A 017	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. 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.	04/12/12 *(date assessment form implemented)*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA250001816	A. BUILDING: _____ B. WING _____	C 01/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD-COACHELLA VALLE	49-111 HIGHWAY 111, UNIT 6 COACHELLA, CA 92236

(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 2 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: 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.	A 017		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA080000260	A. BUILDING _____ B. WING _____	08/13/2014

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - ISABELLA CENTER	1820 MARRON ROAD SUITE 110 CARLSBAD, CA 92008

LICENSING & CERTIFICATION
SAN DIEGO DISTRICT OFFICE

(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 following an investigation of a self-reported breach of a patient's medical information. Complaint number: CA00407631 The investigation was limited to the specific event 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 State ID: 15932.	D 000	a) The deficiency occurred when Patient A and Patient B checked in for their appointments at the same time and multiple patient labels and Fee Tickets for both patients were printed out. In this instance, one or both of the Front Office Staff did not properly verify identification prior to placing Patient A's label on Patient B's Health Access Plan (HAP) card and handing it to Patient B. The center was functioning with two different processes to return HAP cards to patients. We believe this led to the failure in this case to properly identify patient information with HAP card information. The plan of correction will be to have one consistent practice to verify identification between the HAP card and the Fee Ticket whereby the HAP card will not be returned to the patient at the front desk. b) The procedure for implementing the plan of correction includes a consistent process whereby the patient's HAP card will be attached to the patient's Fee Ticket and both will be given to the Medical Assistant. The Medical Assistant will compare the HAP card against the Fee Ticket, call the patient to the back of the center and will then ask the patient to verify their information prior to handing the patient their HAP card. c) Monitoring procedures to ensure that the plan of correction is effective include the Health Center Manager reviewing Fee Tickets and observing both the front office staff and Medical Assistants to ensure verification of patient identity.	
A 001	Informed Medical Breach 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 information.	A 001		
D 177	T22 DIV5 CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records	D 177	The Health Center Manager is responsible for conducting the annual performance evaluation for Front Office Staff which includes ensuring policies are followed regarding the appropriate	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane R. DeZille, TITLE: HIPAA Privacy officer, (X6) DATE: 9/3/14

9/8/14 dh

Accepted 9/8/14
15932

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA080000260	A. BUILDING _____ B. WING _____	08/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - ISABELLA CENTER	1820 MARRON ROAD SUITE 110 CARLSBAD, CA 92008

(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 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 7/26/14. The facility notified the Department of the incident on 7/30/14. The facility reported that the breach included the following PHI related to Patient A: Name, date of birth and medical record number. The Administrative staff confirmed the incident during a telephone interview on 8/13/14. The Administrative staff stated Patient A and Patient B were in the clinic at the same time. Patient B was given a label for her health card that was meant for Patient A.	D 177	handling of HAP cards and the process for verifying patient identity. The annual review process is part of our quality assurance program. The Health Center Manager is also responsible for continuously monitoring compliance to all HIPAA privacy policies and procedures in the health center. This includes protection of patient privacy by following the new procedure outlined above. The HIPAA Privacy Officer also conducts annual audits that may include this issue. d) The Health Center Manager is responsible for implementing the plan of correction. e) The Health Center Manager immediately reviewed with Front Office Staff the appropriate process for handling HAP cards and verifying patient identity on 7-28-14. She also discussed with staff what contributing factors may have led to the error. The Health Center Manager again discussed the consistent process with all staff at their next staff meeting on 8-29-14. She reminded them about the importance of verifying patient identity before providing the patient with a HAP card, and specifically addressed the Medical Assistant's responsibility as outlined above. In addition, the HIPAA Privacy Officer conducts training for all new staff as part of the agency's orientation and training program. An annual HIPAA Compliance Training is also required of all staff. HIPAA compliance audits are also conducted on an annual basis by the HIPAA Privacy Officer All corrective actions were completed by 8-29-14.	

POC ACCEPTABLE YES NO
Reviewed By: Name
Fax
Original
Facility Notified
Name: Elena Cohen
Date: 10/20/14
Time: 10:30 a
Notified By: Name

PRINTED: 09/25/2014
FORM APPROVED

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
	0300001175	A. BUILDING: _____ B. WING _____	C 08/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD	1431 MCHENRY AVENUE, SUITE 100 MODESTO, CA 95350

(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	Initial Comments AMENDED 2567 9/25/14 for correction to the Clinic's policy and procedure used in Tag D177 The following reflects the findings of the California Department of Public Health Licensing and Certification during the investigation of Entity Reported Incident: CA00405313. Representing the California Department of Public Health Licensing and Certification: 31360, RN, HFEN. The inspection was limited to the specific Entity Reported Incidents and does not represent the findings of a full inspection of the facility. One deficiency was written as a result of Entity Reported Incident: CA00405313.	A 000	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 CA00405313, enclosed in CDPH letter dated September 25, 2014, received by PPMM's Modesto Health Center (Modesto) on September 29, 2014 concerning an incident at Modesto that was reported to CDPH on July 9, 2014 (CDPH Report). 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 could not make). **(a) Corrective actions to be accomplished for the affected patient:** On July 9, 2014, the Modesto Center Manager (CM) called Patient 1, discussed the incident with her and apologized. On that day, the Compliance Officer mailed the letter to Patient required by Cal. Health & Professional Code 1280.15. CDPH does not note any deficiency concerning PPMM's communication with Patient 1.	(a) 7/9/14
A 001	Informed Medical Breach 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 information.	A 001	**(b) Identification of other patients potentially affected by the same deficient practice and corrective action to be taken:** PPMM has not identified other patients potentially affected in this instance. **(c) Immediate measures and systemic changes that will be put in place to ensure that deficient practice does not recur:** CM spoke with Staff 1 about the incident on July 7 and July 16, 2014, reinforcing the importance of not disclosing PHI in similar situation unless Patient authorizes. At the September 24, 2014 center-wide staff meeting, CM presented a privacy question for discussion that was based on this incident, and	(b) N/A (c) 7/9/14, 7/16/14, 9/24/14

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elena Cohen
TITLE: PPMM Privacy and Compliance Officer
(X6) DATE: 10/9/14

STATE FORM 6899 KY3Q11 If continuation sheet 1 of 3

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0300001175	A. BUILDING: _____ B. WING _____	C 08/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD	1431 MCHENRY AVENUE, SUITE 100 MODESTO, CA 95350

(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	T22 DIV5 CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws. This Statute is not met as evidenced by: Based on staff interview, clinical record review and administrative document review, the clinic failed to ensure confidential treatment of protected health information (PHI) when Patient 1's information related to a medical appointment was disclosed to an unauthorized person. 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 discussing or providing written PHI (including	D 177	reiterated the importance of not sharing patient's PHI (unless prior patient explicit authorization) with someone who asks to take a patient's appointment when the patient has cancelled, even though that person states that he/she already knows about the patient's appointment. **(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 in the type of circumstance described in the CDPH Report. By October 20, 2014, PPMM's Privacy Officer will begin revising PPMM's Privacy Manual to more explicitly address the circumstance described in the CDPH Report for dissemination in 2015. (d) 10/10/14, 10/20/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0300001175	A. BUILDING: _____ B. WING _____	C 08/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD	1431 MCHENRY AVENUE, SUITE 100 MODESTO, CA 95350

(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 2 prescription, referral forms, etc.) to patient: Before patients receive documents or are spoken to about PHI, [Clinic] staff should at a minimum, ask patients to provide their first and last name and date of birth, and check the document to make sure that it corresponds. Staff should not provide the information first and then ask for confirmation, since 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 professional reasons... Phone calls: The identity of the person on the phone must be confirmed before any PHI is provided and messages should be left only in accordance with [Clinic] policies."	D 177		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA090000256	A. BUILDING _____ B. WING _____	03/03/2014

RECEIVED
CA DEPT OF PUBLIC HEALTH
MAR 17 2014
LICENSING & CERTIFICATION
SAN DIEGO NORTH DISTRICT OFFICE

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - EL CAJON CLINIC	1685 EAST MAIN STREET, SUITE 301 EL CAJON, CA 92020

(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 following an investigation of a self-reported breach of a patient's medical information. Complaint number: CA00388190 The investigation was limited to the specific event 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 State ID: 15932.	D 000	We apologized to Patient B on the telephone and reassured her that Planned Parenthood is committed to protecting patient privacy. Patient B agreed to return the box of emergency contraceptive pills with Patient A's name on it later that day. The Health Center Manager immediately discussed the incident with the Lead Clinician and the clinician involved in the error. She reviewed with them the mandatory process of double checking patient labels prior to handing a box of emergency contraceptive pills to a patient. In addition, the Health Center Manager contacted the Director of Quality Management to conduct a root cause analysis to determine what contributing factors led to the error.	2-12-14 2-12-14
A 001	Informed Medical Breach 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 information.	A 001	Multiple telephone contact attempts were made to Patient B when she failed to return the box of emergency contraceptive pills with Patient A's name on it. The Health Center Manager spoke to Patient B who stated she had not viewed the label on the box of emergency contraceptive pills with Patient A's name on it, had taken the medication and had thrown away the box. An apology letter was mailed to Patient A regarding the privacy breach and letting her know that Patient B stated she had not viewed the label on the box of emergency contraceptive pills with her name on it and had thrown away the box. The Health Center Manager completed a root cause analysis with the Director of Quality Management which resulted in the need to reinforce with all staff the following	2-13-14 2-18-14 2-18-14 3-11-14
D 177	T22 DIV5 CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records	D 177		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Diane R. DeLille	HIPAA Privacy Officer	3/14/14

Approved
3/17/14
AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA090000256	A. BUILDING _____ B. WING _____	03/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - EL CAJON CLINIC	1685 EAST MAIN STREET, SUITE 301 EL CAJON, CA 92020

(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 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 2/12/14. The facility notified the Department of the incident on 2/18/14. The facility reported that the breach included the following PHI related to Patient A: Name, prescribing clinician, clinic address and medication instructions. The Administrative staff confirmed the incident during a telephone interview on 3/3/14. The Administrative staff stated Patient B was given a box of medication that was labeled with Patient A's PHI.	D 177	• Verification of patient identity prior to handing the patient any medication • Verification of a "4 point check" in the patient's Electronic Medical Record prior to handing the patient any medication • Only working on one patient's chart at a time The Health Center Manager will review these expectations with all staff at the next staff meeting on 3-28-14. 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 prior to handing the patient any medication. 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 3-11-14.	5-25-12 *(date assessment form implemented)*

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
	CA250000210	A. BUILDING: _____ B. WING _____	C 10/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - RIVERSIDE CLINIC	3772 TIBBETS STREET RIVERSIDE, CA 92506

(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	Initial Comments The following reflects the findings of the California Department of Public Health during an entity reported incident investigation visit: Entity Reported Incident: CA00413852 Inspection does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor Federal/State ID# 18918/1729 This Department was able to substantiate a violation of the regulations.	A 000	**A.** The MA was immediately terminated following an investigation. The Health Center Manager called the patient, explained that the MA was no longer working for us and provided her with her phone number if she had any questions or concerns. **B.** Planned Parenthood will continue to thoroughly screen potential job candidates including asking interview questions related to the protection of patient privacy. New employees receive training by the HIPAA Privacy Officer as part of their onboarding process and sign an Acknowledgement to abide by the Agency's privacy policies and procedures. In addition, an annual HIPAA Compliance Training is required of all staff. **C.** Planned Parenthood will continue its practice to immediately investigate any suspected violations of our privacy policies and procedures and to immediately implement appropriate disciplinary action, up to, and including termination of employment. **D.** The Health Center Manager is responsible for continuously monitoring compliance to all HIPAA privacy policies and procedures in the health center including appropriate access to patient records. The MA violated our policies and procedures when he inappropriately accessed Patient A's medical record and was promptly terminated as a result. HIPAA compliance audits are conducted on an annual basis by the HIPAA Privacy Officer.	9-17-14 9-18-14
A 001	Informed Medical Breach 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 information.	A 001		
A 017	1280.15(a) Health & Safety Code 1280 (a) A clinic, health facility, home health agency, or	A 017		

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane R. DeLille — TITLE: HIPAA Privacy Officer — (X6) DATE: 10-30-14

Reviewed 11/4/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA250000210	A. BUILDING: _____ B. WING _____	C 10/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - RIVERSIDE CLINIC	3772 TIBBETS STREET RIVERSIDE, CA 92506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 017	Continued From page 1 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. 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	A 017	**E.** The MA was immediately suspended pending an investigation. 9-16-14 The MA's employment was terminated after the investigation. 9-17-14 The Health Center Manager called Patient A to let her know the MA was no longer employed by Planned Parenthood. 9-18-14 The HIPAA Privacy Officer sent Patient A an apology follow up letter. 9-19-14 All corrective actions were completed by 9-19-14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA250000210	A. BUILDING: _____ B. WING _____	C 10/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - RIVERSIDE CLINIC	3772 TIBBETS STREET RIVERSIDE, CA 92506

(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 2 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 information without a direct need for diagnosis, treatment, or other lawful use..."	A 017		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA250000210	A. BUILDING: _____ B. WING _____	C 10/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - RIVERSIDE CLINIC	3772 TIBBETS STREET RIVERSIDE, CA 92506

(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 3 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.	A 017		

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
	CA060000264	A. BUILDING: _____ B. WING _____	C 09/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 000	Initial Comments AMENDED The following reflects the findings of the California Department of Public Health during the investigation of COMPLAINT NUMBER: CA00379879. Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 1835, HFEN. Findings for Complaint Number: CA00379879. The complaint allegation(s) were substantiated and regulatory violations written at A001 and A017.	A 000	**PPOSBC Response to Amended CMS 2567 for COMPLAINT NUMBER CA00379879:** ** PPOSBC former Compliance Officer during the interval in question is no longer with PPOSBC. However, senior management at PPOSBC including the PPOSBC CEO, and COO are aware of the standard processes engaged in by said former Compliance Officer including but not limited to said Compliance Officer's adherence to PPOSBC policies regarding reporting applicable incidents such as that described herein, and direct communication(s) with applicable affected PPOSBC patients. Therefore, the following said PPOSBC response is in good faith with respect to said former Compliance Officer's tenure at PPOSBC.* ***Amended CMS 2567 form CA00379879 Findings:*** a) Patient at issue was contacted by PPOSBC's compliance officer informing patient of the incident, PPOSBC policies on the same and that PPOSBC would thoroughly investigate said incident and remedy as applicable. Patient was provided full contact information at PPOSBC for any additional questions or follow up at patient's discretion. To concretely ensure ongoing safety and privacy of patient's protected health information to the best of PPOSBC's ability, **PPOSBC staff at issue was promptly separated from employment by PPOSBC on or about August 23, 2013.** 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	9.22.14
A 001	Informed Medical Breach 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 information.	A 001		

2014 OCT 17 AM 9 55

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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
	CA060000264	A. BUILDING: _____ B. WING _____	C 09/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 and Information Security Training	9.22.14
A 017	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. This Statute is not met as evidenced by: Based on interview and facility document review, the facility failed to prevent the disclosure of	A 017	• 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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA060000264	A. BUILDING: _____ B. WING _____	C 09/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 2 Patient I's protected health information (PHI) from one staff member (Staff 1). Review of facility documents show on 8/19/13, a caller reported knowing and named a staff member who accessed patient medical records without the need to know and was sharing the information to others. The caller also identified the four patients of whose medical records the staff allegedly accessed. Further review showed the facility investigated the allegation and found evidence the named staff (Staff 1) accessed the medical records of one of the four patients identified. The medical record belonging to Patient I was found accessed by Staff 1 on four different occasions without a need to know. On 8/21/13, an interview with Staff 1 was conducted. During the interview, Staff 1 admitted to knowing Patient I and denied sharing the medical information accessed. However, Staff 1 was unable to explain the reason she accessed Patient I's medical record on four different occasions. Patient I's disclosed PHI may have included the entire medical record including name, demographic data, financial information and physician progress notes, nurses notes and any or all medications, treatments or procedures done within the facility. On 9/9/14 at 1020 hours, a telephone conference with the Privacy Officer occurred regarding the breach as documented.	A 017	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 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	9.22.14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA060000264	A. BUILDING: _____ B. WING _____	C 09/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 3	A 017	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 Patient Right to File Complaints About Use and Disclosure of their Protected Health Information • PPOSBC Compliance Policy CO-1105 HIPAA Privacy and Information Security Training • PPOSBC Compliance Policy CO-1108 Minimum Necessary Rule for Protected Health Information • PPOSBC Compliance Policy CO-111 Protected Health Information Breach Notification • PPOSBC Compliance Policy CO-112 Sanctions for Unauthorized Uses and Disclosures of a Patient's Protected Health Information II. In addition to the promulgation of said policies at PPOSBC, PPOSBC also regularly trains and educates 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	9.22.14

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
	CA060000264	A. BUILDING: _____ B. WING _____	C 09/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 4	A 017	Online module new staff training for **new staff** to be completed with a set period of time immediately post-orientation/hire • Proactive calendared clinic/health center Licensed Clinician trainings that also include training on Protected Health Information/HIPAA • Proactive calendared non-licensed clinic/health center staff (e.g., Medical Assistants, reception staff) trainings that also include training on Protected Health Information • Health Center Managers proactively calendared trainings that focus on managing health center staff with respect to several matters, including Protected Health Information/HIPAA • Proactively calendared Annual **All-Staff** agency Training on Compliance Policies and Procedures • PPOSBC implemented automated audit software that provides information on potential unauthorized access by/disclosure to any level of agency staff, with respect to the agency Electronic Health Records system as well as related patient information systems such as those relevant to patient scheduling and administrative records. This audit software is breach detection technology that is fully integrated with our electronic health record system. On a daily basis, the breach detection technology/software analyzes access into the agency systems, thereby automatically monitoring potential unauthorized access and/or disclosures on numerous levels of the patient record such as lab results, progress notes, appointment information, and related facets • A culture that invites reporting any suspected compliance and/or privacy matters to supervisors in 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	9.22.14

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
	CA060000264	A. BUILDING: _____ B. WING _____	C 09/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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. 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	9.22.14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA060000264	A. BUILDING: _____ B. WING _____	C 09/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 6	A 017	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 agency policies for optimum quality and compliance. • With said new hires, PPOSBC also plans for long term subject matter expertise for matters relevant to optimum protection of patient privacy and security, and compliance with regulatory and agency standards. **d) and e)** : As noted in section (c) in significant detail: 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 PHI	9.22.14 9.22.14

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
	CA060000264	A. BUILDING: _____ B. WING _____	C 09/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 7	A 017	Protected Health Information • PPOSBC Compliance Policy CO-1105 HIPAA Privacy and Information Security Training • PPOSBC Compliance Policy CO-1108 Minimum Necessary Rule for Protected Health Information • PPOSBC Compliance Policy CO-111 Protected Health Information Breach Notification • PPOSBC Compliance Policy CO-112 Sanctions for Unauthorized Uses and Disclosures of a Patient's Protected Health Information II. In addition to the promulgation of said policies at PPOSBC, PPOSBC also regularly trains and educates 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 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	9.22.14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA060000264	A. BUILDING: _____ B. WING _____	C 09/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 8	A 017	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 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.	9.22.14

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
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PLANNED PARENTHOOD ORANGE & SAN BEI	1421 E 17TH STREET SANTA ANA, CA 92705

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A 017	Continued From page 9	A 017	PPOSBC also makes every effort to communicate with any applicable patients at issue to assist them with any questions or concerns, including providing contact information for relevant staff such as patient services department or compliance department staff, and providing said patients with a toll-free phone number to utilize at any time. Thereby, PPOSBC submits in good faith that it is taking all measures feasible to prevent and as applicable in this matter, mitigate, reduce risk, raise quality and address any deficiencies that CPDH may nevertheless perceive. As additional measures: • PPOSBC has hired a chief Compliance Officer, chief Privacy Officer, and chief Security Officer to review PPOSBC systems for additional quality improvement as applicable. (i) One immediate result herein is the updating of the agency process to include the 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 • 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 over a year has passed since**	9.22.14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 10	A 017	**the incident at issue, PPOSBC submits in good faith 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.**	9.22.14

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
	CA250000210	A. BUILDING: _____ B. WING _____	C 03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - RIVERSIDE CLINIC	3772 TIBBETS STREET RIVERSIDE, CA 92506

(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	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of one entity reported incident. Entity Reported Incident Number: CA00388906 Representing the California Department of Public Health: Surveyor 2138/26288, 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. The Department was able to substantiate a violation of the regulations and a deficiency was written for Entity Reported Incident Number: CA00388906	A 000	We apologized to Patient B in person, reassured her that Planned Parenthood is committed to protecting patient privacy and retrieved the Health Access Plan (HAP) card with Patient A's information on it from her. We provided Patient B with a new HAP card with her correct information on it. The Health Center Manager immediately discussed the incident with the Front Office Specialist involved in the error and reminded her that our process includes the mandatory cross checking of all patient labels before they are affixed to the HAP card. The Health Center Manager also immediately implemented a new process that involves cross checking the label on the HAP card against the demographic information on the patient's "Fee Ticket".	2-19-14 2-20-14
A 001	Informed Medical Breach 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 information.	A 001	An apology letter was mailed to Patient A informing her about the breach, reassuring her that Planned Parenthood is committed to protecting patient privacy and to investigating the incident. We also informed Patient A that the HAP card with her information on it had been returned to us. The Health Center Manager conducted a root cause analysis with the Director of Quality Management in order to determine what contributing factors led to the error and to implement any identified system improvements. This led to the following actions and changes: (1) More label printers were ordered for the front desk staff	2-24-14 3-5-14

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane R. DeFrille — TITLE: HIPAA Privacy Officer — (X6) DATE: 4/16/14

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
	CA250000210	A. BUILDING: _____ B. WING _____	C 03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - RIVERSIDE CLINIC	3772 TIBBETS STREET RIVERSIDE, CA 92506

(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	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. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure for one patient (Patient A), that her protected health information (PHI) was not disclosed to another patient (Patient B). This failure resulted in unauthorized access to Patient	A 017	(2) Front desk staff will double check every printed patient label against the printed Fee Ticket with the patient's demographic information on it prior to affixing the label to the HAP card (3) Front desk staff will ensure that the HAP card is labeled with the correct patient's information prior to placing it in the patient's mini chart and handing it to the Medical Assistant. (4) The Medical Assistant will cross reference the patient information on the HAP card against the patient's Fee Ticket (5) The Medical Assistant will ask the patient to verify that the information matches and is correct by initialing the Fee Ticket next to their name The Health Center Manager reviewed the new process with all health center staff at their staff meeting. 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.	3-28-14 5-25-12 *(date assessment form implemented)*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA250000210	A. BUILDING: _____ B. WING _____	C 03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - RIVERSIDE CLINIC	3772 TIBBETS STREET RIVERSIDE, CA 92506

(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 2 A's demographic information. Finding: A telephone interview was conducted on March 11, 2013, at 3:00 p.m., with the HIPAA (Health Insurance Portability And Accountability Act) Privacy Officer (PO). The PO stated on February 19, 2014, Patient B was checking in for a scheduled appointment at the facility. A staff member noticed that Patient B's identification card and health access program card had Patient A's demographic information listed on the cards. The demographic information included Patient A's name, date of birth, and medical record number. The PO stated when Patient B was asked by the staff why her cards had a different patient's 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."	A 017	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 via the new system outlined above. 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 3-28-14.	

