STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050454	A. BUILDING _____ B. WING _____	C 04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UCSF MEDICAL CENTER	505 PARNASSUS AVE SAN FRANCISCO, CA 94143

(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
E 000	Initial Comments Surveyor: 17031 The following represent the findings of the California Department of Public Health during a complaint investigation of CA00146552 regarding Patient Rights. The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Representing the Department: [redacted], Health Facilities Evaluator Nurse Based on interview and record review, the Department substantiated the complaint. Title 22 deficiency written under Patient Rights.	E 000		
E1944	T22 DIV5 CH1 ART7-70707(a) Patients' Rights (a) Hospitals and medical staffs shall adopt a written policy on patients' rights. This Statute is not met as evidenced by: Surveyor: 17031	E1944		
E1953	T22 DIV5 CH1 ART7-70707(b)(8) Patients' Rights (b) A list of these patients' rights shall be posted in both Spanish and English in appropriate places within the hospital so that such rights may be read by patients. This list shall include but not be	E1953		

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E1953	Continued From page 1 limited to the patients' rights to: (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. This Statute is not met as evidenced by: Surveyor: 17031 Based on interview and record review, the facility failed to ensure that the confidentiality of two potential kidney transplant patients (Patients 2 and 3) was maintained when empty blood tubes containing their information were sent to the home of Patient 1. The patient also alleges a possible HIPAA (Health Insurance Portability and Accountability Act) violation of his own, based on his protected health information having been compromised in a computer theft, which was forwarded (fax)to a federal agency on 4/18/08(OCR). Findings: Patient 1 was a 40 year old dialysis patient who at one time was on the kidney transplant list at the facility. According to the patient, who was interviewed by phone on 4/17/08 at 3:30 p.m., he had since moved to southern California and had since removed himself from that list. The patient told the surveyor that he had been receiving empty blood tubes labeled with other patients' names and confidential information at his home address, which the facility mistakenly had addressed as "Dialysis Unit".	E1953		

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E1953	Continued From page 2 He said that this had been happening over the course of years ('04 to '07). He called the transplant coordinator at the hospital to tell her his home was not a dialysis unit and to stop sending the tubes. He spoke to Transplant Coordinator 1 (TC 1) and she did not believe him. She was rude to him and told him that "according to my records, no mistake was made". He subsequently spoke to TC 2 on the phone and she "lied to my face and denied it was happening. I told her, I have the tubes right here in front of me." He got his Social Worker involved when the blood tubes kept coming to his home. SW 1 wrote a letter to TC 1 (a copy of which the complainant sent to the district office) explaining that Patient 1 was becoming increasingly frustrated and angry that basically no one at the facility believed him. Patient 1 said that TC 1 responded on 7/19/04 that "the mistake was caught and the corrections made". Instead, he continued to receive blood tubes for Patient 2 a total of 4 times, and also for Patient 3 once. Patient 1 was so frustrated and upset that he complained to Senator A, who did not respond to him. He then complained to Senator B and Governor S who did respond. Patient 1 said he was very concerned that because he had been receiving empty blood tubes meant for fellow dialysis Patients 2 and 3 to fill and return to the hospital, their places on the kidney transplant list at the facility would be lost because of their presumed non-compliance. Patient 1 had a second complaint against the facility. He stated that on 7/5/07 he had received a letter in the form of a security alert. A computer had been stolen in 3/07 and his name, address	E1953		

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E1953	Continued From page 3 and Medicare number were stored in a file on the computer. He was told in the letter that CMS (Center for Medicare and Medicaid Services) released his information to facility researchers "in accordance with Federal privacy laws and the agency's data release policies and procedures to protect your personal information. Your information was obtained to help us identify persons who might volunteer for important health research." He said the letter was signed by the Research Director of the San Francisco Bay Area Lung Study. He was angry that the facility had not contacted him before it used his name. On 4/18/08 at 9:30 a.m., the hospital Licensing and Certification (L&C) Coordinator was interviewed. She acknowledged that Patient 1 had made several calls to TC 1 and that TC 1 reported to her that he had been somewhat threatening when he called. TC 1 was unavailable for interview the day of the investigation visit. The L&C Coordinator had also been in contact with TC 2 who told her that "just one empty blood tube of Patient 2 had been sent by mistake." She was not aware of any mistake made with Patient 3. The L&C Coordinator emphasized that in no way would the transplant list position of any patient be dependent solely on compliance with returning blood samples to the facility lab. She added that Patient 2 had already been transplanted and that Patient 3 had been removed from the list for other medical reasons. In terms of Patient 1's second allegation, she stated that the School of Medicine, which conducted the Lung Study, was not on the facility license, and therefore she could not address his issue with it. The second allegation and documents were faxed to the Office of Civil	E1953		

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E1953	Continued From page 4 Rights (OCR, a federal agency that addresses HIPAA complaints) Regional Office for review care of the Regional Manager on 4/18/08. A review of the documents that Patient 1 sent to the District Office on 4/17/8 corroborated what he told the surveyor in the phone interview. The facility indeed had sent empty blood tubes to his home, not "just one time" as TC 2 told him, but a total of 5 times over the course of several years. The patient was frustrated and angry when the hospital failed to address the situation, and continued the practice.	E1953		