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
	050150	A BUILDING ______ B WING ______	05/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
Sierra Nevada Memorial Hospital	155 Glasson Way, Grass Valley, CA 95945-5723 NEVADA 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) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during a complaint/breach event visit Complaint Intake Number. CA00306519 - Substantiated Representing the Department of Public Health Surveyor ID # 27945, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility Health and Safety Code Section 1280.15(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			

Event ID:MWRG11 1/29/2013 8:08:07AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: President/CEO — (X6) DATE: 2/12/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050150	A. BUILDING ______ B. WING ______	05/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Nevada Memorial Hospital	155 Glasson Way, Grass Valley, CA 95945-5723 NEVADA 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) COMPLETE DATE

Continued From page 1

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.

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.

Based on interview and document review, the facility failed to prevent the unauthorized access by Business Staff B to the medical records of four patients on 3/14/12 (Patients 1, 2, 3 and 4).

Findings

During an interview on 5/10/12 at 3 pm,

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

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.

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
	050150	A BUILDING ______ B WING ______	05/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Nevada Memorial Hospital	155 Glasson Way, Grass Valley, CA 95945-5723 NEVADA COUNTY

(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

SUMMARY STATEMENT OF DEFICIENCIES

Continued From page 2

Administrative Staff A (Admin) verified that she had reported to the Department on 4/12/12 at 2:14 pm, the unauthorized access to the private health information (PHI) of Patients 1, 2, 3 and 4 by Business Staff (Bus Staff) B. Admin Staff A stated the facility became aware of the breach during a routine audit conducted on 4/9/12 at 9:57 am. Bus Staff B had accessed all four patients' electronic medical records on 3/14/12 starting at 1:53 pm and ending at 1:58 pm. He used his own login and password to access the records. Admin Staff A confirmed that all four patients were Bus Staff B's relatives, and that they had been notified by certified letter on 4/12/12 at 3 pm.

On 5/10/12, copies of the computer searches (query search) on 3/14/12 made by Bus Staff B for Patients 1, 2, 3, and 4 were reviewed. During this period, Bus Staff B made one search each for Patients 1, 2, 3, and 4 in the facility's computerized patient information filing system (Meditech). The information accessed by Bus Staff B included Patients 1, 2, 3, and 4's demographics including their name, date of birth, physician's name, allergies, physician's orders, lab results, vital signs, diagnoses and various nursing assessments.

The facility's policy, "Corrective Process for Breach," dated 4/10/12 was reviewed. The policy defined a "Breach of Patient Privacy or Confidentiality" occurred when any staff member accessed or reviewed PHI for any reason and not necessary to the employee's role in the provision of care and treatment. ...." The policy also indicated a breach had occurred when any staff

PROVIDER'S PLAN OF CORRECTION

04/09/12

HIS Dept. Data Securi[illegible] A[illegible]y[illegible] conducted a mon[illegible]y privacy aud[illegible] requir[illegible] by Dignity Health Privacy Audit Procedure, to valida[illegible] appropriate access t[illegible] M[illegible]Tech and it was identified that an i[illegible]idual (Emergency De[illegible]tment File C[illegible]k) accesse[illegible] 4 medical records w[illegible]out a need to kno[illegible].

S[illegible] [illegible]onducts privacy audits on a monthly basis a[illegible]d results are reported to the [illegible] Health Facility Pr[illegible]y Official. [illegible] coordinato[illegible] [illegible] electronic [illegible] [illegible]tration, [illegible] ancillary sy[illegible] [illegible]o validate [illegible]ce[illegible]s [illegible]opriate an[illegible] authorized for treatme[illegible] [illegible]yment or healthcare [illegible]erations. Privac[illegible] audits were implemented in 200[illegible] for Dign[illegible] [illegible] facilities and are permanently in place. [illegible] Director of HIS is responsible [illegible]o re[illegible] results of monthly audits to the Fac[illegible]y Privacy Official by the 8th day of each month.

04/10/12

The VP of Human Resources, Admitting Dept. Supe[illegible]v[illegible]or and Facility Privacy Liaison met with the File C[illegible] [illegible] investigate the inci[illegible].
The File Clerk was placed on administrative l[illegible].
D[illegible]ector of HIS evaluated the access to [illegible]Tech (electronic medical [illegible]/registration/financial sy[illegible]tem) th[illegible] [illegible]ssigned to the File Clerk for the role [illegible]uties of an Emergency Dept. File Cl[illegible] and determined that access was [illegible]priately assigned.

Event ID MWRG11 | 1/29/2013 | 8:00:0[illegible]

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050150	A. BUILDING B. WING	05/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Nevada Memorial Hospital	155 Glasson Way, Grass Valley, CA 95945-5723 NEVADA 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) COMPLETE DATE
	Continued From page 3 member "discloses any individual's PHI for purposes not related to patient care and treatment." On 2/27/12, Bus Staff B had signed a facility, "Privacy & Data Security Education Update /HIPAA Training Acknowledgement Form" certifying that, "I have read and understand this Acknowledgement Form and hereby agree to fully comply with it." On 5/10/12 at 4:30 pm, Admin Staff A verified that on 3/14/12, Bus Staff B's access to Patients 1, 2, 3 and 4's PHI was unauthorized and that Patients 1, 2, 3 and 4 had not given Bus Staff B authorization to view their records		The File Clerk was terminated on 4/12/12 for unauthorized access to electronic medical records Ongoing: Every new SNMH employee completes New Hire Orientation which includes education on HIPAA and Dignity Health Privacy & Data Security Policies. Annually, every employee completes mandatory training on HIPAA and Dignity Health Privacy & Data Security Policies	04/12/12

Event ID:MWRG11 1/29/2013 8:08:07AM

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

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.