POC ACCEPTABLE YES ☐ NO ☐
Reviewed By: [illegible] Name
Fax
Original
Facility Notified
Name: Elena Cohen
Date: 10/7/14
Time: 1405
Notified By: Rachel Kappmeyer Name

PRINTED: 10/06/2014
FORM APPROVED

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
	040000683	A. BUILDING: _____ B. WING _____	C 06/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY FIRST HEALTH CARE, A SERVICE OF	6095 N FIRST STREET FRESNO, CA 93710

(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	Initial Comments Amended to change Facility Name The following reflects the findings of the California Department of Public Health-Licensing and Certification, during the investigation of Entity Reported Incident: CA00401395. Representing the California Department of Public Health-Licensing and Certification: 32306 RN, 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. One deficiency was issued for Entity Reported Incident: CA00401395.	A 000	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 CA00401395, enclosed in CDPH letter dated October 6, 2014, received by PPMM's Family First Health Center (Family First) on October 7, 2014 concerning an incident at Family First that was reported to CDPH on June 5, 2014 (CDPH Report). 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 Patient 2's chart had Patient 1's label attached to it). **(a) Corrective actions to be accomplished for the affected patient:** On June 5, 2014, a Family First supervisor called Patient 1 to inform her about the mistake and the required letter, confirm mailing address, and apologize for the error. On that day, the Compliance Officer mailed the letter to Patient required by Cal. Health & Professional Code 1280.15. CDPH does not note any deficiency concerning PPMM's communication with Patient 1.	(a) 6/5/14
A 001	Informed Medical Breach 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 information.	A 001	**(b) Identification of other patients potentially affected by the same deficient practice and corrective action to be taken:** PPMM has not identified other patients potentially affected in this instance. **(c) Immediate measures and systemic changes that will be put in place to ensure that deficient practice does not recur:** From June 12 through June 18, 2014, the Family First Front Office Coordinator (FOC) monitored the Health Service Specialist 1's (HSS 1's) check-in-process for 25 patients to ensure that she correctly took the steps needed to save the changes in the entire NextGen (electronic patient record) medical record system. During that same period, FOC monitored HSS 2's label printing for 25 patients to ensure that she checked that the patient's first name, last name, and date of birth	(b) N/A (c) 6/18/14

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
Elena Cohen — PPMM Privacy & Compliance Officer — 10/13/14

California Department of Public Health

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	040000683	A. BUILDING: _____ B. WING _____	C 06/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY FIRST HEALTH CARE, A SERVICE OF	6095 N FIRST STREET FRESNO, CA 93710

(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	T22 DIV5 CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws. This Statute is not met as evidenced by: Based on staff interview, clinical record review, and administrative document review, the clinic failed to ensure confidential treatment of Patient 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. The clinic's policy and procedure titled, "PRIVACY	D 177	match the chart on which she puts the label. These employees did not make any mistakes during this monitoring process. On June 17, 2014, Family First had a center-wide training on a privacy question involving joint responsibility for checking PHI, led by the Registered Nurse. **(d) Monitoring Process/Quality Assurance** During December, 2014, the Front Office Coordinator (or other CM designee) will conduct the same HSS 1 and HSS 2 monitoring described in (c) above. Also during December, 2014, PPMM's Privacy Officer will review Privacy Manual Policy 4 (reasonable safeguards) to specifically include checking chart labels as described above for the 2015 Privacy Manual revision.	(d) 12/31/14

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY FIRST HEALTH CARE, A SERVICE OF	6095 N FIRST STREET FRESNO, CA 93710

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D 177	Continued From page 2 MANUAL POLICY 4: REASONABLE SAFEGUARDS AGAINST PRIVACY BREACHES" dated 4/2012, indicated ". . .Confirmation of patient identity before discussing or providing written PHI (including prescription, referral forms, etc.) to patient: Before patients receive documents or are spoken to about PHI, [Clinic] staff should, at a minimum, ask patients to provide the first AND last name and date of birth, and check the document to make sure that it corresponds. Staff should NOT provide the information first and then ask for confirmation, since that can result in a privacy breach if the person is not the correct patient. . ."	D 177		

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA090000257	A. BUILDING: _____ B. WING _____	C 11/06/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of an Entity Reported Incident. ERI Number: CA 00413369 Category: State Monitoring Sub-category: Non-Breach Patient Medical Information Incident Representing the California Department of Public Health: 29153, Health Facilities Evaluator Nurse The inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the hospital. One deficiency was written as a result of ERI number CA 00413369	D 000	a. Since Patient 2 was still in the health center when the error was recognized, we explained and apologized to ' for the error in person and let ' know that we had already attempted to contact Patient 1 to return the medication with Patient 2's label on it. Multiple telephone contact attempts were made to Patient 1 when she failed to return the medication with Patient 2's name on it. A follow up letter was mailed to Patient 2 regarding the breach and our attempts to contact Patient 1. b. See corrective actions below. c. The Health Center Manager and Lead Clinician immediately discussed the incident with the clinician involved in the error and reminded ' that our process includes the mandatory double checking of all patient information and labels prior to handing medication to a patient. The Health Center Manager completed a root cause analysis with the clinician involved in the error which resulted in the need to reinforce with all staff the following: • The need to verify patient identity prior to handing the patient any information or medication • The need to only work on one patient's chart at a time The Health Center Manager reviewed these expectations with all staff at the next staff meeting.	9-12-14 9-12-14 9-13-14 9-15-14 9-16-14 9-12-14 9-26-14
D 177	T22 DIV5 CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws. This Statute is not met as evidenced by: Based on interview and document review the clinic failed to ensure that Patient 2's personal and protected health information (PHI) was kept confidential when a Physician Assistant (PA) 1 gave Patient 1 medications that contained a label with Patient 2's information. As a result of this failure, Patient 1 had access to Patient 2's	D 177		

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D 177	Continued From page 1 personal information. Findings: An investigation of an entity reported privacy breach was initiated on 10/31/14. It was reported to the California Department of Public Health that on ( ) an unauthorized and inadvertent disclosure of Patient 2's medical information was given to Patient 1 during a visit at the clinic. The Physician Assistant (PA) 1 had seen Patient 1 on . PA 1 had ordered medications for Patient 1 during that same visit. PA 1 gave Patient 1 the medications with a label that contained Patient 2's information. On 11/4/14 at 1:30 P.M., an interview was conducted with the Privacy Officer (PO). The PO stated that the process for ordering medications was that the clinician (doctor or PA) would see the patient, then go to their office and open up the patients electronic medical record (EMR). The clinician would then open their inbox with their scheduled appointments and click on the correct patient. Once in the patients EMR the clinician would then order the medication and print out the labels. The clinician would adhere the labels to the medications. The PO stated that the clinicians were to double check the EMR to ensure it was the correct patient. The medication would then be placed in a bag and would be given to the patient. The PO stated that in this case, PA 1 went into the EMR and opened the next patient scheduled (Patient 2). PA 1 then ordered the medications and printed out the labels and placed onto the medications. The PO stated that the medications were then given to Patient 1. The PO further stated that when the Medical Assistant (MA) 1 went to work on Patient 2's medical record that	D 177	d. The monitoring process will include a review of all patient privacy root cause analysis reports by the HIPAA Privacy Officer, Sr. Director of Quality and the Sr. Director of Center Operations. This will help to identify if any similar errors related to the process for verification of patient identity prior to handing the patient medication or information, have occurred and to address them immediately. Monitoring of compliance to this internal process is routine. In addition, it is part of the annual performance evaluation. The Health Center Manager and Lead Clinician are responsible for conducting the annual performance evaluation. The annual review process is part of our quality assurance program. The Health Center Manager is responsible for continuously monitoring compliance to all HIPAA privacy policies and procedures in their health centers including protection of patient privacy through mandatory double checking of all patient information and labels prior to handing to the patient. In addition, the HIPAA Privacy Officer conducts HIPAA training for all new health center staff as part of the agency's orientation and training program as well as an annual HIPAA Compliance Training review. HIPAA compliance audits are also conducted annually at a minimum of six health centers. e. All corrective actions were completed by 9-26-14.	

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PLANNED PARENTHOOD ASSOC OF SAN DIE	4575 COLLEGE AVENUE SAN DIEGO, CA 92115

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA080000254	A. BUILDING _____ B. WING _____	12/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD ASSN OF SAN DIEGO CO	7526 CLAIREMONT MESA BLVD SAN DIEGO, CA 92111

(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 following an investigation of a self-reported breach of a patient's medical information. Complaint number: CA00419617 The investigation was limited to the specific event 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 State ID: 2794.	D 000	a. The deficiency occurred when one clinician inadvertently selected the wrong printer which resulted in incorrect prescription labels being printed to the wrong exam room. The clinician in that exam room then failed to follow the normal process for reviewing prescription labels prior to placing them on medications and handing them to the patient. RECEIVED CA DEPT OF PUBLIC HEALTH JAN - 8 2015 The plan is to ensure that clinicians (a) always select and print to the correct printer and (b) double check that the patient information on the printed label matches the electronic medical record prior to placing the label on the medication and handing it to the patient. LICENSING & CERTIFICATION SAN DIEGO NORTH DISTRICT OFFICE A breach notification letter was sent to Patient A.	11-6-14
A 001	Informed Medical Breach 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 information.	A 001	The medications labeled with Patient A's information on them, were returned to the health center by Patient B. b. The procedure will include reviewing with all licensed staff our established process which includes (a) the need to print to the correct printer and (b) mandatory double checking of prescription labels prior to placing labels on medications and handing them to the patient. c. Monitoring procedures will include follow up training at center staff meetings regarding the importance of checking every prescription label prior to placing it on the medication and handing it over to the patient. The Health Center Manager and Lead Clinician are responsible for continuously monitoring compliance to all HIPAA privacy policies and procedures in their health centers including protection of patient privacy through mandatory double checking of all prescription labels prior to placing them on medications and handing them to the patient.	11-12-14
D 177	T22 DIV5 CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records	D 177		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane R. DeRille — TITLE: HIPAA Privacy Officer — (X6) DATE: 1-7-2015

Mathewson 1-13-15. OK

1-16-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA080000254	A. BUILDING _____ B. WING _____	12/22/2014

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PLANNED PARENTHOOD ASSN OF SAN DIEGO CO	7526 CLAIREMONT MESA BLVD SAN DIEGO, CA 92111

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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 10/31/14. The facility notified the Department of the incident on 11/6/14. The facility reported that the breach included the following PHI related to Patient A: Name, weight, body mass index (weight to height ratio, medications, instructions for use, name of provider (a provider of medical or health services), and the name of the health center and telephone number. The Administrative staff confirmed the incident during a telephone interview on 12/22/14 at 9:45 A.M. The Administrative staff stated, Patient B was given patient documents and medications labeled with Patient A's PHI. The Administrative staff also said, the error was believed to have occurred, when an employee failed to double check the name on labels that were placed on medications and documents and given to Patient B in error.	D 177	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. HIPAA privacy breaches are also reviewed and discussed with health center leadership at bi-annual meetings. The monitoring process will also include a review of all patient privacy root cause analysis reports by the HIPAA Privacy Officer, Sr. Director of Quality and the Sr. Director of Center Operations. We will identify any similar errors and address them immediately. d. The Health Center Manager and Lead Clinician are responsible for implementing the plan of correction. e. The Lead Clinician immediately reviewed what contributing factors led to the error by conducting a root cause analysis and determined that a clinician had not followed our mandatory internal process for reviewing prescription labels prior to placing them on medications and handing them over to the patient. The Lead Clinician reviewed and discussed the incident with all licensed staff at the next staff meeting and reminded them of the importance of ensuring that correct prescription labels are placed on medications prior to dispensing them to patients. All corrective actions were completed by 11-26-14.	11-26-14

California Department of Public Health

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD/ORANGE & SAN BEI	700 S TUSTIN STREET ORANGE, CA 92863

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A 000	Initial Comments AMENDED The following reflects the findings of the California Department of Public Health during the investigation of COMPLAINT NUMBER: CA00378267. Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 1835, HFEN. Findings for Complaint Number: CA00378267. The complaint allegation(s) were substantiated and regulatory violations written at A001 and A017.	A 000	**PPOSBC Response to Amended CMS 2567 for COMPLAINT NUMBER CA00378267 :** *** PPOSBC former Compliance Officer during the interval in question is no longer with PPOSBC. However, senior management at PPOSBC including the PPOSBC CEO, and COO are aware of the standard processes engaged in by said former Compliance Officer including but not limited to said Compliance Officer's adherence to PPOSBC policies regarding reporting applicable incidents such as that described herein, and direct communication(s) with applicable affected PPOSBC patients. Therefore, the following said PPOSBC response is in good faith with respect to said former Compliance Officer's tenure at PPOSBC.* ***Amended CMS 2567 form CA00378267 Findings :*** a) Patient at issue was contacted by PPOSBC's compliance officer or his/her designee, informing said patient of the respective incident, of PPOSBC policies on the same and that PPOSBC would thoroughly investigate said incident and remedy as applicable. Said patient was provided full contact information at PPOSBC for any additional questions or follow up at patient's discretion. PPOSBC staff involved in each said incident was counseled and placed on administrative suspension as of said 11/7/2013 report by PPOSBC to CDPH. Subsequently, said staff was separated from employment with PPOSBC, so as to ensure optimal and maximum protection of patient medical information and data privacy and security. *b) PPOSBC staff involved in said incident was counseled and placed on administrative suspension as of said 11/7/2013 report by PPOSBC to CDPH. Subsequently, said staff was separated from employment with PPOSBC, so as to ensure optimal and maximum protection of patient medical information and data privacy.*	9.22.14
A 001	Informed Medical Breach 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 information.	A 001		

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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
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PLANNED PARENTHOOD/ORANGE & SAN BEI	700 S TUSTIN STREET ORANGE, CA 92863

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A 001	Continued From page 1	A 001	Additionally, 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.	9.22.14
A 017	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. This Statute is not met as evidenced by: Based on interview and clinic document review, the clinic failed to prevent a disclosure of Patient	A 017	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 Disclo sure 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 said above-referenced incident-specific retraining and counseling, as well as the 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: • 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 Protected Health Information/HIPAA	

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A 017	Continued From page 2 1's protected health information (PHI) from an unauthorized staff member. Findings: Review of the clinic's documents showed Patient 1 was at the clinic on 11/7/13. Before concluding the visit, the patient reported unauthorized access of her medical record by a current staff of the clinic (Staff 1). Patient 1 stated Staff 1 was a paternal family member to her child. Additionally, Patient 1 claimed Staff 1 shared the information after inappropriately accessing the patient's health information. Review of the clinic's investigation showed an analysis of Patient 1's electronic medical record (EMR) was done. The analysis confirmed Staff 1 accessed the patient's EMR four different times, without a need to know. During the times Staff 1 inappropriately accessed Patient 1's EMR, the progress notes of four different clinic visits were viewed. Continued review of the clinic's investigation showed an interview with Staff 1 occurred on 11/8/13. When asked, Staff 1 confirmed a familial relationship to Patient 1's child and stated it was possible the access to the patient's EMR was out of curiosity. When asked, Staff 1 confessed to having accessed the patient's EMR without a need to know. On 9/9/14 at 1020 hours, a telephone conference with the Privacy Officer occurred regarding the breach as documented.	A 017	• Proactive calendared non-licensed clinic/health center staff (e.g., Medical Assistants, reception staff) trainings that also include training on Protected Health Information • Health Center Managers proactively calendared trainings that focus on managing health center staff with respect to several matters, including Protected Health Information/HIPAA • Proactively calendared Annual All-Staff agency Training on Compliance Policies and Procedures • PPOSBC implemented automated audit software that provides information on potential unauthorized access by/disclosure to any level of agency staff, with respect to the agency Electronic Health Records system as well as related patient information systems such as those relevant to patient scheduling and administrative records. This audit software is breach detection technology that is fully integrated with our electronic health record system. On a daily basis, the breach detection technology/software analyzes access into the agency systems, thereby automatically monitoring potential unauthorized access and/or disclosures on numerous levels of the patient record such as lab results, progress notes, appointment information, and related facets • A culture that invites reporting any suspected compliance and/or privacy matters to supervisors in 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	9.22.14

2014 OCT 17 AM 9 54

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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 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	9.22.14

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California Department of Public Health

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

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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 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 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	9.22.14

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A 017	Continued From page 5	A 017	with our electronic health record system. On a daily basis, the breach detection technology/software analyzes access into the agency systems, thereby automatically monitoring potential unauthorized access and/or disclosures on numerous levels of the patient record such as lab results, progress notes, appointment information, and related facets • A culture that invites reporting any suspected compliance and/or privacy matters to supervisors in any department, including but not limited to PPOSBC Human Resources Department, Patient Services Department, Administration and the Compliance Department • Dedicated and consistent agency Quality Management/Quality Assurance meetings through the Patient Services Department to review and as applicable, improve the quality of agency processes • Dedicated and consistent (quarterly) agency Compliance and Enterprise Risk Management Committee to review and as applicable, improve the quality of agency processes • A dedicated Compliance agency Hotline 24 hours a day 7 days a week, 365 days a year • Suspension, Separation of Employment and/or other processes for sanctioning any staff that fails to follow said processes and trainings as described above 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	9.22.14

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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. 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 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.	9.22.14

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A 017	Continued From page 7	A 017	**d) and e)** : As noted in section (c) in significant detail: PPOSBC has a robust series of policies that all staff must adhere to regarding the optimum security and privacy of patient protected health information. Staff are also regularly trained and educated on said policies. I. Pertinent said policies include: • PPOSBC Compliance Policy CO-600 Corporate Compliance Program • PPOSBC Compliance Policy CO-1104 Patient Right to File Complaints About Use and Disclosure of their Protected Health Information • PPOSBC Compliance Policy CO-1105 HIPAA Privacy and Information Security Training • PPOSBC Compliance Policy CO-1108 Minimum Necessary Rule for Protected Health Information • PPOSBC Compliance Policy CO-111 Protected Health Information Breach Notification • PPOSBC Compliance Policy CO-112 Sanctions for Unauthorized Uses and Disclosures of a Patient's Protected Health Information II. In addition to the promulgation of said policies at PPOSBC, PPOSBC also regularly trains and educates 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 Protected Health Information/HIPAA	9.22.14

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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 trainings as described above	9.22.14

