POC + EOC accepted on 6/20/14 at 9:35am. from faxed copy. Waited for original via mail, JH

PRINTED: 06/12/2014
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
	CA070000149	A. BUILDING: _____ B. WING _____	C 06/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANTA CLARA VALLEY MEDICAL CENTER	751 SOUTH BASCOM AVENUE SAN JOSE, CA 95128

(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 CA00344957, regarding an alleged Breach of Patient Health Information (PHI). 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 and 29328, Health Facilities Evaluator Supervisor. The hospital detected the Breach of Patient Health Information (PHI) on 2/19/13. The hospital reported the Breach of PHI to the Department on 2/25/13. The hospital notified Patient 1 of the Breach of PHI on 2/25/13.	A 000	CALIFORNIA DEPARTMENT OF PUBLIC HEALTH JUN 23 2014 L & C DIVISION SAN JOSE	
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	A 017	a. The Ethics & Compliance Officer notified the patient regarding the breach. b. The Ethics & Compliance Officer met with the employee who inappropriately accessed and disclosed the patient's protected health information (PHI) to discuss the privacy violation.	2/25/13 3/19/13

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 6-19-14

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A 017	Continued From page 1 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 hospital failed to prevent the unauthorized access of patient health information (PHI), when a clinic staff member (Staff A) accessed Patient 1's PHI without a job related reason to do so. The California Department of Public Health received a faxed report on 2/25/13, which indicated Patient 1's acquaintance knew medical knowledge about Patient 1, which Patient 1 had neither disclosed nor consented for Patient 1's acquaintance to know. During an interview on 5/12/14 at 3 p.m., in the presence of the compliance and privacy officer, the quality improvement manager, and the Ethics and Compliance officer, the following was stated. Patient 1 notified hospital staff, Patient 1's acquaintance knew medical information regarding her care received at the hospital. An audit of Patient 1's medical record was conducted and the	A 017	c. The employee's supervisor completed disciplinary action against the employee according to County policy. The employee is no longer employed by the County. d. The Ethics & Compliance Officer and Department Nurse Manager implemented corrective actions, including: 1. The Ethics & Compliance Office provided an educational session to Department Clerical Staff regarding privacy laws and tips on how to technically, administratively and physically safeguard our patients' protected health information, as well as regarding the "minimum necessary standard." 2. Signage was posted throughout Department reminding staff to safeguard patient information. 3. All Employees are required to complete on-line HIPAA training modules regarding privacy laws on how to technically, administratively and physically safeguard patients' protected health information.	5/15/13 6/11/13 5/15/13 12/31/13 and annually

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A017	Continued From page 2 hospital identified Staff A had accessed Patient 1's PHI on two separate occasions, 2/19/13 and 2/20/13. The hospital determined Staff A had no business related reason to access Patient 1's PHI because Staff A did not work at the clinic where Patient 1 was receiving care. A review on 5/20/14 of a copy of the audit log, indicated Patient 1's medical record was accessed via computer, on 2/19/13 at 2:58 p.m. and on 2/20/13 at 3:01 p.m. The audit log indicated the user ID accessing Patient 1's medical record belonged to Staff A. A review on 6/4/14 of an email correspondence sent to the Department from the hospital indicated, the audit log did not provide details to what information was accessed by Staff A, but Staff A could have accessed the following information regarding Patient 1; demographic information, emergency contact information, insurance information, clinical orders. and appointment information. On 5/23/14 review of a copy of a letter sent to Patient 1 from the hospital indicated Patient 1's medical information was disclosed. Disclosed information included date of and reason of a visit, and procedure performed. Staff A was terminated by the Hospital and was unable to be interviewed.	A017	e. All HIPAA events are evaluated by the Ethics and Compliance Officer and tracked for the development of trends. Currently this is a one-time event of this nature. Any identified trend is escalated to the Santa Clara Valley Health and Hospital System (SCVHHS) Privacy Committee for analysis and action. as per phone conversation with MM on 6/20/14 @ 9:25am., The Santa Clara Valley Health and Hospital System Privacy Committee is an in-hospital QA committee. ZB	2/25/13