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
	CA070000147	A. BUILDING: _____ B. WING _____	C 11/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALINAS VALLEY MEMORIAL HOSPITAL	450 EAST ROMIE LANE SALINAS, CA 93901

(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		
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 11/13/14. For Entity Reported Incident CA00418594, regarding State Monitoring, Privacy Breach to Person Outside Hospital, 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	CALIFORNIA DEPARTMENT OF PUBLIC HEALTH APR 13 2015 L & C DIVISION SAN JOSE	

Licensing and Certification Division

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

Pres/CEO | 4/10/15

4/14/15 POC accepted, the Interim Privacy Officer was notified - TK

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A 000	Continued From page 1 The hospital detected the Breach of Patient's Health Information (PHI) on 10/24/14. The hospital reported the Breach of PHI to the Department on 10/29/14. The hospital notified Patient 1 of the Breach of PHI on 10/28/14.	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 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	HSC Section 1280.15(a) a. Corrective Action Accomplished for Affected Patient 1. The Hospital Privacy Official and other administrative members visited the affected patient to apologize and discuss the breach in patient privacy. The patient was provided a letter stating event had been reported to CDPH. See Attachment #1. 2. The physician involved was counseled by Hospital Privacy Official for failure to verify with patient, through an approved interpretation method, the patient's wishes for interpretation to ensure patient's right to privacy. See Attachment #2	10/28/14 10/28/14

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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 hospital failed to prevent the unauthorized disclosure of patient health information (PHI) for one of one sampled patient (1), when a staff member disclosed Patient 1's sensitive diagnosis to a visitor. 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 10/29/14, which indicated on 10/24/14 a physician (MD A) entered Patient 1's room to consult with the non-English speaking patient. MD A noticed a visitor in Patient 1's room and asked if she was a family member. When the visitor answered "yes", MD A asked if she would translate for MD A, and she agreed. Using the visitor as a translator, MD A consulted with Patient 1. At the end of the consultation, MD A advised Patient 1 to seek treatment for his "sensitive diagnosis", which the visitor translated to Patient 1. Patient 1 wanted to keep his "sensitive diagnosis" private. During an interview on 11/13/14 at 10:40 a.m., the interim privacy officer (PO) stated MD A entered Patient 1's room to consult with him. After entering Patient 1's room she noticed a visitor at the bedside who spoke English to MD A. MD A asked the visitor if she was a family member and she replied "yes". MD A asked the visitor if she would interpret for her and the visitor agreed. MD A had a conversation with Patient 1 with the visitor as her interpreter. PO stated, at the end of the conversation, MD A mentioned Patient 1 needed to get treatment for his "sensitive	A 017	b. Corrective Action Accomplished for Potentially Affected Patient 1. Pursuant to the investigation, there was only one patient affected and our audit method did not identify any other patients affected. 2. The Hospital Privacy Official created a HIPAA presentation for the Medical Staff. Notice of presentation was sent to all Medical Staff for review. The presentation focus included but was not limited to: a) Unauthorized Access to PHI; b) Sharing PHI; c) Types of Breaches; d) Fines & Penalties. See Attachment #3 3. Director of the Medical Staff created a one page education resource, targeted at the Medical Staff, and it was sent via e-mail to the Medical Staff regarding when speaking to a patient things to be aware of such as checking to see who's in the room and importance of asking if it is okay to speak to patient while others are present. See Attachment #4	10/29/14 10/29/14 10/29/14

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A 017	Continued From page 3 diagnosis", then left the room. PO stated MD A returned to Patient 1's room to retrieve an electronic interpreter (hand-held electronic equipment used as a language interpreter) she had left in the room. Using the electronic interpreter, Patient 1 requested to speak with the hospital's CEO. PO stated the CEO and MD A spoke with Patient 1 who notified them the visitor was not a family member, and Patient 1 wanted to keep his "sensitive diagnosis" private. PO further stated staff is supposed to ask all visitors to leave the room when discussing any patient medical information. During an interview on 11/13/14 at 11:30 a.m., MD A stated she had twice asked Patient 1's visitor if she was a family member, and she said "yes" both times. MD A stated Patient 1's visitor was speaking English to her so she asked if the visitor could interpret for MD A. MD A stated at the end of the conversation, she mentioned Patient 1 should get treated for his "sensitive diagnosis", since he had not been compliant in the past. MD A stated, when she went back later to get her electronic interpreter, Patient 1 had asked to speak with the CEO. MD A further stated hospital staff were trained to ask if it was ok to talk with others in the room, and she should have asked Patient 1 if it was ok for the visitor to stay. A review of a copy of a letter dated 10/28/14, from the hospital to Patient 1 indicated, on 10/24/14 MD A allowed a visitor in Patient 1's room to interpret a consultation between Patient 1 and MD A in which PHI was disclosed. A review of a copy of the hospital's 4/2/14 "Release of Patient's Confidential Health Information Policy" indicated when releasing	A 017	4. The Physician group involved in the event discussed HIPAA Compliance at their staff meeting. Information focused on: a) Do not view anyone's record unless you are involved in care and b) If a guest is in room, ask if it is okay to discuss care or ask guest to leave room. See Attachment #5 c. Immediate Measures and Systematic Changes Put Into Place 1. Immediately upon notification of deficiency, a focused random audit was performed by the Hospital Privacy Official to confirm the understanding of the Medical Staff related to: a) Do not view anyone's record unless you are involved in care and b) If a guest is in room, ask if it is okay to discuss care or ask guest to leave room. See Attachment #6	11/6/14 3/26/15

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A 017	Continued From page 4 information at the bedside to the patient when visitors are present, staff should respect the patient's right to privacy by verifying with the patient if discussing their care in front of the visitor is ok.	A 017	d. Monitoring process 1. The Hospital Privacy Official will perform ongoing random monitoring/trending of incidents related to not checking with patient before discussing PHI in front of family/visitors and report any incidents to the Quality & Safety Committee as well as the Department Director affected. See Attachment #7 Responsible Person: Hospital Privacy Officer	3/26/15