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A 017	Continued From page 9	A 017	Accordingly, as with any healthcare agency, such as hospitals, the CDPH, DHCS and other entities, PPOSBC is subject to common human errors or independent acts against established and reinforced agency policies. However, PPOSBC sets forth robust, consistent and good faith efforts to prevent and/or as applicable remediate towards optimum protection of health information for all patients. PPOSBC also makes every effort to communicate with any applicable patients at issue to assist them with any questions or concerns, including providing contact information for relevant staff such as patient services department or compliance department staff, and providing said patients with a toll-free phone number to utilize at any time. Thereby, PPOSBC submits in good faith that it is taking all measures feasible to prevent and as applicable in this matter, mitigate, reduce risk, raise quality and address any deficiencies that CPDH may nevertheless perceive. As additional measures: • PPOSBC has hired a chief Compliance Officer, chief Privacy Officer, and chief Security Officer to review PPOSBC systems for additional quality improvement as applicable. (i) One immediate result herein is the updating of the agency process to include the 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 • With said new hires, PPOSBC is also embarking on a long-term plan to continue to review all said applicable	9.22.14

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A 017	Continued From page 10	A 017	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 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.**	9.22.14

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A 000	Initial Comments AMENDED The following reflects the findings of the California Department of Public Health during the investigation of COMPLAINT NUMBER: CA00397908. Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 1835, HFEN. Findings for Complaint Number: CA00397908. The complaint allegation(s) were substantiated and regulatory violations written at A001 and A017.	A 000	**PPOSBC Response to Amended CMS 2567 for COMPLAINT NUMBER CA00397908 :** *.* PPOSBC former Compliance Officer during the interval in question is no longer with PPOSBC. However, senior management at PPOSBC including the PPOSBC CEO, and COO are aware of the standard processes engaged in by said former Compliance Officer including but not limited to said Compliance Officer's adherence to PPOSBC policies regarding reporting applicable incidents such as that described herein, and direct communication(s) with applicable affected PPOSBC patients. Therefore, the following said PPOSBC response is in good faith with respect to said former Compliance Officer's tenure at PPOSBC.* ***Amended CMS 2567 form CA00397908 Findings #1- #8 (inadvertent incidents):*** a) Patients at issue were contacted by PPOSBC's compliance officer or his/her designee, informing each said patient of the respective incident, of PPOSBC policies on the same and that PPOSBC would thoroughly investigate said incident and remedy as applicable. Each said patient was provided full contact information at PPOSBC for any additional questions or follow up at patient's discretion. Given each said incident was varying in nature, each PPOSBC staff involved in each said incident was counseled and retrained relevant to the incident at issue; this counseling and retraining included retraining on the privacy and security of protected health information and ensuring agency policies are conformed to, so as to ensure optimal and maximum protection of patient medical information and data privacy and security. b) Given each said incident was varying in nature, each PPOSBC staff involved in each said incident was counseled and retrained relevant to the incident at issue;	9.22.14
A 001	Informed Medical Breach 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 information.	A 001		

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE President (X6) DATE 10/9/14

STATE FORM 10/20/14 Acceptable POC - HFEN1835. 6899 CV0D11 If continuation sheet 1

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A 001	Continued From page 1	A 001	however, this counseling and retraining collectively included retraining on the privacy and security of protected health information and ensuring agency policies are conformed to, so as to ensure optimal and maximum protection of patient medical information and data privacy and security.	9.22.14
A 017	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. This Statute is not met as evidenced by: Based on interview and facility document review, the facility failed to prevent the disclosure of eight	A 017	Additionally, 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 said above-referenced incident-specific retraining and counseling, as well as the 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: • Protected Health Information/HIPAA in-person training at staff orientation day/hire	

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A 017	Continued From page 2 patients (Patients A, B, C, D, E, F, G and H) protected health information (PHI) to unauthorized individuals. Findings: 1. Review of the clinic documentation shows a breach of Patient A's PHI occurred at the Anaheim Health Center on 12/5/12. The clinic staff were made aware the incorrect patient was handed a urine cup labeled with Patient A's PHI on it. Patient A's disclosed PHI included initial of first name, last name and date of birth (DOB). 2. On 1/2/13, the Department was notified a breach of Patient B's PHI occurred at the Mission Viejo Health Center on 12/31/12. A clinic Physician's Assistant inadvertently handed a prescription intended for Patient B to another patient. Patient B's disclosed PHI included first and last name, DOB, address and phone number. 3. Review of the clinic's report showed a breach of Patient C's PHI occurred on 1/11/13, at the Westminster Health Center. The investigation showed a patient checked in and stated her first name. An Administrative staff asked if the patient's last name began with a certain letter in the alphabet to which the patient agreed. The Administrative staff typed and printed labels which were affixed to the paperwork and handed the paperwork to the patient to fill out. The patient took the paperwork to complete and went back to the administrative staff and stated the last name on the labels were incorrect.	A 017	• An **additional** Protected Health Information/HIPAA Online module new staff training for **new staff** to be completed with a set period of time immediately post-orientation/hire • Proactive calendared clinic/health center Licensed Clinician trainings that also include training on Protected Health Information/HIPAA • Proactive calendared non-licensed clinic/health center staff (e.g., Medical Assistants, reception staff) trainings that also include training on Protected Health Information • Health Center Managers proactively calendared trainings that focus on managing health center staff with respect to several matters, including Protected Health Information/HIPAA • Proactively calendared Annual **All-Staff** agency Training on Compliance Policies and Procedures • PPOSBC implemented automated audit software that provides information on potential unauthorized access by/disclosure to any level of agency staff, with respect to the agency Electronic Health Records system as well as related patient information systems such as those relevant to patient scheduling and administrative records. This audit software is breach detection technology that is fully integrated with our electronic health record system. On a daily basis, the breach detection technology/software analyzes access into the agency systems, thereby automatically monitoring potential unauthorized access and/or disclosures on numerous levels of the patient record such as lab results, progress notes, appointment information, and related facets • A culture that invites reporting any suspected compliance and/or privacy matters to supervisors in 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	9.22.14

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A 017	Continued From page 3 Patient C's disclosed PHI included first and last name, DOB and medical record number. 4. Review of the clinic's documentation showed, on 3/5/13, clinic staff became aware a breach of Patient D's PHI occurred at the Santa Ana Health Center on 2/21/13. On 2/21/13, a new patient (Patient D) checked in and staff made a Family Pact Identification Card for Patient D. Just after Patient D checked in, an established patient checked in and handed their Family Pact Card to the staff. When finished checking in, staff handed the established patient the newly made Family Pact Identification Card for Patient D. Patient D's disclosed PHI included name, DOB and Family Pact Identification Card number. 5. Review of the clinic's reported incident showed a breach of Patient E's PHI occurred at the Anaheim Health Center on 3/21/13. Patient E had already checked in at the clinic when a new walk-in patient checked in shortly afterwards. The new patient completed all the paperwork and a Family PACT Identification Card was made for this patient. However, after about 15 minutes of waiting, the new patient could not wait any longer. A staff member handed the new patient what was thought to be the Family PACT Identification Card made for the new patient. Later, the staff member realized Patient E's Family PACT Identification Card was inadvertently given to the new patient. Patient E's disclosed PHI included name, DOB and the Family PACT Identification Card number. 6. Review of the Anaheim Health Center's documentation showed on 4/30/13, they discovered a breach involving Patient F occurred	A 017	the Patient Services Department to review and as applicable, improve the quality of agency processes • Dedicated and consistent (quarterly) agency Compliance and Enterprise Risk Management Committee to review and as applicable, improve the quality of agency processes • A dedicated Compliance agency Hotline 24 hours a day 7 days a week, 365 days a year • Suspension, Separation of Employment and/or other processes for sanctioning any staff that fails to follow said processes and trainings as described above 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	9.22.14

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	CA060001620	A. BUILDING: _____ B. WING _____	C 09/09/2014

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A 017	Continued From page 4 on 9/29/12. The investigation showed when a returning patient came into the center on 4/30/13, the patient's card with NexPlan on it had Patient F's name on it. It was discovered a Physician Assistant (PA) saw both the returning patient and Patient F on 9/29/12. On 9/29/12 while the PA was preparing NexPlan for the returning patient, Patient F's chart was open and the PA inadvertently documented Patient F's name on the incorrect card. Patient F's disclosed PHI included name only. 7. Review of a Costa Mesa Health Center report showed on 6/7/13 a breach of Patient G's PHI occurred. On 6/7/13, a patient came into the clinic requesting a copy of their medical record. A staff printed the medical record and gave it to the patient. Later the patient called to inform the staff the last page in the medical record packet belonged to another patient. Patient G's disclosed PHI included name, DOB, address, phone number, last four digits of the social security number and a laboratory requisition. 8. Review of a report regarding the Costa Mesa Health Center showed a patient who was at the clinic on 6/6/13, called on 6/7/13 to inform staff she received notification of being Web enabled to the Patient Portal online. However, when the patient logged on the information belonged to Patient H. Investigation showed this patient and Patient H were seen at the clinic at approximately the same time on 6/6/13 and a staff inadvertently put Patient H's information into this other patient's medical record. Patient H's disclosed PHI included name and	A 017	• PPOSBC Compliance Policy CO-1104 Patient Right to File Complaints About Use and Disclosure of their Protected Health Information • PPOSBC Compliance Policy CO-1105 HIPAA Privacy and Information Security Training • PPOSBC Compliance Policy CO-1108 Minimum Necessary Rule for Protected Health Information • PPOSBC Compliance Policy CO-111 Protected Health Information Breach Notification • PPOSBC Compliance Policy CO-112 Sanctions for Unauthorized Uses and Disclosures of a Patient's Protected Health Information II. In addition to the promulgation of said policies at PPOSBC, PPOSBC also regularly trains and educates 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 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	9.22.14

California Department of Public Health

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A 017	Continued From page 5 year of birth. On 9/9/14 at 1020 hours, a telephone conference with the Privacy Officer occurred regarding the breaches as documented.	A 017	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 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	9.22.14

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A 017	Continued From page 6	A 017	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: • 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.	9.22.14

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A 017	Continued From page 7	A 017	• 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. **d) and e)** : As noted in section (c) in significant detail: PPOSBC has a robust series of policies that all staff must adhere to regarding the optimum security and privacy of patient protected health information. Staff are also regularly trained and educated on said policies. I. Pertinent said policies include: • PPOSBC Compliance Policy CO-600 Corporate Compliance Program • PPOSBC Compliance Policy CO-1104 Patient Right to File Complaints About Use and Disclosure of their Protected Health Information • PPOSBC Compliance Policy CO-1105 HIPAA Privacy and Information Security Training • PPOSBC Compliance Policy CO-1108 Minimum Necessary Rule for Protected Health Information • PPOSBC Compliance Policy CO-111 Protected Health Information Breach Notification • PPOSBC Compliance Policy CO-112 Sanctions for Unauthorized Uses and Disclosures of a Patient's Protected Health Information II. In addition to the promulgation of said policies at PPOSBC, PPOSBC also regularly trains and educates 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	9.22.14 9.22.14

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A 017	Continued From page 8	A 017	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 Protected Health Information/HIPAA • Proactive calendared non-licensed clinic/health center staff (e.g., Medical Assistants, reception staff) trainings that also include training on Protected Health Information • Health Center Managers proactively calendared trainings that focus on managing health center staff with respect to several matters, including Protected Health Information/HIPAA • Proactively calendared Annual **All-Staff** agency Training on Compliance Policies and Procedures • PPOSBC implemented automated audit software that provides information on potential unauthorized access by/disclosure to any level of agency staff, with respect to the agency Electronic Health Records system as well as related patient information systems such as those relevant to patient scheduling and administrative records. This audit software is breach detection technology that is fully integrated with our electronic health record system. On a daily basis, the breach detection technology/software analyzes access into the agency systems, thereby automatically monitoring potential unauthorized access and/or disclosures on numerous levels of the patient record such as lab results, progress notes, appointment information, and related facets • A culture that invites reporting any suspected compliance and/or privacy matters to supervisors in any department, including but not limited to PPOSBC Human Resources Department, Patient Services Department, Administration and the Compliance Department	9.22.14

California Department of Public Health

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A 017	Continued From page 9	A 017	• Dedicated and consistent agency Quality Management/Quality Assurance meetings through the Patient Services Department to review and as applicable, improve the quality of agency processes • Dedicated and consistent (quarterly) agency Compliance and Enterprise Risk Management Committee to review and as applicable, improve the quality of agency processes • A dedicated Compliance agency Hotline 24 hours a day 7 days a week, 365 days a year • Suspension, Separation of Employment and/or other processes for sanctioning any staff that fails to follow said processes and trainings as described above 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: • PPOSBC has hired a chief Compliance Officer, chief Privacy Officer, and chief Security Office to review	9.22.14

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A 017	Continued From page 10	A 017	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 • 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 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.**	9.22.14

2014 OCT 17 AM 11

California Department of Public Health

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A 000	HSC Initial Comments The following reflects the findings of the California Department of Public Health during a complaint investigation for COMPLAINT NO: CA00352542. Inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 28950, HFEN. Deficencies were found and written at H&S 1293.2. GLOSSARY OF ABBREVIATION: CDPH - California Department of Public Health	A 000	**Response to A001 -** We will work to make every attempt to provide records within a timely manner. **Corrective action for identified patients -** We cannot change the charting or medical doctor assessment of EBL for the patients identified in this report or any additional past patients. We did intervene with these physicians and discussed clear documentation of EBL in the future.	2013 SEP 26 PM 12 15
A 001	HSC 1293.2. H & S Code 1293.2.(a) 1293.2. It is a misdemeanor for any person to do any of the following: (a) Willfully prevent, interfere with, or attempt to impede in any way the work of any duly authorized representative of the state department in the lawful enforcement of this chapter. This Statute is not met as evidenced by: Based on interview, the facility failed to provide access to medical records, as required by law, for the CDPH representative. This has the potential to impede a medical investigation. Findings: On 4/29/13 at 1420 hours, a visit was made to the	A 001	**Response to D183-1 -** Our recovery room nurses are trained to measure EBL on sanitary pads, and a pictorial of sanitary pad soaking is placed on the wall in the recovery room bathroom. As a result of these incidents, a direct intervention with the physician occurred in which he was advised to more closely monitor EBL and was limited in gestational age in which he may perform procedures. In addition, an in-service has been held with the staff and MDs on September 26, 2013 that reviewed modes of estimating EBL, including weighing chucks and measuring suction canister volume. Training components included reference to visual aids, review of PPOSBC protocols, and practice in calculating EBL to better support accurate EBL documentation	

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Assistant 9/26/13

STATE FORM 6899 G61V11 If continuation sheet 1 of 4

Accepted 10-3-13

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A 001	Continued From page 1 facility to begin a complaint investigation. Upon arrival, the Facility Manager was informed a complaint investigation was being conducted, official state identification was provided and a request for a tour of the facility was made. The Facility Manager provided a tour after calling the CDPH office to verify the identity of the surveyor. At 1500 hours, the Facility Manager was interviewed and was asked for access to the medical records to continue the investigation. The manager left the room and returned a few minutes later. The manager stated the CEO had been called and would not permit access to the medical records. The manager stated a written request for patient records from the CDPH could be made and medical information would then be sent to the department. At 1530 hours, a copy of the Health and Safety Code 1293.2 was provided to the Facility Manager. The Facility Manager still refused access to the medical records.	A 001	During the past year, we have also initiated a more vigilant incident monitoring program through our Quality Management Department to identify areas for potential improvement in care and documentation. In addition to documenting quality improvement activities, detailed summaries of all adverse events occurring in the health centers are reported to Planned Parenthood Federation of America (PPFA). After this intervention, and routinely thereafter, the Director of Quality Management and Medical Director will complete a chart audit using PPFA-approved audit tools for evaluating surgical abortion procedures which includes the assessment of documented EBL estimations. In addition to a review of medical records, we will also utilize the PPFA-approved observation tool to assess adherence to PPOSBC protocols for surgical abortion procedures. The chart audit and observations will be performed by our Director of Quality Management and supervised by the Medical Director. Subsequent reviews will consist of an annual comprehensive program review of surgical abortion procedures. This review has been added to the Annual Quality Management calendar of activities and is 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 document EBL and track complications. This will be completed in September 2013.	2013 SEP 25 PM 12 15
D 183	T22 DIV5 CH7 ART6-75055(f) Unit Patient Health Records (f) Patients' health records shall be current and kept in detail consistent with good medical and professional practice and shall describe the services provided to each patient. All entries shall be dated and be authenticated with the name, professional title, and classification of the person making the entry. This Statute is not met as evidenced by: Based on health record review and interview, the	D 183		

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D 183	Continued From page 2 clinic failed to document accurate blood loss using professional practices for two of five sampled patients (Patients 1 and 2). The estimated blood loss (EBL) for Patient 1 was documented as a total of 215 ml (milliliters). The patient had a significant drop in her hemoglobin from 13.8 to 8.6, indicating a higher loss of blood. Patient 2 had a drop of her hemoglobin from 11.8 to 9.4; and was documented as having heavy bleeding. Physician 2 estimated Patient 2's blood loss as less than 15 ml. This has the potential for the patients' physical assessments to be incorrect which can lead to complications from blood loss. Findings: 1. Health record review for Patient 1 was initiated on 5/7/13. Review of the Progress Notes dated 2/22/13, showed at 1140 hours, Patient 1's hemoglobin level prior to her surgical procedure was 13.8 gm/dl (grams per deciliter) (normal 12-14 gm/dl). The procedure was initiated at 1331 hours. At the end of the procedure, the physician documented an EBL of 15 ml. Patient 1 was transferred to the recovery room at 1353 hours. The progress notes show an EBL of 200 ml and a hemoglobin of 11 gm/dl (a drop of 2.8) while in the recovery room. At 1417 hours, Patient 1 was transferred back to the procedure room for active bleeding. The documentation shows at 1743 hours, the indwelling catheter was removed and Patient 1 had "copious vaginal bleeding." The hemoglobin was re-measured at 8.6 gm/dl (a total drop of 5.2 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	D 183	**Response to D183-2-** Our recovery room nurses are trained to measure EBL on sanitary pads, and a pictorial of sanitary pad soaking is placed on the wall in the recovery room bathroom. As a result of these incidents, a direct intervention with the physician occurred in which he was advised to more closely monitor EBL. This physician has now retired and is no longer working for PPOSBC. In addition, an in-service was held with the staff and MDs on September 26, 2013 that reviewed modes of estimating EBL, including weighing chucks and measuring suction canister volume. Recovery room staff will be empowered to quantify EBL in their notes based on their training. Of note, enhanced use of the electronic medical record system will better facilitate documentation of EBL in the patient's record. During the past year, we have also initiated a more vigilant incident monitoring program through our Quality Management Department to identify areas for potential improvement in care and documentation. After this intervention, we will complete a chart audit to assess EBL estimations going forward. The chart audit will be performed by our Director of Quality Management and supervised by the Medical Director. As noted in PPOSBC's Quality Management Plan, all audit results will be shared with the Quality Management Committee. Quality Improvement activities will be implemented as needed to address deficiencies and strengths identified during the review.	2013 SEP 26 PM 12 15

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	CA060001620	A. BUILDING: _____ B. WING _____	C 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 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 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 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.	D 183	**Monitoring** - Per PPOSBC's Quality Management Plan, all quality activities and corrective action steps will be formally documented and managed by the Director of Quality Management. The Corrective Action Plan will be signed by the Medical Director and Chief Administrative Officer once completed.	
	At 1430 hours, Patient 2 returned to the clinic complaining of having heavy bleeding. The hemoglobin was 9.4 gm/dl (a 2.4 gm/dl drop). An interview with the Medical Director was initiated on 7/11/13 at 1000 hours. The Medical Director stated a drop in the hemoglobin by one point usually means a loss of 300 ml of blood (2.4 point drop x 300 ml = 720 ml blood loss).			

