CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050089	A. BUILDING _____ B. WING _____	03/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL OF SAN BERNARDINO	1805 MEDICAL CENTER DRIVE, SAN BERNARDINO, CA 92411 SAN BERNARDINO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLET DATE
	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit. Complaint Intake Number: CA00181838 - Substantiated Representing the Department of Public Health: [redacted] REGULATION VIOLATION: Title 22 70707 Patient's Rights (a) Hospitals and medical staffs shall adopt a written policy on patient's rights. (7) Full consideration of privacy concerning the medical care program. Case discussion, consultation, examinations and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual. (8) Confidential treatment of all communications and records pertaining to the care and the stay in the hospital. Written permission shall be obtained before the medical records can be made available to anyone not directly concerned with the care. Based on observation, interview, and record review the facility failed to maintain patient privacy of information by not advising 3 patients of a visitor's presence during collection of registration information. This failure had the potential for unauthorized persons to use the disclosed information in a			

Event ID: 7UP111 10/21/2009 2:38:40PM

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Continued From page 1 way not authorized by the patients, such as identity theft or other unauthorized uses. FINDINGS: On 3/18/09 the facility reported to the California Department of Public Health that an employee had a visitor in a secure location, and that the visitor was exposed to confidential patient information including but not limited to: name, address, phone number, next of kin, financial information, diagnosis and social security number. In an interview with the Risk Manager on 3/25/09 at 9:20 AM, the Risk Manager stated that the Privacy Officer was notified by the admitting department manager that on 3/10/09, there was an employee in the medical imaging department who reported to her supervisor that there was a person visiting an admitting staff member who was allowed behind a locked and restricted access door. This visitor was sitting at a desk in the admitting area and could overhear all of the patient information that the admitting staff member was obtaining from the patients. An investigation was conducted and it was determined that a breach of patient privacy did occur. During an observation on 3/20/09 at 3:55 PM of the registration area in the CMP (Community Medical Plaza), an outpatient building belonging to the facility, the entry door to the		Following the event, the affected departments and individuals were provided timely education regarding the protection of patient privacy and confidentiality (HIPPAA). This was followed by organization wide education that was completed on April 30, 2009. In addition, a HIPAA refresher course has been initiated and will be completed by November 30, 2009 On April 20, 2009, the ability to access patients through the electronic discharge and admission functions (PCI) was removed from all users to ensure unauthorized access has been minimized and any further access will be strictly role based and individualized.	4/30/09 11/30/09 4/30/09

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	Continued From page 2 registration area could only be accessed with a card key (a card that electronically signals the door lock). Inside the door, to the left was a desk with 2 chairs. The Risk Manager stated that the visitor was seated in one of the 2 chairs at the desk. On the other side of the desk was a registration area with computers to register patients. Review of the facility computer user activity log dated 3/10/09 from 9:00 AM through 10:59 AM showed that three patients were registered by the admitting staff member during the time the visitor was at the desk in the admitting area. Review of the admitting staff member's employee file on 3/23/09 revealed a document titled Counseling/Disciplinary Memorandum. Under section 1 it is documented that "On March 10, 2009 you were at your work station and allowed a visitor friend of yours to sit at your work station while you were on duty and working. This person was sitting within a range that allowed them to observe and overhear your conversations with patients while you were registering them. This visitor was exposed to confidential patient medical information which is a violation of the hospital's privacy policy." Review on 3/24/09 of a facility policy and procedure titled Safeguarding PHI (protected health information) and Confidential Information, revealed that "It is the policy of ... (the facility) to comply with the requirements of the federal, state, and organizational		In addition, the current audit process was reviewed and revised to ensure early identification of inappropriate access to PHI. The revised audit process addresses visual, auditory, electronic and written monitoring by the Department Directors and Facility Privacy Officer (FPO) to ensure all PHI has the appropriate technical and physical safeguards in place and maintained. On a bimonthly basis, the Facility Privacy Officer (FPO) randomly selects a sample of individuals with access to PHI for auditing. Any breaches will be addressed immediately and reported in accordance with regulations and organizational policies. The results of all monitoring will be reported to the FPO, HIPPAA Team, Executive Management Team and Governing Body.	

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	Continued From page 3 framework for health information privacy protection as pertains to the Use and Disclosure of Protected Health Information (PHI). (The facility)... shall implement reasonable and appropriate administrative, technical, and physical safeguards to protect the privacy of PHI and Confidential Information." The facility policy defines Confidential Information as any information in any medium not otherwise defined as PHI, which is deemed confidential by law, rule, regulation, or would otherwise be considered confidential based on (the facility corporation) practices.			

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