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA060001620	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD/ORANGE & SAN BEI	700 S TUSTIN STREET ORANGE, CA 92863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of COMPLAINT NUMBER: CA00334630. Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 1835, HFEN. Findings for Complaint Number CA00334630: The complaint allegation(s) were substantiated and regulatory violations written at A001 and A017.	A 000	**Complaint Number CA00334630** a) Corrective Actions accomplished for the patients identified to have been affected are as follows: **1. Mission Viejo Health Center** Letters sent to Patients A, B and F notifying them of an unintentional breach of their personal information which included their name, date of last menstrual period, size of family, income and the internal medical record number. Letter sent to Patient C notifying her of an unintentional breach of her personal information which included her name.	3/19/12 3/19/12
A 001	Informed Medical Breach 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 information.	A 001	Letter sent to Patient D notifying her of an unintentional breach of her personal information which included her name, date of birth and date of last menstrual period. Letter sent to Patient E notifying her of an unintentional breach of her personal information which included her name, date of birth, phone number, social security number, name of her insurance company and the insurance identification number. Provided all patients resources on how to contact our office for additional assistance.	3/19/12 3/19/12

Licensing and Certification Division

Pat Velting Pat Velting — Operations Manager for CDPH — 1/25/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

1/29/13 - Accepted - 18.365 HFEN

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA060001620	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD/ORANGE & SAN BEI	700 S TUSTIN STREET ORANGE, CA 92863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 017	Continued From page 1	A 017	a) Corrective Actions Continued	
A 017	1280.15(a) Health & Safety Code 1280 (a) 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. This Statute is not met as evidenced by: Based on interview and hospital document review, the facility failed to prevent the disclosure of 11 patients' protected health information (PHI) to unauthorized individuals (Patients A, B, C, D, E, F, G, H, I, J and K).	A 017	**2. Costa Mesa Health Center** Letter sent to Patient H notifying them 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 for additional assistance. **3. Anaheim Health Center** Letter sent to Patient J notifying her of an unintentional breach of her first initial, last name and date of birth. Also provided patient resources on how to contact our office for additional assistance. **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. 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. **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.	6/21/12 10/19/12 5/3/12 8/2/12 11/9/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA060001620	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD/ORANGE & SAN BEI	700 S TUSTIN STREET ORANGE, CA 92863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 017	Continued From page 2 Findings: 1. Review of Mission Viejo Health Center documentation showed a breach of PHI involving six patients. On 3/14/12, a back office Medical Assistant was handed four pieces of paper, folded in half, and dated 3/13/12, by a patient. The papers contained the hand written PHI of Patients A, B, C, D, E, and F. Further review of the health center's investigation showed on 3/13/12, a call center representative was taking the four pieces of paper with the six patient's PHI to the shredder. However, the call center representative had to go to the bathroom. The patient, who returned the papers stated they were found on top of the paper towel dispenser in the bathroom. The disclosed PHI belonging to Patients A, B, C, D, E and F are as follows: 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. 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	A 017	b) How other patients having the potential to be affected by the same deficient practice can be identified and what corrective actions will be taken. In the above findings members of our staff neglected to follow our procedure for verifying the identity of a patient before giving them a urine cup, supply or prescription. We continue to education our staff on patient verification before distribution of supplies or paperwork. We also stress the importance of verifying FAX numbers before transmitting information. We remind staff to follow our FAX policy regarding PHI information. When a HIPAA violation occurs the health center manager investigates the 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 and communicated with staff. Employees we were able to identify as violators of HIPAA incidents receive Corrective Action Warning Notices.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA060001620	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD/ORANGE & SAN BEI	700 S TUSTIN STREET ORANGE, CA 92863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 017	Continued From page 3 documentation showed on 6/19/12, it was discovered two urine cups with Patient H's PHI, had been given to another patient to take home on 12/20/11. The PHI disclosed belonging to Patient H included name, date of birth, the health center's internal chart number and the Health Access Program number. 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	A 017	c) What immediate measures and systemic changes will be put in place to ensure that deficient practices do not recur? On the above listed findings we made the following changes: We placed a personal shredder next to the health center's call representative's desk so they could shred documents before they left their desk. Since this 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 pre-program those FAX numbers that are used repeatedly. One must always verify the numbers they have entered before transmitting a FAX.	

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA060001620	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD/ORANGE & SAN BEI	700 S TUSTIN STREET ORANGE, CA 92863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 017	Continued From page 4 identification card belonging to Patient I. The health center discovered the inadvertent act on 7/29/2012. The PHI belonging to Patient I that was disclosed included name, date of birth, and the Family Pact card identification number. 6. On 11/5/12, the Westminster Health Center discovered staff had inadvertently given another patient a form belonging to Patient K on 11/1/12. The PHI disclosed on the form showed Patient K's name and a test result. 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.	A 017	d) Description of the monitoring process. Monitoring process includes Management overseeing the operations of our health centers including the distribution of supplies and prescriptions. Newly hired staff receive HIPAA training on their first day of work before going to their worksite. Health Center Medical Assistants receive additional HIPAA training during their weeklong orientation training within 30 days of new hire. We also have quarterly Medical Assistant trainings where we train and reinforce the importance of Privacy and following HIPAA requirements and regulations. This training is provided by the Compliance Department. Health Center staff are also reminded of the importance 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 understand the importance of following our policies. e) Date when corrective action will be completed.	Ongoing 1/6/13

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
	CA220001034	A. BUILDING: _____ B. WING _____	C 11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD	225 SAN ANTONIO ROAD MOUNTAIN VIEW, CA 94040

(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 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	D 000		

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Center Manager

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA080001701	A. BUILDING _____ B. WING _____	03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - MISSION BAY CLINIC	4501 MISSION BAY DRIVE, SUITE 1C & D SAN DIEGO, CA 92109

(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 following an investigation of a self-reported breach of a patient's medical information. Complaint number: CA00420907 The investigation was limited to the specific event 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 State ID: 15932.	D 000	a. The deficiency occurred when Patient B was handed an enrollment letter with instructions for how to set up a patient portal account and password that was intended for Patient A. The medical assistant involved in the error failed to follow the normal process for confirming the patient's identity prior to handing over the enrollment letter. Once we became aware of the error, we immediately dis-enrolled Patient A from the patient portal to ensure that Patient B was unable to gain further access to Patient A's portal. In addition, we apologized to Patient A in person at her next visit three days later and she received an updated enrollment letter with instructions for how to set up her patient portal account and password. A follow up breach notification letter was then sent to Patient A the day after her visit. The plan is to ensure that medical assistants always establish correct patient identity prior to handing an enrollment letter to a patient. Since this incident occurred, a third identifier has been added to the patient portal enrollment process. In order to set up a patient portal account, the patient must now enter their date of birth in addition to the token listed on the enrollment letter and their email address. Since the date of birth is not listed on the enrollment letter, a patient would not be able to inadvertently access another patient's portal without knowing this additional identifier. b. The procedure will include reviewing with all staff our established process for ensuring that the correct patient receives the correct enrollment letter. This includes (a) verbally establishing correct patient identity and (b) asking the patient to ensure the name and email address on the enrollment letter belong to them. c. Monitoring procedures will include follow up training at routine center staff meetings regarding the mandatory process for establishing correct patient identity prior to handing over a patient portal enrollment letter to the patient.	11-14-14 11-17-14 11-18-14
A 001	Informed Medical Breach 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 information.	A 001		
D 177	T22 DIV5 CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records	D 177		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane R. DeRille — TITLE: HIPAA Privacy officer — (X6) DATE: 4/21/15

Accepted 4/27/15
15932

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA080001701	A. BUILDING _____ B. WING _____	03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - MISSION BAY CLINIC	4501 MISSION BAY DRIVE, SUITE 1C & D SAN DIEGO, CA 92109

(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 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 11/14/14. The facility notified the Department of the incident on 11/18/14. The facility reported that the breach included the following PHI related to Patient A: Name, laboratory results, visit description and provider name. The Administrative staff confirmed the incident during a telephone interview on 3/18/15. The Administrative staff stated Patient B received a welcome letter that was meant for Patient A. The welcome letter contained instructions on how to access the portal that contained the PHI of Patient A.	D 177	Continued From Page 1 **c.** The monitoring process will also include a review of all patient privacy root cause analysis reports by the HIPAA Privacy Officer, Sr. Director of Quality and the Sr. Director of Center Operations. We will identify any similar errors and address them immediately to avoid system-wide errors. **d.** The Health Center Manager is responsible for implementing the plan of correction and for continuously monitoring compliance to all HIPAA privacy policies and procedures in their health centers. This includes the protection of patient privacy through the mandatory process of establishing correct patient identity prior to handing over an enrollment letter to a patient. In addition, the HIPAA Privacy Officer conducts HIPAA training for all new health center staff as part of the agency's orientation and training program as well as an annual HIPAA Compliance Training review. HIPAA compliance audits are also conducted annually at a minimum of six health centers. HIPAA privacy breaches are also reviewed and discussed with health center leadership at bi-annual meetings. **e.** The Health Center Manager immediately reviewed what contributing factors led to the error by conducting a root cause analysis and determined that a medical assistant had not followed our mandatory internal process for establishing correct patient identity prior to handing over a patient portal enrollment letter. The Health Center Manager reviewed and discussed the incident with all staff at the next staff meeting and reminded them of the importance of ensuring that correct patient identity is always established prior to handing over a patient portal enrollment letter. The third identifier was added to require date of birth in order to enroll in the patient portal. All corrective actions were completed by 11-26-14.	11-26-14 11-20-14

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
	CA250001778	A. BUILDING: _____ B. WING _____	C 02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - MORENO VALLEY	12900 FREDERICK STREET, SUITE C MORENO VALLEY, CA 92553

(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	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of one entity reported incident. Entity reported incident number: CA00429105 Representing the California Department of Public Health: 25937 / 2122 The inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility. This Department was able to substantiate a violation of the regulations.	A 000	We spoke to Patient A on the phone and apologized to her for the error. She agreed to return the letter with Patient B's information on it to us in a self-addressed, stamped envelope that was mailed out to her. In addition, an RN in the Case Management Department called Patient A, discussed her lab results with her and scheduled an appointment for her to receive treatment. A follow up letter was mailed to Patient A informing her that Patient B had returned the letter with Patient A's information on it. We apologized to Patient B in person, retrieved the letter from her with Patient A's information on it and provided her with appropriate treatment.	1-12-15 1-26-15 1-13-15
A 001	Informed Medical Breach 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 information.	A 001	A follow up letter was mailed to Patient B informing her that Patient A had agreed to return the letter to us with Patient B's information on it. We have determined that this is not a system error; it is a one-off error by an employee. The RN Manager of Case Management immediately discussed the incident with the Case Management Specialist involved in the error and reminded her that our process includes the mandatory double checking of the patient name and address on a lab results letter against the patient name and address on the envelope label, prior to placing the letter.	1-26-15 1-20-15

AE Reviewed 3-30-15 KL

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane R. DeFille — TITLE: HIPAA Privacy Officer — (X6) DATE: 3/25/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA250001778	A. BUILDING: _____ B. WING _____	C 02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - MORENO VALLEY	12900 FREDERICK STREET, SUITE C MORENO VALLEY, CA 92553

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 017	Continued From page 1	A 017		
A 017	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. 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	A 017	in the envelope. The Case Management Manager also reinforced with the employee the need to handle only one patient letter and envelope at a time. Every new Case Management RN receives training which includes mandatory double checking of patient name and address on a lab results letter against the patient name and address on the envelope label prior to placing the letter in the envelope. The RN Case Management Manager is responsible for continuously monitoring compliance to all HIPAA privacy policies including our process of mandatory double checking of patient name and address on a lab results letter against the patient name and address on the envelope label prior to placing the letter in the envelope. It is part of the annual performance evaluation, which is conducted by the RN Case Management Manager. HIPAA training for all new staff is conducted by the HIPAA Privacy Officer as part of the agency's orientation and training program in addition to an annual HIPAA Compliance Training review. HIPAA compliance audits are also conducted on an annual basis by the HIPAA Privacy Officer. All corrective actions were completed by 1-26-15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA250001778	A. BUILDING: _____ B. WING _____	C 02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - MORENO VALLEY I	12900 FREDERICK STREET, SUITE C MORENO VALLEY, CA 92553

(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 2 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 positive Chlamydia results (a sexually transmitted disease). 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	A 017		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - MORENO VALLEY	12900 FREDERICK STREET, SUITE C MORENO VALLEY, CA 92553

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A 017	Continued From page 3 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.	A 017		

California Department of Public Health

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	240001766	A. BUILDING: _____ B. WING _____	01/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD/ORANGE & SAN BEI	1873 COMMERCENTER WEST SAN BERNARDINO, CA 92408

(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 an abbreviated standard survey to investigate an entity reported incident. Entity Reported Incident Number: CA00421439 Representing the California Department of Public Health: 34388-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. One deficiency was issued for entity reported incident number: CA00421439	D 000	RE: CMS 2567 Entity Reported Incident Number CA00421439 PPOSBC submits that to PPOSBC's knowledge, no PHI may have been actually been breached in this matter, as the receiving entity was a covered and treating entity that recognized based on patient name that the document at issue was not the intended patient record; and furthermore, that covered/treating entity expeditiously contacted PPOSBC and expeditiously returned the PHI to PPOSBC via certified mail. However, as reported in PPOSBC's initial report to your facility, PPOSBC nevertheless reported this matter in good faith; thereby, PPOSBC respectfully submits that this form may be inapplicable to PPOSBC for this matter. However, PPOSBC respectfully submits its plan of correction to your form 2567 as follows. Your CMS 2567 correspondence dated January 14, 2015 states in pertinent part:	01.23.15
D 177	T22 DIV5 CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure the confidential treatment of protected health information (PHI) for Patient B, when a medical assistant (MA 1) inadvertently scanned a release form into the medical record of Patient B instead of Patient A. A medical records clerk (MRC 1) then processed the release of records and mailed the medical records for Patient B to an outside entity. This failure resulted in an unauthorized release of PHI for Patient B.	D 177	The Plan of Correction for each deficiency must contain the following: a) What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice. b) How other patients having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken. 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 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. Per your request, please find the following pertinent Plan of Correction.	

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE President/CEO (X6) DATE 1/27/15

1-29-15 PW

California Department of Public Health

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	240001766	A. BUILDING: _____ B. WING _____	01/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD/ORANGE & SAN BEI	1873 COMMERCENTER WEST SAN BERNARDINO, CA 92408

(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 Finding: 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 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 Patient B.	D 177	a) PPOSBC contacted the patient at issue by phone as well as mailed a written correspondence Notice to the patient at issue; said correspondence included identifying the incident at issue, identifying PPOSBC commitment to patient privacy and security as well as PPOSBC"s commitment to retraining and counseling of staff at issue; as well as contact information for three credit reporting agencies, and contact information for PPOSBC's Privacy Officer in the event patient wished to further communicate regarding this matter. Said correspondence to patient was previously provided to your facility and is again attached. (b), (c), (d), and (e): PPOSBC takes this matter very seriously both for the matter at issue and regarding other patients. Thereby, PPOSBC continues with quality assurance measures to train and re-train all staff on management and protection of protected health information (PHI). PPOSBC conducts on-going quality assurance focused PHI trainings, with both patient services staff, and PPOSBC other staff. PHI training includes in-depth training at onset of hire with PPOSBC, as well as annual PHI trainings; as well as one-to-one re-trainings with specific staff involved in this specific matter. PPOSBC also completes pro-active ongoing PHI compliance and risk management trainings, including the annual all-staff training completed during October 2014; and further trainings during July 29, 2014, and July 30, 2014 for patient services staff. Please find previously-submitted enclosed copies of agendas for ongoing patient services, and all-staff PPOSBC compliance, privacy and PHI training. PPOSBC has a proactive program whereby clinical, and non-clinical staff are proactively trained/retrained on security and privacy of PHI, and PHI process(es). Specific trainings to specific staff are also conducted regarding any pertinent matters such as this matter. Thus, PPOSBC conducts both proactive	01.23.15

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD/ORANGE & SAN BEI	1873 COMMERCENTER WEST SAN BERNARDINO, CA 92408

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D 177	Continued From page 2		on-going training as well as any applicable re-training as warranted. Also attached are relevant and previously submitted policies regarding compliance, privacy, PHI, and records release processing. In reviewing the matter at issue, PPOSBC submits in good faith that applicable robust trainings on pertinent policies were implemented proactively and consistently irrespective of this matter; and the matter at issue was an inadvertent, human-error matter requiring retraining and counseling of specific staff at issue as described. Nevertheless, as stated, PPOSBC has further retrained and counseled staff on the import of the privacy and security of PHI and related processes (please kindly again note by the several training agendas and programs copies attached hereto). Both the PPOSBC medical records clerk and the PPOSBC MA at issue have also received specific retraining and counseling on agency processes and policies required for release of records including verifying correct patient data and identification at each stage of said process Also as part of PPOSBC's commitment to quality assurance processes, PPOSBC will continue to focus on on-going robust trainings at all applicable levels. This includes not only a full compliance and PHI training at inception of employment, and at applicable departmental levels, but also, ongoing "Annual," all-staff trainings as exemplified by the newly implemented annual PPOSBC Compliance & Risk Management All-Staff training program commencing with the 2014 annual program (a paper copy of which program is also attached hereto). Applicable supervisory staff for ongoing trainings and monitoring of compliance include PPOSBC compliance management staff, PPOSBC Administrative management staff, PPOSBC Information Technology management staff, and PPOSBC Patient Services management staff,	01.23.15

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D 177	Continued From page 3		all staff work together on training applicable staff and issue, maintaining parallel policies on protected Health information privacy and security and monitoring compliance regarding the same. Additionally, through the supervision of PPOSBC Information Technology staff, PPOSBC has implemented new electronic security measures/processes through a third-party software program designed to automatically detect, and report to PPOSBC unauthorized access to protected health information and related systems. PPOSBC has also hired a Compliance Officer and Privacy Officer in addition to other additional compliance staff. PPOSBC Health Center Managers have also received additional training regarding on-site training, monitoring, reporting and management of protected health information privacy and security. PPOSBC therefore, respectfully and in good faith submits it has an efficient and good faith patient and protected health information plan of correction program for this matter currently implemented. Thank you for your attention to this matter.	01.23.15

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PLANNED PARENTHOOD/ORANGE & SAN BEI	1873 COMMERCENTER WEST SAN BERNARDINO, CA 92408

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

11-10-15 DW

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D 177	Continued From page 1 Officer (CO) on October 7, 2015 at 3:55 PM, the CO stated that the breach was discovered on September 21, 2015, when Registered Nurse (RN 1) noticed the fax confirmation sheet indicated the documents were faxed to two fax numbers instead of just the one for which it was intended. RN 1 contacted the agency where the fax was sent in error, and employees of the agency advised her that the faxed documents would be destroyed. The documentation contained Patient A's name, account number, date of birth, address, phone number, past medical history, past surgical history, vital signs (blood pressure, heart rate, height, weight, and temperature) current medication, medication/treatment prescribed, negative Human Immune Deficiency Virus Antibody (HIV) test results, recent sexual history, drug use history, and family medical history. A concurrent interview was conducted on October 09, 2015 at 9:45 AM with the CO and RN 1. When asked how the incident occurred, RN 1 stated, "We have numbers (fax numbers) that are already pre-populated (entered previously). I pick from the drop-down menu and press send ....The confirmation sheet noted it was sent to (agency name where it was intended to be faxed) and another fax number ... There was another fax number somewhere in fax machine history ...The other fax number did not appear anywhere when I sent the fax." The CO was asked about what facility or departmental measures have been established to prevent an occurrence like this in the future. The CO stated, "Information Technology (IT)	D 177	thoroughly evaluated said facsimile machine functions for performance improvement; PPOSBC was able to expeditiously devise bolstered quality assurance for said facsimile machine wherein the machine is now programmed to prompt a user to affirmatively approve any fax number(s) to which a user intends to submit authorized facsimile transmissions. Additionally, PPOSBC case management staff members were promptly counseled and retrained on or about September 29, 2015 regarding protected health information privacy and security, as well as use of said updated facsimile process (please see copy of September 29, 2015 PPOSBC Case Management Training Agenda, attached hereto and incorporated herein). ***"(b) How other patients having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken."*** **(b):** 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 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	10/12/15

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D 177	Continued From page 2 Department has changed the fax machine to force the sender to confirm the fax number before sending the fax ... The sender cannot fax without first confirming the number." A review of the facility policy titled, "Confidentiality of Protected Health Information," revised February, 2015, indicated, "Procedures: 1 ...Protected Health Information (PHI) may not be disclosed or released without a completed valid written authorization signed by the patient or legally authorized representative."	D 177	(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. • An **additional** 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). • Proactively calendared Annual **All-Staff** Training 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.	10/12/15

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D 177	Continued From page 3	D 177	(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 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 protected health information. Staff is also	10/12/15

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PLANNED PARENTHOOD/ORANGE & SAN BEI	1873 COMMERCENTER WEST SAN BERNARDINO, CA 92408

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D 177	Continued From page 4	D 177	regularly trained on said policies. I. 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. • An **additional** 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).	10/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	240001766	A. BUILDING: _____ B. WING _____	C 10/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD/ORANGE & SAN BEI	1873 COMMERCENTER WEST SAN BERNARDINO, CA 92408

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D 177	Continued From page 5	D 177	• Proactively calendared Annual **All-Staff Training** 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 fails to follow policies and processes described herein. IV. As further, additional measures: • PPOSBC employs a chief Compliance Officer, chief HIPAA Privacy Officer, and chief HIPAA	10/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 177	Continued From page 6	D 177	Security Officer to review PPOSBC systems for 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, 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.	10/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PLANNED PARENTHOOD/ORANGE & SAN BEI	1873 COMMERCENTER WEST SAN BERNARDINO, CA 92408

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D 177	Continued From page 7	D 177	Thereby, PPOSBC further submits in good faith 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 PPOSBC Confidentiality of PHI, (2) Compliance Policy 200-307 PPOSBC PHI Minimum Necessary Rule, (3) Compliance Policy 200-308 PPOSBC Sanctions,	10/12/15

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
	240001766	A. BUILDING: _____ B. WING _____	09/21/2016

STATE DEPT OF HEALTH SERVICES
16 OCT 12 AM 9:10
LIC. & CERT. SAN BERNARDINO COUNTY

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD/ORANGE & SAN BEI	1873 COMMERCENTER WEST SAN BERNARDINO, CA 92408

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D 000	Initial Comments The following reflects the findings of the California Department of Public Health during an investigation of a Community Clinic reported incident. Entity Reported Incident number: CA00488868 Representing the California Department of Public Health: 34959 The inspection was limited to the specific incident reported, and does not represent the findings of a full inspection of the facility. One deficiency was issued as a result of entity reported event: CA00488868	D 000	a) What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice. PPOSBC respectfully submits it was not deficient in practice but rather, was required to mitigate, remediate and address behavior by then-staff that was fully noncompliant with established PPOSBC policies. PPOSBC previously had and continues to have established policies and training on protected health information security and privacy, effective both prior to the incident at issue and continuing after the incident at issue. Nevertheless, and in good faith, PPOSBC corrective action plans include (1) 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 protected heatlh information, (2) notifying the patients at issues by individual phone calls by PPOSBC (3) notifying the patients by individual written notifications by PPOSBC, (4) by expeditiously separating the noncompliant staff at issue from employment with PPOSBC (5) by contacting Upland police department to request additional law enforcement measures against the noncompliant staff at issue (6) by completing additional training with staff for optimum mitigation of future noncompliance by any remaining staff. (b) How other patients having the potential to be affected by the same deficient practice by identified, and what corrective action will be taken. PPOSBC respectfully submits it was not deficient in practice but rather, was required to mitigate, remediate and address behavior by th	10/1/16
D 177	T22 DIV5 CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to protect the confidential medical information (CMI) for 19 patients (Patients A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, and S), when the Medical Assistant (MA) (one who assists a qualified physician in an office or other clinical settings) sent a text message to her domestic partner through the phone that contained Patients A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, and S confidential medical information (CMI), resulting in a breach of	D 177		

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: President — (X6) DATE: 10/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD/ORANGE & SAN BEI	1873 COMMERCENTER WEST SAN BERNARDINO, CA 92408

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D 177	Continued From page 1 Patients A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, and S's CMI. During a phone interview on June 2, 2016 at 9:48 AM, with the Assistant Manager (AM), when asked if she knew MA's boyfriend since she said it came from an anonymous source, but the text had been sent to her phone number, she denied it. During a phone interview on June 2, 2016 at 11:00 AM, with the AM, she stated that she received an anonymous text screen shot to her cell phone that showed the scheduled appointments for the 19 patients that included: Patients first and last name, medical record number and the reason for the visit. The screen shot included the name and phone number of the MA as it appeared when the MA sent it to the person who reported it to the AM. During a phone interview on September 15, 2016 at 5:22 PM, with the General Counsel (GC), she stated that the MA sent a text to her boyfriend to 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 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	D 177	staff at issue who was fully noncompliant with established PPOSBC policies. PPOSBC previously had and continues to have established policies and training on protected health information security and privacy, effective both prior to the incident at issue and continuing after the incident at issue. Additionally, the information at issue was limited, illegible and did not contain detailed medical or protected health information. 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 affected by the practice at issue. However, and nevertheless, as described in subsection (a), PPOSBC corrective action plans included (1) investigating and verifying the limited nature of the information at issue (2) notifying the patients at issues by individual phone calls by PPOSBC (3) notifying the patients by individual written notifications by PPOSBC, (4) by expeditiously separating the noncompliant staff at issue from employment with PPOSBC (5) by contacting Upland police department to request additional law enforcement measures against the noncompliant staff at issue (6) by completing additional training with staff at the center site at issue for optimum mitigation of future noncompliance by any remaining staff at the PPOSBC center at issue. C) What immediate measures and systemic changes will be put into place ensure that the deficient practice does not recur. 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	10/1/16

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

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PLANNED PARENTHOOD/ORANGE & SAN BEI	1873 COMMERCENTER WEST SAN BERNARDINO, CA 92408

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D 177	Continued From page 3	D 177	both immediate and systemic changes towards ensuring no deficient practice shall occur. (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 integrated into the quality assurance system. The incident at issue was reported in May 2016. The date of this notice form 2567 is September 28, 2016. PPOSBC received said notice on or about October 5, 2016. Thereby, PPOSBC has completed quality assurance, quality improvement and corrective action plans during this extended time period, including continuing to monitor performance to ensure corrections are achieved and sustained and the plan is integrated into the quality assurance system. The plan is directly administered by Patient Services Department via Senior Director of Operations, and the Training Manager. The Patient Services Quality Management Director also monitors all trends associated with this type of incident and plan effectiveness, should any future trends appear. Additionally, the PPOSBC VP of HR as well as the PPOSBC VP of Compliance 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	10/1/16

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D 177	Continued From page 4	D 177	and ensuring notice to the patients at issue by 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 noncompliant staff at issue from employment with PPOSBC (5) by coordinating with Upland police department to request additional law enforcement measures against the noncompliant staff at issue (6) by completing additional training with staff at the center site at issue for optimum mitigation of future noncompliance by any remaining staff at the PPOSBC center at issue. Moreover (7) PPOSBC has expanded its 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, 2016, 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 its performance to ensure corrections are achieved and sustained its plan of correction is implemented, and the corrective actions are evaluated for effectiveness, and integrated into the quality assurance and compliance systems.	10/1/16

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D 177	Continued From page 5	D 177	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. 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.	10/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 000	Initial Comments The following reflects the findings of the California Department of Public Health during an investigation of a Community Clinic reported incident. Entity Reported Incident number: CA00460847 Representing the California Department of Public Health: HFEN 35290 The inspection was limited to the specific incident reported, and does not represent the findings of a full inspection of the facility. One deficiency was issued as a result of entity reported event: CA00460847	D 000	**RE: CDPH Intake File Number: CA00460847** *"The Plan of Correction for each deficiency must contain the following:* ***a) What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice."*** **a):** The patient at issue was contacted by PPOSBC informing patient of the incident, that PPOSBC would investigate said incident and remediate (please see copy of PPOSBC written correspondence to (patient at issue attached hereto and incorporated herein (Name and Address of patient redacted for privacy; a non-redacted copy of said letter was provided to at CDPH on or about October 12, 2015). Patient was provided full contact information at PPOSBC for any additional questions or concerns at patient's discretion. To concretely ensure ongoing safety and privacy of patient's protected health information, PPOSBC R.N. staff member at issue was also promptly counseled and retrained by the agency Compliance Officer and by the agency Director of Quality Management on or about September 28, 2015 and September 29, 2015. Said PPOSBC R.N. staff member at issue also re-completed the agency compliance annual training on or about October 2, 2015 (please see copy of proof of training of R.N. for both 2014, and 2015 PPOSBC annual Compliance Training on protected health information/HIPAA, attached hereto and incorporated herein). Moreover, on or about September 29, 2015, PPOSBC promptly	10/12/15
D 177	T22 DIV5 CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure the confidential treatment of protected health information (PHI) for Patient A, when a progress note for Patient A that contained PHI, was faxed to an incorrect FAX number. This resulted in the unauthorized release of Patient A's PHI to an unauthorized entity. Findings: During a phone interview with the Compliance	D 177		

11-10-15 DW

PR file

PRINTED: 02/04/2016
FORM APPROVED

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
	CA070000691	A. BUILDING: _____ B. WING _____	C 01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD	398 S GREEN VALLEY ROAD WATSONVILLE, CA 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 001	Informed Medical Breach 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 information.	A 001		
D 000	Initial Comments The following reflects the findings of the California 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.	D 000		

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
FEB 26 2016
L & C DIVISION
SAN JOSE

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

VP HR + Privacy Officer | 2-12-16

3/6/14 DC accepted signed compliance plan MC

California Department of Public Health

PRINTED: 02/20/2014
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA070000691	A. BUILDING: _____ B. WING _____	C 02/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD	398 S GREEN VALLEY ROAD WATSONVILLE, CA 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	Initial Comments 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 patient information on 2/18/14. 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: 29328, Health Facilities Evaluator Supervisor. Facility detected the breach of patient health information on 2/7/14. Facility reported the breach of patient health information to the Department on 2/14/14. Facility notified patient of the breach of patient health information on 2/11/14.	A 000	CALIFORNIA DEPARTMENT OF PUBLIC HEALTH MAR 6 - 2014 L & C DIVISION SAN JOSE 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 CA00387919 (CMS 2567) enclosed in CDPH letter dated February 20, 2014 concerning an incident at PPMM's Watsonville Health Center (Watsonville) that was reported to CDPH on February 13, 2014 (CDPH Report).	all dates refer to 2014.
A 001	Informed Medical Breach 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 information.	A 001	Deficiency cited as not complying with Cal Health & Safety Code 1280.15(a) (facility failed to prevent unauthorized disclosure of Patient 2's protected health information (PHI) because Staff A mistakenly put Patient 2's label on a prescription intended for Patient 1, Staff B gave that prescription to Patient 1's mother, and neither staff member followed PPMM's procedures for checking the PHI matched the patient). **(a) Corrective actions to be accomplished for the affected patient:** One of Watsonville's supervisors called Patient 2 on February 11, 2014, explaining the mistake and apologizing for the error. On February 13, 2014, PPMM's Compliance Officer also sent Patient 2 the letter required by 1280.15. CMS 2567 does not note any deficiency concerning PPMM's communication with Patient 2.	2/11, 2/13

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elena Cohen — TITLE: PPMM Compliance Officer — (X6) DATE: 3/5/14

STATE FORM 6899 MCPI11 If continuation sheet 1 of 3

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A 001	Continued From page 1	A 001		
A 017	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. This Statute is not met as evidenced by: Based on interview and facility document review,	A 017	**(b) Identification of other patients potentially affected by the same deficient practice and corrective action to be taken:** PPMM has not identified other patients potentially affected in this instance. **(c) Immediate measures and systemic changes that will be put in place to ensure that deficient practice does not recur:** Staff B no longer works at PPMM as of February 14, 2014. On February 18, 2014, the Watsonville center manager reviewed at the center-wide staff meeting the PHI-checking procedures and forms when the electronic system is not working (since disclosure occurred because the standard prescription-writing process was not working). On February 27, 2014, the center manager also gave Staff A a copy of PPMM's policy about reasonable safeguards to protect PHI (Privacy Manual Policy 4) and the most recent version of PPMM's New Hire Orientation privacy presentation, which she acknowledged in writing on that date that she read, understood, and would follow. **(d) Monitoring Process/Quality Assurance** On February 24, 2014, Watsonville center manager (or designee) began randomly spot-checking Staff A for consistent use of PPMM's PHI-checking procedure and will conclude on March 28, 2014, which point the center manager will determine whether additional monitoring is necessary.	N/A 2/14, 2/18, 2/27 3/28

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A 017	Continued From page 2 the clinic failed to prevent unauthorized disclosure of patients' medical information when Patient 2's health information (PHI) was mistakenly given to Patient 1. Findings: The Department received a self-reported incident on 2/14/14. The report revealed that on 2/5/14, Patient 1's family member mistakenly received a prescription with Patient 2's PHI. Patient 1's family member returned the prescription to the clinic on 2/7/14. During a telephone interview with the clinic director on 2/18/14 at 11:53 a.m., she confirmed the self-reported incident and stated that the prescription had Patient 2's date of birth, insurance and medical record number. She stated the clinic reported the incident to the Department on 2/14/14. The clinic called Patient 2 on 2/11/14 and sent him a written notification letter as well of the incident on 2/13/14. Review of the facility's letter to Patient 2 dated 2/13/14 indicated the facility called Patient 2 on 2/11/14 about the incident and explained how his PHI was mistakenly given to Patient 1.	A 017		

California Department of Public Health

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DEPARTMENT OF HEALTH

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MAR 06 2015
L & C DIVISION
SAN JOSE

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A 001	Informed Medical Breach 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 information.	A 001	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 CA00419571, enclosed in CDPH letter dated December 15, 2014, received by by PPMM's AVP of HR & Privacy Officer on February 20, 2015 concerning an incident at the Watsonville Health Center on October 31, 2014, that was reported to CDPH on November 7, 2014. Deficiency cited as not complying with Cal. Health and Safety Code 1280.15(b)(2) 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. (a) Corrective actions to be accomplished for the affected patient: On October 31/ 2014, CASX observed employee twice at separate times during the afternoon, demonstrating the checks she does to make sure that the name and address on the envelope matches the name and address on the contents, and both times she performed the checks correctly. (b) Identification of other patients potentially affected by the same deficient practice and corrective action to be taken: PPMM has not identified other patients potentially affected in this instance.	
A 000	Initial Comment The following reflects the findings of the California Department of Public Health during the investigation of an entity reported incident conducted on 12/4/14. For Entity Reported Incident CA00419571, regarding State Monitoring, Privacy Breach to Person Outside Healthcare System, one State deficiency was identified (see California Health and Safety Code, Section 1280.15(a)). Inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the hospital. Representing the California Department of Public Health: 32398, Health Facilities Evaluator Nurse.	A 000		

3/16/15
POC Accepted
Privacy Officer notified
M.E.

California Department of Public Health

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A 000	Continued From page 1 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.	A 000	(c) Immediate measures and systemic changes 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	
A 017	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		

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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. 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	A 017		

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A 017	Continued From page 3 at once and mistakenly placed information for Patient 1 into the envelope addressed to Patient 2. During an interview on 12/4/14 at 11:30 a.m., the center manager designee (CMD) stated the patient care primary care coordinator (PCC) did not follow the policy to match the name on the documents to the name on the envelope. During an interview on 12/4/14 at 12:10 p.m., the health service specialist (HSS) stated Patient 2 brought the letter into the clinic and handed HSS the letter. Patient 2 had stated she had received a letter with laboratory results for someone else. HSS stated she looked at the letter and saw it was for Patient 1, so she gave the letter and envelope to CMD. During an interview on 12/4/14 at 12:20 p.m., PCC stated she used one computer system to pull up Patient 1's laboratory results and printed them, and then went to another system to get Patient 1's address. PCC stated usually when she pulled up patient information in the laboratory system, it would automatically pull up the same patient in the address system. PCC stated she had assumed both systems had Patient 1's information, and she should have checked the name and address. Review of a copy of a letter sent to Patient 1 (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.	A 017		

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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.	A 017		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - ANTIOCH	1104 BUCHANAN ROAD, SUITE C10 ANTIOCH, CA 94509

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D 001	Initial Comments The following represents the finding of the California Department of Public Health during the investigation of a complaint. Complaint Number: CA00425037 Representing the Department: HFEN 25206 and HFES 25205. The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Three deficiencies were written as a result of the investigation. The following definitions are included for clarity. Transvaginal ultrasound: a type of ultrasound used by doctors to examine female reproductive organs by inserting a probe into the vagina. Complete Abortion: the complete expulsion or extraction from its mother of a fetus or embryo; complete expulsion of any other product of gestation. Incomplete Abortion: an abortion that was partially successful. The pregnancy has ended-no fetus will develop, but the body has only expelled part of the tissue and products of pregnancy. D&C: also known as dilation and curettage, is a surgical procedure often performed after a first-trimester miscarriage. In a D&C, dilation refers to opening the cervix; curettage refers to removing the contents of the uterus. Invasive procedure is a medical procedure in	D 001	N/A – definitions and background only.	

3/8/17

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D 001	Continued From page 1 which the body is "invaded" or entered by a needle, tube, device or scope. Examples of invasive procedures are needle prick for a blood test, inserting a tube, device or scope. Medical Board of California (MBC): the state agency that licenses medical doctors, investigates complaints, and disciplines those who violate the law. Medication abortion: Use of a synthetic steroid medication which blocks a hormone (progesterone) necessary for pregnancy to continue. Medical Assistants (MAs): The classification of a MA is defined under the provisions of the California Medical Practice Act (Business and Professions Code sections 2069-2071.) "Medical Assistants means a person who may be unlicensed who performs basic administrative, clerical, and technical supportive services..." who functions under the supervision of a licensed physician and physician assistant, nurse practitioner, or nurse midwife in a medical office or clinic setting. "Medical assistants are not allowed to perform such invasive procedures as: placing the needle or starting and disconnecting...an IV[intravenous line]...administering medications or injections into the IV line...inserting a urine catheter...using lasers..." (www.medbd.ca.gov) "Technical supportive services means simple routine medical tasks and procedures that may be safely performed by a medical assistant who has limited training..." (Business a Professions Code §2069.) Unlicensed Assistive Personnel: ..."Refers to those health care workers who are not licensed to	D 001		

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D 001	Continued From page 2 perform nursing tasks; it also refers to those health care workers who may be trained and certified, but are not licensed...Tasks which require a substantial amount of scientific knowledge and technical skill may not be assigned to unlicensed assistive personnel." (The California Board of Registered Nursing's advisory statement on Unlicensed Assistive [UAPs] NPR-B-16 11/94.)	D 001		
D 046	T22 DIV5 CH7 ART4-75026(b) Basic Services--General Requirements (b) All advice, diagnosis, treatment, drugs and appliances shall be provided only by persons authorized by law to provide such services. This Statute is not met as evidenced by: Based on staff interview and record review, the facility (Clinic 1) failed to ensure that the lead clinician, nurse practitioner (NP 2), followed a standardized procedure, in accordance with California laws governing nurse practitioners, when ordering medications for Patient 1. This failure resulted in the safety elements inherent in the law not being followed and therefore had the potential to compromise the safety of Patient 1. (Standardized procedures are the legal mechanism for registered nurses and nurse practitioners to perform functions which would otherwise be considered the practice of medicine. CA Board of Registered Nursing on Nurse Practitioner Practice: NPR-B-23 04/1999 and revised 4/2011). Findings:	D 046	1. On March 3, 2017, we reviewed our standardized procedures (SPs) and determined that the following changes need to be made: a. Our standardized procedures must either include, or reference specifically, information from PPNorCal's existing protocols and procedures that address (1) how the SPs were developed and approved in collaboration by the nurse practitioners (NPs), the supervising physicians, and the administrator of the health center; (2) the extent to which physician supervision is required for specific functions; (3) the method of periodic review of the NP's competence, including peer review and review of the provisions of the SPs; (4) the entire regimen of medication the NP can administer/dispense; and (5) the supervisory relationships between the NPs and the supervising physician, provided that a physician shall not supervise more than 4 full time equivalent NPs at one time. b. As mentioned in the Statement of Deficiencies, PPNorCal's clinicians practice in accordance with written medical protocols, policies, and procedures contained in its Manual of Medical Standards and Guidelines (MS&Gs) and standard operating procedures. The MS&Gs and standing operating procedures (collectively, Protocols) are based on the evidence-based protocols issued by the Planned Parenthood national office, Planned Parenthood Federation of America. These protocols are adapted for use by each affiliate, including PPNorCal.	

3/8/17 CMG

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

3/8/17

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D 046	Continued From page 4 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, "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_____[national organization's] protocols." Director could not say who wrote the protocols, and didn't know the process of policy development. Director said: "I only implement the protocols." On 11/10/16 at 2:21 p.m., during an interview, NP 2 said she didn't know what the surveyor meant by a standardized procedure. NP 2 said she followed the health organizations protocols. NP 2 said she had a furnishing number from the the Board of Registered Nursing of CA., and "That's what I need to prescribe drugs. Why would I need	D 046	To clarify: PPNorCal has two levels of physician supervision and oversight: agency-wide and NP-specific. The agency-wide level of supervision is performed by either the Medical Director, the AMD, or another contracted OB/GYN, at least one of whom is available (either in person, over the phone, or via electronic communication) 24 hours a day, seven days a week (any time services are being provided and after hours) for consultation and guidance. The AMD was referring to this level of oversight when she stated on 11/08/16 that she had oversight over 20 clinics. However, we believe the inspector was attempting to determine who the assigned supervisor for the NP in question was, which relates to the second level of review. All PPNorCal NPs are assigned an individual physician supervisor. The physician supervisor conducts chart reviews, discusses cases, and reviews the results of medical audits. Each physician supervisor is assigned no more than 4 full-time equivalent NPs. The guidelines for physician supervision are documented in PPNorCal's Protocols, and as discussed above, will be incorporated either directly into the revised SPs or referenced by name and page number.	

3/8/17

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D 046	Continued From page 5 a standardized procedure if I have a furnishing number." NP 2 said that she was the lead clinician in the clinic. Review of one of the laws, Business and Professions Code (BPC) sections 2834 - 2837, governing the scope of practice of Nurse Practitioners in California requires that nurse practitioners who order drugs and devices must have a furnishing (to order drugs) certificate and provide drugs in accordance with approved standardized procedures. Also, in section 2836.1 of BPC, the nurse practitioner may order drugs when all the following apply: "...(a) Drugs or devices are furnished or ordered by a nurse practitioner in accordance with standardized procedures or protocols developed by the nurse practitioner and the supervising physician...when the drugs or devices furnished or ordered are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained..." "(b)...The standardized procedure or protocol shall be developed and approved by the supervising physician and surgeon, the nurse practitioner, and the facility administrator... "...(c) (1) The standardized procedure or protocol covering the furnishing of drugs or devices shall specify which nurse practitioners may furnish or order drugs or devices, which drugs or devices may be furnished or ordered, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the nurse practitioner's competence, including peer review, and review of the	D 046		

3/8/17 amy

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D 046	Continued From page 5 a standardized procedure if I have a furnishing number." NP 2 said that she was the lead clinician in the clinic. Review of one of the laws, Business and Professions Code sections 2834 - 2837, governing the scope of practice of Nurse Practitioners in California requires that nurse practitioners who order drugs and devices must have a furnishing (to order drugs) certificate and provide drugs in accordance with approved standardized procedures. Also, in section 1236.1 of BPC, the nurse practitioner may order drugs when all the following apply: "...(a) Drugs or devices are furnished or ordered by a nurse practitioner in accordance with standardized procedures or protocols developed by the nurse practitioner and the supervising physician...when the drugs or devices furnished or ordered are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained..." "(b)...The standardized procedure or protocol shall be developed and approved by the supervising physician and surgeon, the nurse practitioner, and the facility administrator... "...(c) (1) The standardized procedure or protocol covering the furnishing of drugs or devices shall specify which nurse practitioners may furnish or order drugs or devices, which drugs or devices may be furnished or ordered, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the nurse practitioner's competence, including peer review, and review of the	D 046		

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D 046	Continued From page 6 provisions of the standardized procedure..." "...(d) The furnishing or ordering of drugs or devices by a nurse practitioner occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time of patient examination by the nurse practitioner." "(e) For purposes of this section, no physician and surgeon shall supervise more than four nurse practitioners at one time..." Review of the document, "Mifepristone Medication Abortion," showed it did not comply with standardized procedure elements described in the above law in that: *There was no evidence of collaboration on the development and approval of the standardized procedure by the nurse practitioner, the supervising physician, and administrator. *The extent of physician and surgeon supervision was not included. *The method of periodic review of the nurse practitioner's competence, including peer review, and review of the provisions of the standardized procedure were not specified in the document. *The document had a "IX. Medication Regimens" section which included Mifepristone and Misoprostol (medication abortion pills) and antibiotics (Azithromycin.) The regimen did not include the other medications prescribed: Micrhogam, acetaminophen-codeine, and Promethazine. *The physician had oversight of nurse practitioners in twenty clinics as stated in an	D 046		

3/8/17

California Department of Public Health

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D 046	Continued From page 7 interview on 11/8/16 at 11:59 a.m. as reported above.	D 046		
D 068	T22 DIV5 CH7 ART4-75029(b) Basic Services--Other 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. 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. 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	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 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.	

3/18/17

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D 068	Continued From page 8 exceeded the scope of service of the RHS. This failure had the potential RHS' and other staff would rely on the job description and be unaware of the limitations of an RHS. Findings: 1. Review of Patient 1's clinic Office Visit, dated 11/4/14, showed that Patient 1 received medication abortion pills; Mifepristone on 10/28/14 and Misoprostol on 10/29/14. Review with the Vice President of Medical Services (VP and also a nurse practitioner,) showed NP 2 interpreted the ultrasound and documented Patient 1 had an empty uterus and a complete abortion. In a phone interviews, on 12/30/14 at 11:25 a.m., Patient 1 said she returned to Clinic 1 for a follow-up appointment on 11/4/14. Patient 1 said clinic staff informed her the vaginal ultrasound showed a complete abortion, and she was released. Patient 1 said, on 11/15/14 around 1:30 a.m., she bled heavily, and passed clots. On 11/16/14, she went to an emergency room because she passed out at home. Patient 1 said she was hospitalized and had surgery to remove the contents from inside her uterus, and had a blood transfusion. Patient 1 said hospital staff told her the uterus' opening was not closed yet, and she still had blood and pregnancy tissue in her uterus. 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 she did a manual check herself later at home, 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.,	D 068	d. The PPNorCal Medical Quality Assurance Committee reviews all medical incidents on a quarterly basis. At Monday, March 6, 2017 meeting, a retrospective review of all abortion-related incidents was performed to determine whether any incidents from 2014 to date may have been related to an RHS' performance of a TVU. No incidents were determined to have been the result of RHS performance of a TVU. The Medical Quality Assurance Committee will continue to monitor and discuss all incidents on a quarterly basis. 2. RHS job descriptions. a. The current job description for RHS position will be reviewed no later than Thursday, March 9, 2017 by legal counsel and the VP of Medical Services to ascertain compliance with all relevant rules and regulations, including but not limited to California Business and Professions Code §§ 2069-2070. Any needed revisions to the job description will be completed no later than Monday, March 13, 2017. Health center managers will review with all RHS staff the scope of their work and limitations of their scope, using the revised job description as a guide. b. The revised job description will reflect existing PPNorCal policy with respect to RHS staff, which includes the direction that unlicensed staff may not give advice or provide recommendations to patients. Rather, RHS staff provide patient information and instruction, as authorized under 16 CCR 1366. This includes reviewing written information sheets with patients and directing any patient questions to a licensed clinician or physician. 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.	

3/8/17 dpp

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D 068	Continued From page 9 showed Patient 1: "Presents with vaginal bleeding--patient had a tab [therapeutic abortion] about 2 weeks ago, had large amount of spotting and clots. Saturday [11/15/14] started heavy vaginal bleeding...had 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. 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 perform transvaginal ultrasounds. Director also said she did not know Title 22 (California	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.	

3/8/17

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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, 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 RHS.	D 068		

3/8/17

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D 068	Continued From page 11 On 11/10/16 at 1:20 p.m., during an interview, Director said she did not contact the Medical Board of California to determine what MAs/RHS' can do: "We follow_____[national organization's] protocols." Director could not say who wrote the protocols, and didn't know the process of policy development. Director said: "I only implement the protocols." Director said that she was the RHS' supervisor. Director said that RHS' had to submit a certain number of ultrasound views to the clinic's medical services, and they were evaluated and signed off by one of the physicians. Clinic 1 had three to four RHS' who performed the transvaginal ultrasounds. Director said that a high school diploma was the minimum qualification to become an RHS. In a staff interview, on 11/10/16 at 2:45 p.m., NP 2 said she was the lead clinician and clinical supervisor of RHS 1, who performed the transvaginal ultrasound on Patient 1 by inserting a probe into the vagina. NP 2 was not in the room during the procedure. NP 2 said she relied on Clinic 1's policies and procedures about what medical assistants could do and not do. In a staff interview on 11/10/16 at 3:32 p.m. - 4:10 p.m., RHS 1 said she inserted the vaginal probe into Patient 1's vagina to take pictures of the uterus in different planes, and at least two different views. RHS 1 said that she did a final swipe, but the swipe was not a video for different views. RHS 1 said that no staff observed how she did the swipe. RHS 1 said she attended a school for medical assistants. RHS 1 said she performed vaginal ultrasounds since 2004, and the former medical director signed her off to do ultrasounds. RHS 1 also said she submitted various ultrasound images to a physician for annual ultrasound competency renewal. The physician	D 068		

3/8/17 apty

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D 068	Continued From page 12 viewed the images, off site, through a shared computer drive and did not observe the performance of the ultrasound. RHS 1 did not remember if the clinic had any policy regarding the limitations of her job classification. 2. Review of the "Reproductive Health Specialist" job description, undated, included a list of clinic responsibilities including: "...Answer questions about birth control, health, and pregnancy. Screen calls, give advice...Abortion services: Provide comprehensive education and options counseling to client, allowing client to make informed decision...answer questions regarding the abortion procedure, possible complications, and birth control options...Primary Care/Well Child Services: Provide health education about prevention..." On 11/8/16 at 9:32 a.m., after an inquiry regarding the above job description, an e-mail from the MBC had the following: "This position would require, at the minimum the training required by law for a medical assistant; however, many of the duties listed in the job description do not fall within the scope of practice for a medical assistant, and may only be performed by a licensed RN or above...A medical assistant is not permitted to counsel patients or give medical advice, which is mentioned several times in the job description. A medical assistant is not permitted to examine the patient or to obtain informed consent from a patient...A medical assistant may provide only technical supportive services that are simple, routine medical tasks and services." On 11/10/16 at 1:20 p.m., Director said the RHS' "...Don't give advice--they relay advice." Director said RHS' follow information sheets and explain	D 068		

3/8/17 ahg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA140000241	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - ANTIOCH	1104 BUCHANAN ROAD, SUITE C10 ANTIOCH, CA 94509

(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 068	Continued From page 13 choices/options counseling depending on the situation. "The RHS' may ask a few clarifying questions to get them [patients] close to making a decision." Director said she did not question what was in the job description. Regarding whether there was a written guidance for RHS' limitations, Director said there was nothing specifically written: "They follow the protocols." In a staff interview, on 11/10/16, beginning at 2:45 p.m., NP 2 said she was the lead clinician in Clinic 1 and the clinical supervisor of RHS'. NP 2 said she relied on the clinic's policies and procedures about what medical assistants could do and could not do. NP 2 said she did not get involved in policy-making and she did not contact the California Medical Board to inquire about the medical assistants' scope of service. On 11/10/16 at 3:54 p.m., RHS 1 said she didn't give advice. She reviewed educational forms, mainly about birth control, with patients. RHS 1 said she discussed side effects of birth control. RHS 1 did not recommend one type of birth control or another. Regarding consent forms, RHS 1 described her process. RHS 1 obtained the patient's signature on a service consent form and on the medication abortion consent out of the presence of the NP or physician. RHS 1 read off what the consent was and gave a copy to the patient. RHS 1 said after the patients received the information they decided to sign or not and then she witnessed the signature. Mutual review of Patient 1's Client Information For Informed Consent Using The Abortion Pill, dated 10/30/14, showed that RHS 2 witnessed Patient 1's signature. Typed in above RHS 2's signature was: "The patient got this information. She said she read and understood it. She [Patient 1] was able to ask any questions she had."	D 068		

3/8/17 afm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA140000241	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - ANTIOCH	1104 BUCHANAN ROAD, SUITE C10 ANTIOCH, CA 94509

(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 068	Continued From page 14 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 direction...for 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." On 11/8/16 at 8:55 a.m., after an inquiry, the	D 068		

3/8/17 ofmg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA140000241	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - ANTIOCH	1104 BUCHANAN ROAD, SUITE C10 ANTIOCH, CA 94509

(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 068	Continued From page 15 Medical Board of California's Analyst sent an email with the following statements: "According to the Medical Board of California's legal counsel, conducting a vaginal ultrasound is outside of the scope of a medical assistant. This is an invasive procedure, and is not authorized under the statutes and regulations applicable to medical assistants."	D 068		

3/8/17 adg

PRINTED: 06/29/2017
FORM APPROVED

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
	CA070000183	A. BUILDING: _____ B. WING _____	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD	5440 THORNWOOD DRIVE, SUITE G SAN JOSE, CA 95123

(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	Initial Comment The following reflects the findings of the California Department of Public Health during the investigation of entity reported incident CA00538248 regarding state monitoring (breach). 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: 35302, Health Facilities Evaluator Nurse. The Department did not substantiate a violation of Federal or State regulations.	A 000		

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
JUL - 6 2017
L & C DIVISION SAN JOSE

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Center Manager (X6) DATE 7/6/17

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
	CA630004341	A. BUILDING: _____ B. WING _____	C 07/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA FAMILY HEALTH CENTER	3569 ROUND BARN CIRCLE SANTA ROSA, CA 95403

(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	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of complaint number CA00530016. Representing the California Department of Public Health Services: Health Facility Evaluator Nurse, #2533. 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 NUMBER: CA00530016.	A 000		

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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
	CA630004341	A. BUILDING: _____ B. WING _____	C 01/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA FAMILY HEALTH CENTER	3569 ROUND BARN CIRCLE SANTA ROSA, CA 95403

(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	Initial Comments 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.	A 000		

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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
	CA630004341	A. BUILDING: _____ B. WING _____	C 11/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA FAMILY HEALTH CENTER	3569 ROUND BARN CIRCLE SANTA ROSA, CA 95403

(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	Initial Comments 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.	A 000	RECEIVED JAN - 3 2017 BY:_____	

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 12-27-16

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
	CA630004341	A. BUILDING: _____ B. WING _____	C 09/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA FAMILY HEALTH CENTER	3569 ROUND BARN CIRCLE SANTA ROSA, CA 95403

(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	Initial Comments 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.	A 000		

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA630004341	A. BUILDING: _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA FAMILY HEALTH CENTER	3569 ROUND BARN CIRCLE SANTA ROSA, CA 95403

(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 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	D 000		

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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
	CA630004341	A. BUILDING: _____ B. WING _____	C 10/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA FAMILY HEALTH CENTER	3569 ROUND BARN CIRCLE SANTA ROSA, CA 95403

(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	Initial Comments 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	A 000	RECEIVED FEB 0 4 2014 BY:_____	

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: JR Ward MD — TITLE: Chief Medical Officer — (X6) DATE: 1/31/14

PRINTED: 08/21/2017
FORM APPROVED

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
	CA070000182	A. BUILDING _____ B WING _____	C 05/24/2017

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
JUN 30 2017
L&C SAN JOSE

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD	1691 THE ALAMEDA SAN JOSE, CA 95126

(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
D005	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of an entity reported incident conducted on 10/12/16, 10/14/16 and 5/24/17. For Entity Reported Incident CA00482515 regarding State Monitoring, Breach to Person/Entity Outside Facility/Health Care System, a State deficiency was identified (see Title 22, Section 75055(b)). Inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the hospital. The clinic detected the Breach of Patient's Health Information (PHI) on 3/22/16. The clinic reported the Breach of PHI to the Department on 4/1/16. The clinic notified the affected patients of the Breach of PHI on 3/22/16. Representing the California Department of Public Health: 37883, Health Facilities Evaluator Nurse.	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 CA00482515, enclosed in CDPH letter dated June 21, 2017, received by PPMM's San Jose Health Center first Reported to CDPH on April 1, 2016 (CDPH Report) Deficiency cited as not complying with Title 22, Section 75055(b). (the clinic failed to prevent the unauthorized Disclosure of patient health information) (a) Corrective actions to be accomplished for the affected patient(s) identified to have been affected by the deficient practice. On March 22, and March 30, 2016, the Privacy Officer spoke with patient regarding this incident. A notification letter was mailed on March 22, 2016. The Center Manager has taken additional precautions to protect this patient's medical records. The employee who committed this breach no longer works for PPMM. (b) How other patients having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken PPMM has not identified other patients affected in this instance.	
D1440	T22 DIVS CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws. This Statute is not met as evidenced by: Based on interview and record review, the clinic failed to prevent the unauthorized disclosure of	D1440	(c) What immediate measures and systematic changes will be put into place to ensure that the deficient practice does not recur. 1. Immediately ensure all staff is current with annual HIPPA/Privacy modules through the Center for Affiliated Learning (CAL). 2. Review PPMM's Sanctions for Unauthorized use and/or Disclosure of PHI (Policy #CO1020) in the Health Center's weekly micro meeting. 3. Highlight and review "Minimum Necessary/Need to Know" policy only as necessary for duties assigned section of PPMM's Privacy Policy #CO1030	

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: VPHR/Privacy Officer — (X6) DATE

STATE FORM GOZH11 If continuation sheet 1 of 2

7/10/17

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

Americans United for Life

California Deoartment of Public Healt.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDEA/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA070000182	A. BUILDING _____ B WING _____ CALIFORNIA DEPARTMENT OF PUBLIC HEALTH	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE ZIP CODE
PLANNED PARENTHOOD	1691 THE ALAMEDA SAN JOSE, CA 95126

JUL 13 2017
L & C DIVISION
SAN JOSE

(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
D005	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of an entity reported incident conducted on 10/12/16, 10/14/16 and 5/24/17. For Entity Reported Incident CA00482515 regarding State Monitoring, Breach to Person/Entity Outside Facility/Health Care System, a State deficiency was identified (see Title 22, Section 75055(b)). Inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the hospital. The clinic detected the Breach of Patient's Health Information (PHI) on 3/22/16. The clinic reported the Breach of PHI to the Department on 4/1/16. The clinic notified the affected patients of the Breach of PHI on 3/22/16. Representing the California Department of Public Health: 37883, Health Facilities Evaluator Nurse.	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 CA00482515, enclosed in CDPH letter dated June 21, 2017, received by PPMM's San Jose Health Center first Reported to CDPH on April 1, 2016 (CDPH Report) Deficiency cited as not complying with Title 22, Section 75055(b). (the clinic failed to prevent the unauthorized Disclosure of patient health information) (a) Corrective actions to be accomplished for the affected patient(s) identified to have been affected by the deficient practice. On March 22, and March 30, 2016, the Privacy Officer spoke with patient regarding this incident. A notification letter was mailed on March 22, 2016. The Center Manager has taken additional precautions to protect this patient's medical records. The employee who committed this breach no longer works for PPMM. (b) How other patients having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken PPMM has not identified other patients affected in this instance.	
D1440	T22 DIVS CH7 ART6-75055(b) Unit Patient Health Records (b) Information contained in the health records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws. This Statute is not met as evidenced by: Based on interview and record review, the clinic failed to prevent the unauthorized disclosure of	D1440	(c) What immediate measures and systematic changes will be put into place to ensure that the deficient practice does not recur. 1. Immediately ensure all staff is current with annual HIPPA/Privacy modules through the Center for Affiliated Learning (CAL). 2. Review PPMM's Sanctions for Unauthorized use and/or Disclosure of PHI (Policy #C01020) in the Health Center's weekly micro meeting. 3.Highlight and review "Minimum Necessary/Need to Know" policy only as necessary for duties assigned section of PPMM's Privacy Policy #CO1030	

California Oecartment of Public Healt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	{X2) MULTIPLE CONSTRUCTION	(XJ) DATE SURVEY COMPLETED
	CA070000182	A BUILDING _____ B WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY. STATE ZIP CODE
PLANNED PARENTHOOD	1691 THE ALAMEDA SAN JOSE, CA 95126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS,REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D1440	Continued From page 1 patient health information (PHI) for Patient 1, when Patient 1's PHI was accessed by an employee. The failure resulted in the disclosure of Patient 1's PHI to an unauthorized individual. Findings: Review of an audit trail of the electronic medical record (EMA) indicated Employee 1 accessed Patient 1's PHI on 22 occasions from 6/24/14 to **12/14/15.** During an interview on 10/12/16 at 10:11 a.m., the Privacy Officer (PO) confirmed that an employee (Employee 1) had accessed the PHI of Patient 1 and disclosed the PHI to an unauthorized individual. The PO confirmed that the employee accessed Patient 1's PHI on approximately 22 occasions from 6/24/14 to 12/14/15. **Review** of "2015 CERTIFICATION TO ADHERE TO" the clinic's compliance program, signed and dated by Employee 1 on 6/26/15, indicated the employee agreed and promised that at all times, the employee would not use or disclose the confidential information except as authorized.	D1440	(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 evaluation for its effectiveness, and it must be integrated into the quality assurance system. Center Managers, Supervisors and staff are notified via email when employees are due for HIPAA/Privacy renewal certification. This ensures HIPAA compliance for all employees, contractors and volunteers. Center Managers facilitate weekly meetings for trainings, reviews and immediate system changes. All staff are required to attend and sign in on the attendance log. Those not in attendance are sent the meeting notes. Review of privacy practices at these quarterly mandatory staff meetings will be a standing agenda item. Evaluation of staff knowledge will include but not limited to "pop quizzes", staff role play, and zero preventable privacy deficiencies. Random audits of the EHR System are already in place to review access and identify odd activity, such as accessing a chart at 2:00am. (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. Meeting took place on 6/302017. Next meeting is scheduled for 7/7/2017.	

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
	040000200	A. BUILDING: _____ B. WING _____	C 06/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD MAR MONTE	650 N FULTON FRESNO, CA 93728

(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	Initial Comments The following reflects the findings of the California Department of Public Health-Licensing and Certification during the investigation of complaint: CA00483026 Representing California Department of Public Health-Licensing and Certification: Federal ID # 31505, RN, HFEN The inspection was limited to the specific complaint investigated and does not represent the finding of a full inspection of the facility. NO DEFICIENCY was issued for Complaint: CA00483026	A 000		

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA060001620	A. BUILDING: _____ B. WING _____	05/29/2018

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 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 COMPLAINT NUMBER: CA00580846. 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: Surveyors 29865, HFEN and 34387, HFEN. THE DEPARTMENT WAS UNABLE TO SUBSTANTIATE THE COMPLAINT ALLEGATION AND FOUND NO REGULATORY VIOLATIONS.	D 000		

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shannon Rains — TITLE: Director of Quality — (X6) DATE: 6/13/18

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
	CA11000000812	A. BUILDING: _____ B. WING _____	07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETALUMA HEALTH CENTER	1179 MCDOWELL BLVD PETALUMA, CA 94954

(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 010	Initial Comments 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	D 010		

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

PRINTED: 10/18/2018
FORM APPROVED

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
	CA11000000812	A. BUILDING: _____ B. WING _____	10/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETALUMA HEALTH CENTER	1179 MCDOWELL BLVD PETALUMA, CA 94954

(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 represents the findings of the California Department of Public Health during an investigation for Complaint or Entity Reported Incident Number(s): CA00578840. 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 DEFICIENCY WAS ISSUED FOR COMPLAINT: CA00578840.	D 000		

RECEIVED
OCT 26 2018
CDPH L&C
Santa Rosa D.O.

Licensing and Certification Division

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

TITLE

(X6) DATE

Chief administrative officer

10/24/2018

STATE FORM 6899 W0VJ11 If continuation sheet 1 of 1

cc: Pam Shriber, RN

Americans United for Life

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
	CA11000000812	A. BUILDING: _____ B. WING _____	C 10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETALUMA HEALTH CENTER	1179 MCDOWELL BLVD PETALUMA, CA 94954

(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	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Compiaint: 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	A 000		

RECEIVED
DEC 2 2 2014
BY: _____

Americans United for Life

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: PEDRO TOLEDO
TITLE: INTERIM CEO
(X6) DATE: 12/17/2014

PRINTED: 01/09/2014
FORM APPROVED

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
	CA11000000812	A. BUILDING: _____ B. WING _____	C 11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETALUMA HEALTH CENTER	1179 MCDOWELL BLVD PETALUMA, CA 94954

(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	Initial Comments The following represents the findings of the California Department of Public Health during an investigation of an ENTITY REPORTED INCIDENT: CA00369789 Representing the California Department of Public Health: Health Facilities Evaluator Nurse State #2214- Federal #27035 Inspection was limited to the investigation of one entity reported incident and does not represent the findings of a complete Inspection of the facility. The Department of Public Health was notified within the required timeframe for ENTITY REPORTED INCIDENT: CA00369789 One deficiency was issued for ENTITY REPORTED INCIDENT: CA00369789	A 000		
A 001	Informed Medical Breach 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 information.	A 001		

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Compliance Officer — (X6) DATE: 2/3/2014

STATE FORM 8899 PRNH11 If continuation sheet 1 of 4

2/3/14 at 1028 AM received and accepted POC
Teresa Freeman, Compliance officer
V.D. Ebert, HFE

RECEIVED
JAN 27 2014
CDPH L&C
Santa Rosa D.O.

PRINTED: 01/09/2014
FORM APPROVED

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
	CA11000000812	A. BUILDING: _____ B. WING _____	C 11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETALUMA HEALTH CENTER	1179 MCDOWELL BLVD PETALUMA, CA 94954

(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 Patient 1 (CA00369789) informed of the breach, by mail, on 11/21/13	A 001		
A 017	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. This Statute is not met as evidenced by:	A 017		

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
	CA110000000812	A. BUILDING: _____ B. WING _____	C 11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETALUMA HEALTH CENTER	1179 MCDOWELL BLVD PETALUMA, CA 94954

(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 2 Based on interview and record review, the facility failed to prevent unauthorized access and disclosure of a patient's (Patient 1) protected health information when some of Patient 1's medical information was handed to Patient 2' Family. This failure allowed the unlawful or unauthorized access of protected health information. Findings: The California Department of Public Health was notified on 9/16/13 that a, "Breach of Protected Health Information (PHI)", occurred on 9/10/13. During an interview on 10/31/13 at 9 a.m., Administrative Staff A stated that Patient 1's PHI was handed, in error, to Patient 2's Family by Unlicensed Staff B, on 9/10/13 after she printed it from a community database, without comparing the dates of birth for both patients. Patient 1's PHI included her name, medical record number, date of birth, and immunization record. Administrative Staff A also stated that it was an error, on the part of Unlicensed Staff B, in that both patients had the same first and last names but different dates of birth and Unlicensed Staff B self reported the error to Licensed Staff C, on 9/11/13, who subsequently called Administrative Staff A. Administrative Staff A further stated that, as Patient 1 was not a patient of his facility, he communicated with the Community Database Helpdesk Supervisor, on 9/16/13, regarding Patient 1 so that she could help Administrative Staff A in notifying Patient 1's Physician. The	A 017	Corrective Actions: • Notification: Individual whose information was accessed on from the California Immunization Registry (CAIR) was not a patient at Petaluma Health Center and, therefore, we did not have the individual's contact information to notify the affected individual within 5 business days. a. Upon discovery on 9/11/2013 we notified the CAIR Help Desk of the breach on 9/13/2013 and requested that the patient be contacted or that we receive the individual's contact information to complete notification. We were advised that our message would be forwarded to the appropriate individual at CAIR for action. b. 9/16/2013, we emailed CAIR Data Exchange (see attached email marked Exhibit A). We were advised by the CAIR specialist that the message would be send to the Helpdesk Supervisor for action. c. 10/31/2013, PHC telephoned CAIR to confirm that the patient was notified. d. 11/21/2013, PHC received a call from CADPH RN, who inquired about the breach. We discussed our attempts to secure contact information from CAIR. The CADPH RN contacted CAIR and verified our previous contacts with CAIR. The CAIR Helpdesk Supervisor verified that they had received our requests, and CAIR had failed to respond timely to our notification (Exhibit B). CAIR provided the address and phone number for the patient's primary care provider, as they not have the patient's contact information (Exhibit C). e. 11/21/2013 PHC phoned the primary care provider and left a message requesting contact information for the patient. f. 11/27/2013 PHC called the primary care provider confirming that the individual was their patient, but the PCP would not disclose the patient's address. g. 11/27 Mailed letter to patient's primary care provider with instructions to forward our notification letter to the patient. Patient advised of steps for recourse to protect against harmful use of disclosed PHI.	11/21/2013

FORM APPROVED

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
	CA11000000812	A. BUILDING: _____ B. WING _____	C 11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETALUMA HEALTH CENTER	1179 MCDOWELL BLVD PETALUMA, CA 94954

(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 3 Community Database Helpdesk Supervisor responded, 11/21/13, by giving Administrative Staff A the name and address for Patient 1' physician, so that a letter could be sent, in care of the physician, advising Patient 1's Family of the breach . A review of the facility Policy and Procedure for, "Authorizations for Uses and Disclosure of Protected Health Information", (9/29/10), reveals the following: "RESPONSIBILITY: 1. It is the responsibility of all [facility] staff to verify the identity of a patient prior to releasing protected health information. Patient identity will be verified using date of birth as the primary indicator, supplemented by a second identifier as appropriate".	A 017	h. 11/27/2013 discussed actions with CADPH RN, and faxed a copy of our correspondence to primary care provider and patient notification letter. ▪ Medical Assistant counseled on following policy to verify patient identity using date of birth and second identifier prior to giving documents to a patient. ▪ Systematic change: a. Prior to distributing paper documents, circle or highlighter the date of birth on the paper document against the patient's date of birth. b. Have established a contact person at CAIR, CAIR Help Desk Supervisor, to facilitate future timely patient breach notifications. Help Desk Supervisor will provide the primary care provider's address so that we can obtain the patient's contact information to complete notification. ▪ Monitoring: The Team Manager, in conjunction with the COO and Compliance Officer, is responsible for monitoring the staff person's performance for sustained improvement to follow privacy policy. Quality and Risk Manager and Quality Improvement coordinator conduct random HIPAA audits weekly. ▪ Quality Oversight: PHC's Internal Risk Management Committee oversees reportable incidents and reports trends to the Board Risk Management Committee. The Compliance Officer evaluates privacy breaches to ensure staff is appropriate trained and that our processes are effective to ensure privacy. Corrective actions are identified and implemented to prevent breach recurrence.	09/17/2013 4/2013 11/27/2013 Ongoing Ongoing

PRINTED: 12/31/2013
FORM APPROVED

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
	CA11000000812	A. BUILDING: _____ B. WING _____	10/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETALUMA HEALTH CENTER	1179 MCDOWELL BLVD PETALUMA, CA 94954

(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 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 000		
D 083	T22 DIV5 CH7 ART4-75032(a) Drug Distribution Service--General Req (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	D 083		

POC accepted T/C to Teresa Tillman 3/12/14 #21156 HFEN

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
	CA110000000812	A. BUILDING: _____ B. WING _____	10/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETALUMA HEALTH CENTER	1179 MCDOWELL BLVD PETALUMA, CA 94954

(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 083	Continued From page 1 complaint alleging that the facility had administered an incorrect vaccine to a four month old patient on 1/26/10. On 10/3/13 at 10:40 a.m., the facilities Quality Assurance Director A was interviewed. He provided a facility incident report indicating that the four year old Patient 1 came in the facility with his mother and was due to receive the immunizations Hib (Haemophilus influenza type b, a vaccine to prevent a bacterium that can infect the outer lining of the brain causing meningitis), and the IPV (polio vaccine.) Although these medications can be administered in a combined formula, Patient 1's mother wanted the immunizations to be administered separately. On 10/3/13 at 10:55 a.m., Medial Assistant B was interviewed regarding the administration of the immunization. She stated she gave the immunization to the child. She stated she prepared the vaccine and showed the the prepared vaccine to the provider for accuracy. She stated that the Hib was to be given to children the ages of 2, 4, and 6 months and there was a booster which was given at 15 months. On 10/3/13 at 11:05 a.m., Quality Assurance Director A provided a copy of Patient 1's progress note dated 1/26/10 which indicated that the plan was to immunize Patient 1 with Hib 0.5 milliliters. On 10/3/13 at 11:10 a.m., Quality Assurance Director A provided a copy of a telephone encounter dated 1/27/10. The caller was Patient 1's family member and stated she was concerned about the (HIBERIX) dose that was administered as an initial dose, to Patient 1, instead of the Hib. The HIBERIX is a booster and should be administered at the ages of 15 months. This was	D 083		

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
	CA11000000812	A. BUILDING: _____ B. WING _____	10/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETALUMA HEALTH CENTER	1179 MCDOWELL BLVD PETALUMA, CA 94954

(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 083	Continued From page 2 confirmed by a staff member call to a staff at the immunization manufacturer. On 11/13/13, the facilities Immunization Coordinator C provided an email with acknowledgment that the error occurred because the facility did not have the HIB immunization that the family member had asked for. The Hiberex vaccine, was the only vaccine available and the facilities provider approved the vaccine for administration to the four month patient. She further indicated that the error had occurred because the vaccine order "deviated from the norm" and special care required to safely administer the vaccine, off schedule, was not adequately done.	D 083	Corrective Actions: • Patient identification: Identified patient's parent was notified by the provider via telephone that the HIBERIX booster was administered instead of the HIB immunization that was ordered. • Determination of Risk: Medical Director contacted the Hibirix manufacturer and verified that the booster posed minimal risk to the patient. The dose of vaccine is the same in the HIBIRIX as the HIB immunization. However, the Hiberix contains a small amount of lactose. The parent was informed by the provider that there was not a risk of adverse reaction to the patient and of the quantity of lactose in the Hibirix. Patient's mother acknowledged satisfaction with the information provided. • Immediate Measures: Medical Assistant was counseled on following the Injectable Medicine, 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 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. • 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.	1/28/2010 1/28/2010 01/28/2010 Ongoing Ongoing

PRINTED: 02/04/2013
FORM APPROVED

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
	CA11000000812	A. BUILDING _____ B. WING _____	C 01/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETALUMA HEALTH CENTER	1179 NORTH MCDOWELL BLVD PETALUMA, CA 94954

(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	Initial Comments The following represents the findings of the California Department of Public Health during an investigation of an ENTITY REPORTED INCIDENT: CA00339762 Representing the California Department of Public Health: Health Facilities Evaluator Nurse 2214. Inspection was limited to the investigation of one entity reported incident and does not represent the findings of a complete inspection of the facility. The Department of Public Health was notified within the required timeframe for ENTITY REPORTED INCIDENT: CA00339762 One deficiency was issued for ENTITY REPORTED INCIDENT: CA00339762	A 000		
A 001	Informed Medical Breach 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 information. Patient 1 (CA00339762) informed of breach, by	A 001	Corrective Actions: ① 1/30/2013 Quality Assurance processes implemented (multiple QA processes to all staff to ensure patient identity on documents is confirmed prior to release: Steps A. Medical Assistant confirm the patients identity confirmed on each document and envelope matches intended patient's DOB and Name or SSN. B. MA initials bottom right hand corner of document to ind. care identity was confirmed C. Staff receive confirmation from a second staff member	1/30/2013

Licensing and Certification Division

Compliance Officer TITLE 2/15/2013 (X6) DATE

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

STATE FORM 6899 FC3Q11 If continuation sheet 1 of 5

Accepted POC E
Teresa Tillman, privacy officer
ON 2/25/13 at 945AM Kent Hamlin HFEN

RECEIVED
FEB 15 2013
By

PRINTED: 02/04/2013
FORM APPROVED

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
	CA11000000812	A. BUILDING _____ B. WING _____	C 01/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETALUMA HEALTH CENTER	1179 NORTH MCDOWELL BLVD PETALUMA, CA 94954

(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 phone on 1/15/13 and by mail on 1/22/13	A 001	confirm the patient's identity contained on each document and envelope matches the intended patient's DOB and Name or SSN. D. The staff person providing the double-check initials the right bottom corner of the documents to the right of the individual who is completing the mailing to indicate identity has been verified.	
A 017	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. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to prevent unauthorized access and disclosure of a patient's (Patient 1) protected	A 017	Team 1 - Roll play training The QA policy described above was walked through by clinical support staff so everyone is knowledgeable about the process.	2/13/2013

PRINTED: 02/04/2013
FORM APPROVED

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
	CA11000000812	A. BUILDING _____ B. WING _____	C 01/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETALUMA HEALTH CENTER	1179 NORTH MCDOWELL BLVD PETALUMA, CA 94954

(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 2 health information, when some of Patient 1's medical information was mailed to Patient 2 instead of Patient 1. This failure allowed the unlawful or unauthorized access of protected health information. Findings: The California Department of Public Health was notified on 1/15/13 that a, "Breach of Protected Health Information (PHI)", occurred on 1/9/13. During an interview on 1/16/13 at 11:30 a.m., Administrative Staff A stated that the clinic received a phone call, on 1/11/13, from Patient 2 that she had received a mailed copy of Patient 1's laboratory results which included Patient 1's name, medical record number, date of birth, and type of test done with results. Administrative Staff A further stated that it was an error, on the part of Team Member B, in that facility policy and procedure were not followed. A review of the facility Policy and Procedure for, "PRIVACY POLICY STATEMENT", (1/1/13), reveals the following: "Purpose:...Protection of patient privacy is of paramount importance to this organization...Safeguards It is the policy of the facility that appropriate physical safeguards will be in place to reasonable safeguard protected health information from any intentional or unintentional use or disclosure that is in violation of the HIPAA Privacy Rule...Training and Awareness It is the policy of the facility that all members of our workforce have been trained by the compliance date on the policies and procedures governing protected health information and how this medical practice complies with the HIPAA Privacy and Security	A 017	Quality Assurance / Monitoring: Petaluma Health Center's Risk Management Committee of the Board oversees all reportable incidents that occur within the health center. The Risk Management 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. Monitoring performance to ensure corrections are achieved and sustained is the responsibility of department managers, Chief Clinical Operations Officer, and Compliance Officer in conjunction PHC's Risk Management Committee.	Ongoing

Teresa Compliance Officer 2/22/2013

PRINTED: 02/04/2013
FORM APPROVED

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
	CA11000000812	A. BUILDING _____ B. WING _____	C 01/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETALUMA HEALTH CENTER	1179 NORTH MCDOWELL BLVD PETALUMA, CA 94954

(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 3 Rules". A review of the facility Policy and Procedure for, "Notice of Privacy Practices", (4/14/03), reveals the following: "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION...We understand that health information about you and the health care you receive is personal. We are committed to protecting your health information...We are required by law to: Make sure that health information that identifies you is kept private in accordance with relevant law". A review of the facility Policy and Procedure for, "Authorizations for uses and disclosure of Protected Health Information", (4/14/03), reveals the following: "RESPONSIBILITY: 1. It is the responsibility of all facility staff to verify the identity of a patient prior to releasing protected health information. Patient identity will be verified using date of birth as the primary indicator, supplemented by a second identifier as appropriate". A review of the facility Privacy Training at employee point of hire and annual thereafter (1/16/13), reveals the following: "Why comply with HIPAA? Protecting confidentiality of (sic) critical to maintaining our patient's trust and confidence in healthcare and public health systems...The HIPAA "privacy Rule" requires the confidentiality of medical records. Specifically it:...applies to protecting health information no matter wether it is in electronic, oral, or paper form...,Any information or record (including electronic, paper, or oral), about an individual's mental or physical health, condition, or treatment (wether past, present, or future), should be considered	A 017		

PRINTED: 02/04/2013
FORM APPROVED

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
	CA11000000812	A. BUILDING _____ B. WING _____	C 01/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETALUMA HEALTH CENTER	1179 NORTH MCDOWELL BLVD PETALUMA, CA 94954

(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 Protected Health Information (PHI)...All staff members are responsible for taking reasonable measures to the (sic) protect information from unauthorized or accidental disclosure, including:...Transmission awareness: Recheck/verify mail addresses and fax numbers before sending documents".	A 017		

PRINTED: 01/03/2013
FORM APPROVED

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
	CA110000000812	A. BUILDING _____ B. WING _____	C 03/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETALUMA HEALTH CENTER	1179 NORTH MCDOWELL BLVD PETALUMA, CA 94954

(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	Initial Comments The following represents the findings of the California Department of Public Health during an investigation of an ENTITY REPORTED INCIDENT: CA00302434. 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. The Department verified that the facility was unable to determine the identity of the patient possibly affected by the unauthorized disclosure of protected health information.	A 000		
A 001	Informed Medical Breach 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 information.	A 001		

Licensing and Certification Division

Teresa Tillman — TITLE Compliance Officer — (X6) DATE 4/18/2013

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

STATE FORM 6899 A91311 Revised If continuation sheet 1 of 5

1/24/2013

4-18-13 T/c Teresa Tillman, Compliance Officer
Notified revised POC accepted. HFEN 2139/26290

PRINTED: 01/03/2013
FORM APPROVED

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
	CA11000000812	A. BUILDING _____ B. WING _____	C 03/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETALUMA HEALTH CENTER	1179 NORTH MCDOWELL BLVD PETALUMA, CA 94954

(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		
A 000	Initial Comment The following represents the findings of the California Department of Public Health during an investigation of an ENTITY REPORTED INCIDENT: CA00302434. 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. ONE DEFICIENCY WAS ISSUED FOR CA00302434.	A 000		
A 017	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	A 017		

PRINTED: 01/03/2013
FORM APPROVED

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
	CA110000000812	A. BUILDING _____ B. WING _____	C 03/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETALUMA HEALTH CENTER	1179 NORTH MCDOWELL BLVD PETALUMA, CA 94954

(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 2 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. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to prevent unauthorized access to a patient's protected health information (PHI) when: 1. Patient 1 found copies of another patient's medical information included with a copy of her medical records; and 2. Staff did not follow the facility's policy and procedure regarding proper authorization for release of PHI. Findings: The Department was notified via fax of possible unauthorized disclosure of an unknown patient's PHI to Patient 1. The Department verified the facility was notified of the privacy breach on 3/2/12, and the facility then notified the Department on 3/9/12, within the required five business days. During interview on 3/15/12 at 12:20 p.m., Administrative Staff A stated Patient 1 was seen at the facility on 2/22/12 and requested a copy of her medical record because she was transferring her care to a new physician in another city. Administrative Staff A stated Staff B, who worked	A 017	Corrective Actions: 1) Medical assistant and OB supervisor counseled and retrained about our obligation to protect patient health information. 3/2/2012 2) Trained on identification of a breach, our obligation to report a breach, and the potential sanctions and fines related to privacy breaches. 3/2/2012 3) Trained staff to verify the identity of the patient against the identity of the patient listed on any document that is	

PRINTED: 01/03/2013
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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
	CA110000000812	A. BUILDING _____ B. WING _____	C 03/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETALUMA HEALTH CENTER	1179 NORTH MCDOWELL BLVD PETALUMA, CA 94954

(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 3 in the facility that day, printed the records, placed them in an envelope, and released them directly to Patient 1 without appropriate signed authorization for the Medical Records Department, which was responsible for fulfilling such requests. Administrative Staff A stated Staff B should not have provided the records to the patient. Administrative Staff A stated Patient 1 called the facility on 3/2/12 and left a voicemail, and stated she had another patient's medical information in the envelope but did not remember that patient's name. Patient 1's voicemail indicated she had gone to her new doctor's office and given them the records, but she did not recall her new doctor's name. Administrative Staff A stated after several attempts, she spoke with Patient 1 on 3/5/12 and obtained the new physician's name, but Patient 1 was still unable to recall the name of the other patient or what type of information she had inadvertently received. Administrative Staff A stated she contacted the new provider's office, and was told that there had been information that belonged to another patient included in the copy of Patient 1's records, but staff had shredded it and did not recall the name of the patient or what information had been destroyed. Administrative Staff A stated she was unable to determine the name of the patient who may have had unauthorized disclosure of PHI and was therefore unable to provide notification of a privacy breach to the affected patient. The facility's policy and procedure, titled "Authorizations for Uses and Disclosure of Protected health Information," revised 9/29/10,	A 017	being disclosed to confirm that the information is being disclosed correctly. 4) Instructed Staff to use the patient's date of birth as the primary means of identification, plus a secondary identifier such as name or Social Security number. 3/2/2012 5) All staff completed annual HIPAA training. PHC utilizes www.Learnsom.com to assign and monitor completion of annual HIPAA training. MA involved in this incident completed training on 6/13/2012. 6/2012-8/2012 6/13/2012	

PRINTED: 01/03/2013
FORM APPROVED

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
	CA110000000812	A. BUILDING _____ B. WING _____	C 03/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETALUMA HEALTH CENTER	1179 NORTH MCDOWELL BLVD PETALUMA, CA 94954

(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 indicated the following: "The [named facility] will obtain a valid authorization from the patient . . . : prior to the release of protected health information . . . It will be the responsibility of the Medical Records staff to obtain a signed authorization from the patient . . . "	A 017	b) Quality Assurance Process Change: • Requests for transfer of OB/Gyn records will be processed by the department manager or designee. We will hire an additional medical record staff person to support OB/Gyn as operating funds are available (targeting February 2013). • The individual completing the record release request will confirm the patient identifiers on each document and the mailing envelope against the intended patient's identity. The individual will initial the record release form and secure a second staff person to confirm the contents against the intended patient's identity. Confirmation of contents will be indicated by initialing the record release to the right of the individual's initials who processed the request. (NOTE: See continuation page)	1/1/2013 1/23/2013

Licensing and Certification Division
STATE FORM 6899 A9I311 If continuation sheet 5 of 5

Tim Smith, Compliance Officer
Representative Signature

11/24/2013
Date

Provider Identification Number: CA 11000000812
Complaint Number: CA00302434
Name of Provider:
Petaluma Health Center
1179 North McDowell Blvd
Petaluma CA

Provider Plan of Correction - ID Prefix Tag A017 (*continuation from State Form A9I311*)	Date Complete
7) Quality Assurance Monitoring 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.	Ongoing
8) Mitigate Risk of Harm to the Individual as a result of Disclosure: 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 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.	3/8/2012

Compliance Officer 1/24/2013
Representative Signature Title Date

Americans United for Life

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
	CA070000183	A. BUILDING: _____ B. WING _____	C 08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD	5440 THORNWOOD DRIVE, SUITE G SAN JOSE, CA 95123

(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 005	Initial Comments The following reflects the findings of the California Department of Public Health during investigation of an Entity Reported Incident CA00627620 regarding Patient Rights; Patient's Privacy Not Protected. 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: 39588, Health Facilities Evaluator Nurse. The Department was unable to substantiate a violation of Federal or State regulations.	D 005		

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
OCT 17 2019
L & C DIVISION
SAN JOSE

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CAFO | 10-03-2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA050000118	A. BUILDING: _____ B. WING _____	09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF SANTA BARBAR	516 GARDEN ST SANTA BARBARA, CA 93101

(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
J 000	Initial Comments The following reflects the findings of the California Department of Public Health, Licensing and Certification, during an investigation of one Facility Reported Incident (FRI). FRI: CA00649646--Substantiated Representing the Department: HFEN 39106 The inspection was limited to the specific facility reported incident investigated and does not represent the findings of a full inspection of the facility.	J 000	**a. What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice.** The patient was informed of the breach including the action we took to terminate employment with the employee involved in the incident. The patient was reassured that the copy of the identification and medical cards retrieved from her medical record would not impact her current employment or ability to be employed in another department. In fact, they were deleted. The patient verbalized appreciation for the swift action taken.	8/6/19
J 099	CCR TITLE 22 DIV5 CH7 ART6 -75055(b) Unit Patient Health Records (b) Information contained in the health records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to protect the privacy of a patient (Patient 1) when an employee intentionally accessed the patient's electronic health record. This failure resulted in disclosure of information to another employee and the potential for misuse of the patient's information. Findings: The facility policy and procedure titled "General Security Compliance" dated 12/01/2018, indicates in part "As a covered entity under the Security Regulations, the facility works to protect against any reasonably anticipated uses or disclosures of	J 099	**b. How other patients having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken.** This was a unique situation with an action taken by one employee. We do not believe this will happen again. **c. What immediate measures and systemic changes will be put into place to ensure that the deficient practice does not recur.** The employee involved in this incident was the Director of Revenue Cycle (DOR). In their role, they have access to patient medical records. However, they violated HIPAA policy when they used that access to retrieve information for the purpose of employment. The patient was concurrently an employee seeking a position in a different department. The DOR's employment was terminated for violating policy and using poor judgement.	8/2/19

POC accepted 9/25/19 E. Wesson

RECEIVED SEP 25 AM 5

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA050000118	A. BUILDING: _____ B. WING _____	09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF SANTA BARBAR.	518 GARDEN ST SANTA BARBARA, CA 93101

(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
J 099	Continued From page 1 such information that are not permitted or required by the Privacy Regulations". The facility policy and procedure titled "Uses and Disclosure of PHI based on an Authorization" dated 01/01/2019, indicates in part "A use or disclosure of PHI for purposes other than treatment, payment or healthcare operations must be accompanied by an Authorization signed by the patient..". During an interview on 8/14/19, at 11:30 a.m., the chief financial officer (CFO) indicated the director of revenue cycle (DRC) communicated on 8/1/19 that she needed clarification of the spelling of a prospective employee's first name. The DRC was directed to the human resources director (HRD) for assistance with this matter. The CFO further explained that later that same day, the DRC emailed the prospective employee's driver's license and insurance card to the CFO. The CFO indicated the DRC acknowledged accessing the prospective employee's (who had been a patient of the facility in the past) medical record to obtain a copy of the driver's license and health insurance card. During an interview on 8/14/19, at 1150 a.m., the chief operating officer (COO) confirmed the unauthorized access of Patient 1's electronic health record by the DRC on 8/1/19. The COO further confirmed there was not a legitimate reason for the DRC to have accessed the health record.	J 099	**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 quality assurance system.** We do not believe this was a systemic problem. All employees go through intensive HIPAA training within the 1st week of employment and participate in an annual review. We believe this was a one-time occurrence involving one employee who used poor judgement. As a result, they are no longer employed with the agency. **e. Dates when corrective action will be completed. The corrective action completion 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.** Coincidently, we were due for our annual HIPAA training. The HIPAA Privacy 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 names of participants along with the	

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
	CA630003541	A. BUILDING: _____ B. WING _____	C 07/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF THOUSAND OAK	1200 W HILLCREST DR STE 100 THOUSAND OAKS, CA 91360

(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	Initial Comment 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	A 000		
A 170	The investigation was limited to the investigation of the ERI and does not reflect the findings of a full inspection of the facility. 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 Section 56.05 of the Civil Code and consistent with Section 1280.18. For purposes of this section, internal paper records, electronic mail, or facsimile transmissions inadvertently misdirected within the same facility or health care system within the course of coordinating care or delivering services shall not constitute unauthorized access to, or use or disclosure of, a patient's medical information. 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 patient's medical	A 170	**a. What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice.** We were informed that Patient A's letter was received by a person who was not the intended recipient. We apologized for the error and she agreed to return the letter. Several phone calls were made to Patient A with the attempt to inform her of the breach. The patient did not reply. 7/6/18 A letter was mailed informing patient of the breach. In addition, we have been working with Ventura's Public Health Department to locate the patient given that treatment for STD has not been attained. They have attempted phone calls and field visits without success. 7/13/18 **b. How other patients having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** A report was run identifying all of the 8/1/18	

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: COO — (X6) DATE: 8/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA630003541	A. BUILDING: _____ B. WING _____	C 07/24/2018

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A 170	Continued From page 1 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 whether to investigate and the amount of an administrative penalty, if any, pursuant to this section. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure a patients' (Patient A) protected health information (PHI) was kept private, when Patient A's confidential information was sent by US postal service to the wrong recipient. This failure resulted in the unauthorized disclosure of Patient A's PHI and the potential for misuse of the information. 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	A 170	patients who had letters mailed out regarding lab follow-up on the same day. Each patient was contacted to ensure they received letters intended for them. **c. What immediate measures and systemic changes will be put into place to ensure that the deficient practice does not recur.** Call Center Director did an immediate review of procedures regarding abnormal lab follow up. He spoke with the Abnormal Lab Coordinator involved and 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 reviewed with all of the case management team. **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 quality assurance system.**	7/9/18

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A 170	Continued From page 2 and lab results (Patient A). The letter and lab result were related to a sexually transmissible disease. The COO explained that case management personnel had accidentally enclosed a letter and lab result intended for Patient A into the wrong envelope. According to the facility they were unable to contact Patient A by phone but sent a letter to inform her of the unintentional disclosure. The facility policy and procedure entitled "Notice of Health Information Privacy Practices" revised 11/2016, indicated in part "The privacy and security provisions of the Health Insurance Portability and Accountability Act ("HIPAA") requires us to: Make sure that health information that identifies you is kept private." The facility policy and procedure entitled "Case Management and Abnormal Follow-Up Policies and Procedure" revised 2/2016, indicated in part "Case management staff will handle medical records request and medical record release according to HIPAA guidelines."	A 170	The Call Center Director and Sr. Medical Services Director are responsible for monitoring and supervision of the case management team. They will provide an additional review of entire Case Management and Abnormal Follow-Up Policies and Procedures on 8/24/18. The training could not be scheduled earlier due to a few team members' scheduled vacations. The Risk and Quality Manager will be doing a quality follow up audit on 8/24/18 and quarterly thereafter. This new audit will be incorporated into the affiliate's Compliance, Quality and Risk Management 2018-2019 Work Plan. e. **Dates when corrective action will be completed. The corrective action completion 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.** All corrective actions will be completed by August 24, 2018	

California Department of Public Health

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	CA630003541	A. BUILDING: _____ B. WING _____	C 12/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF THOUSAND OAK	1200 W HILLCREST DR STE 100 THOUSAND OAKS, CA 91360

(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 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 000		
D 070	T22 DIV5 CH7 ART4-75030(a)(1) Basic 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: Based on interview and record review the facility failed to implement it's written policy and procedure for scope of services when an abortion procedure was initiated on Client A whose pregnancy was beyond the gestational age of the clinics established limits. Findings: Review of the clinic's policy in the "Manual of Medical Standards and Guidelines", dated 12/14/12, revised 6/12, page 5 subhead "Client Selection" #2 indicates "...is pregnant and is not more than the gestational age limit of the affiliate program". This clinic was approved for abortion services up to 16 weeks gestation.	D 070	The majority of corrective actions outlined in this document occurred immediately following the incident. This was shared with the DPH surveyor when on site. Safeguards are now in place to ensure the deficient practice does not recur. PPSBVSLO's medical standards and guidelines are being updated (performed on an annual basis). The policy and procedure portion regarding our ability to perform procedures to 16 weeks gestational age remains unchanged.	

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Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jayanta Negrete MD — TITLE: Medical Director — (X6) DATE: 3/5/15

STATE FORM 8899 GQ2311 If continuation sheet 1 of 3

Rec'd 3-11-15 KK

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
	CA630003541	A. BUILDING: _____ B. WING _____	C 12/30/2014

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D 070 Date is 11/18 not 11/11	Continued From page 1 Review of client A's medical record on 12/18/14, revealed the following: Client A was seen on 11/11/14 for a surgical abortion. The procedure was started and the physician, realizing the gestational age was greater than 16 weeks, stopped the procedure. Client A was transported to a nearby hospital for completion of the procedure. During an interview with the physician assistant (PA) on 12/18/14, at 1:45 p.m., the PA indicated she had performed the ultrasound on Client A prior to the procedure. The PA also indicated this was her first time using this particular ultrasound machine (Brand S). According to the PA, all of the other ultrasound machines in this and the other two associated clinics were a different brand (Brand G). Further investigation revealed prior to the ultrasound being performed, the patient services representative routinely enters the clients stated last menstrual period date, into the (Brand S) ultrasound machine. This results in the Brand S ultrasound machine printing out two dates. The first line date is the calculated gestational age according to the patients stated last menstrual period. The second line date is the actual ultrasound calculated gestational age according to the ultrasound image. However, when using the G brand ultrasound there is only the first line date which with the G brand ultrasound is the actual ultrasound calculated gestational age. The PA indicated she requested assistance from the nurse practitioner (NP) with the ultrasound because "She wasn't getting a clear picture". During an interview with the NP on 12/18/14, at 5:10 p.m., the NP indicated she took another ultrasound and after reviewing the image she	D 070	The following corrective actions took place immediately following this incident: 1) A debriefing with the clinic staff took place immediately following the incident. Attachment I shows the incident as the first agenda time on a staff meeting that had already been scheduled to take place that day after clinic. 2) Three days later, a clinical debriefing took place with the staff and was lead by the medical Director (also the surgeon). During this meeting the incident was reviewed, outcomes discussed and Attachment II outlines the corrective actions to be implemented which would prevent a similar incident from occurring again. The emergency was handled appropriately with all staff carrying out their roles effectively. 3) On December 2, 2014 a Root Cause Analysis was performed by our Manager of Quality and Risk. Attachment III outlines the analysis followed by corrective action to be taken. Follow up on the recommendations were made on January 2, 2015 with most tasks completed. The remaining action item is the purchase of an ultrasound machine (same as Brand G) which was ordered on 2/19/15. We anticipate arrival within the next 2-3 weeks. Brand S machine was removed from abortion services on 11/21/14.	11/18/14 11/21/14 12/2/14 1/2/15

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D 070	Continued From page 2 stated she "Wasn't seeing the classic landmarks for the gestational age". The NP approached the MD to ask "If the image was OK ?" According to the NP when she was discussing the ultrasound image with the MD, she relayed to the MD,in error, the gestational age was the first line age printed on the ultrasound image, 13 weeks 1 day (which was actually the age calculated by the clients stated last menstrual period). The actual ultrasound calculated gestational age prints out on the second line when using the Brand S. In this case the actual ultrasound calculated gestational age was actually 21 weeks and 1 day. During a concurrent review of the ultrasound results and an interview with the MD on 12/18/14, at 6 p.m.,The MD indicated prior to the procedure, when asked to look at the ultrasound, she was "only looking at the image" and was responding as to whether or not the image was "clear". The MD confirmed that two dates showed up on the ultrasound Brand S machine and the Brand S machine is the only ultrasound machine used which has a different system of printing out the gestational age.	D 070	4) As part of this incident review, it was determined that the PA appropriately consulted with the more experienced clinician. Both appropriately consulted with the physician. 5) On the day of the incident, the Medical Director (surgeon) appropriately was in communication with the receiving hospital physician before the patient arrived. Follow up with the same local physician took place the following day to obtain information on the patient outcome and current patient status. 6) In an effort to ensure that no other patients were effected by this incident, an audit was conducted on all patients receiving abortion service that same day. All tissue examinations matched gestational age obtained on ultrasound and were appropriately documented in EHR. As stated above, the ultrasound Brand S was removed service. Attachment IV. Quarterly gestational age audit added to QM Plan effective January 2015.	11/18/14 11/18/14 11/19/14 2/20/15

California Department of Public Health

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12/17/13	CA050000445	A. BUILDING: _____ B. WING _____	C 12/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF VENTURA	5400 RALSTON ST VENTURA, CA 93003

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D 000	Initial Comments The following represents the findings of the California Department of Public Health-Licensing and Certification during a complaint investigation. Complaint No. CA00372073- Substantiated Representing the Department of Public Health Surveyor ID # 22363, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.	D 000		
D 172	T22 DIV5 CH7 ART6-75053 Unusual Occurrences Unusual Occurrences. Occurrences such as epidemic outbreaks, poisonings, fires, major accidents, deaths from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety or health of patients, personnel or visitors shall be reported by the facility within 24 hours either by telephone (and confirmed in writing) or by telegraph to the local health officer and the Department. An incident report shall be retained on file by the facility for one year. The facility shall furnish such other pertinent information related to such occurrences as the local health officer or the Department may require. Every fire or explosion which occurs in or on the premises shall be reported within 24 hours to the local fire authority or in areas not having an organized fire service, to the State Fire Marshal. This Statute is not met as evidenced by: Based on interview and record review, the facility (Clinic A) failed to report an unusual event which	D 172	Upon notification from DPH, of the requirement to notify them of Unusual Occurrences within 24 hours, our policy and procedure was updated. We have since shared these expectations with all health centers. In summary: 1. When there is an Unusual Occurrence, health center staff must immediately notify Clinical Services Administration. 2. Clinical Services Administration (specifically, the VP of Clinical Services) will send DPH a fax outlining the event with specific dates/times. 3. Clinical Services will follow up on Unusual Occurrences as we normally do with notification/ submission of documentation to our insurance carrier and Planned Parenthood Federation of America. 4. All occurrences are monitored by our internal quality management program. This is not a change. This type of DPH reporting does not change how we currently handle occurrences nor does it affect the outcome of patient care.	

CA DEPT OF PUBLIC HEALTH
2013 DEC 19 AM 11:09
LICENSING & CERTIFICATION VENTURA DISTRICT OFFICE

1/8/14

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
12/17/13	CA050000445	A. BUILDING: _____ B. WING _____	C 12/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF VENTURA	5400 RALSTON ST VENTURA, CA 93003

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D 172	Continued From page 1	D 172		

threatened the health of one Patient (Patient A) to the California Department of Public Health (CDPH) within 24 hours of the occurrence.

Findings:

Patient A, a 23 year old female, was seen in the facility (Clinic A) on 9/18/13 for a planned abortion at approximately 15 weeks gestation (date per transactional ultrasound performed on 9/12/13).

The medical record was reviewed with administrative staff on 10/8/13. According to the record Patient A came to the facility for a planned surgical abortion which began at 11:32 a.m. The physician (Physician X) performing the abortion noted the following: "...complication occurred during procedure Bleeding-Amount 1000 cc. ..." According to Physician X's notes, the facility attempted to control the bleeding with medication suspecting uterine atony (a loss of tone in the uterine musculature. Normally, contraction of the uterine muscle compresses the vessels and reduces flow. This increases the likelihood of coagulation and prevents bleeds. Thus, lack of uterine muscle contraction can cause an acute hemorrhage). Patient A failed to respond to medication and the facility called 911.

The Paramedic Prehospital Ambulance Report was reviewed. According to the Paramedic notes, upon arrival Patient A had a blood pressure of 73/48 was confused, with slurred speech, pale and cool to touch. Patient A was taken to a local Hospital (Hospital B) Emergency Department (ED) by paramedics, arriving at 12:15 p.m., according to the Prehospital Ambulance Report.

Upon arrival to Hospital B at 12:15 p.m., the ED Physician noted Patient A to be in "Severe

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D 172	Continued From page 2 distress, cool, pale, and in hemorrhagic shock"(resulting from acute hemorrhage and characterized by hypotension, tachycardia, oliguria, and by pale, cold, and clammy skin.) Patient A was rapidly transfused with 6 units of blood and taken to surgery at 1:23 p.m. (according to the ED physician notes). The operative report from the surgeon (Physician C) was reviewed. According to the report, "...After the procedure (Patient A) began having heavy vaginal bleeding and was transferred emergently to (Hospital B). Upon arrival (Patient A) was in hemorrhagic shock and had profuse vaginal bleeding...Massive transfusion protocol was begun and the patient was taken emergently to the operating room...examination of the uterus revealed a perforation (a hole made by boring or piercing; an aperture passing through or into something) of the left lateral lower portion of the uterus..because of the volume of bleeding and the location of the laceration...the decision was made to proceed with hysterectomy (a surgical operation to remove all or part of the uterus). The California Department of Public Health (CDPH) was notified of the above unusual occurrence through an anonymous complainant on 10/4/13. CDPH entered Clinic A on 10/8/13, twenty days after the date of occurrence (9/18/13). Clinic A staff were interviewed on 10/8/13 and stated they recognized the occurrence as unusual for their facility, management staff stated administrative staff were aware of the incident and it was administrative staff that reported any occurrences to the correct authority. Administrative staff at Clinic A were interviewed on 10/30/13 by telephone. According to administrative staff, they were unaware unusual occurrences such as this should be reported to	D 172		

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D 172	Continued From page 3 the CDPH.	D 172		