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
	CA070000155	A. BUILDING: _____ B. WING _____	C 02/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATSONVILLE COMMUNITY HOSPITAL	75 NIELSON STREET WATSONVILLE, CA 95076

(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 1/16/15. For Entity Reported Incident CA00418062, regarding State Monitoring, Privacy Breach, 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 MAR 3 0 2015 L & C DIVISION SAN JOSE	

Licensing and Certification Division

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

Chief Quality Officer — 3/24/15

3/5/15

4/1/15 - POC accepted via fax on 3/26/15 - hospital was notified - rb

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A 000	Continued From page 1 The hospital detected the Breach of Protected Health Information (PHI) on 10/20/14. The hospital reported the Breach of PHI to the Department on 10/23/14. The hospital notified the affected patients of the Breach of PHI on 10/24/14.	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		

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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 protected health information (PHI) for 3 patients (1-3) when three face sheets were mailed to an individual outside of the hospital. The failure resulted in the disclosure of 3 patients' PHI to an unauthorized individual. Findings: The California Department of Public Health received a faxed report on 10/23/14, which indicated a union representative for the hospital received in the mail on 10/20/14, an anonymous complaint along with three patients' registration facesheets. A hospital internal investigation revealed the facesheets contained patients' names, addresses, dates of birth, social security numbers, insurance names, diagnoses, and medical record numbers. During an interview on 1/16/15 at 1 p.m., the facility privacy officer (FPO) stated one or more staff members mailed their union representative (Rep) three patients' facesheets accompanied by a complaint letter. FPO stated Rep brought the facesheets to the human resources director who in turn contacted FPO. FPO stated the hospital conducted an internal investigation and was unable to determine who sent these documents to Rep. During an interview on 2/9/15 at 10:30 a.m., Rep stated some patients' facesheets along with other documents were put through the mail slot of his office some time during the night. He arrived in the morning and saw the package on the floor, addressed to him. He opened the package,	A 017	**How correction was accomplished:** At the time of the incident all 3 patients affected were sent an apology letter. The Union Representative signed an attestation that all copies he received had been shredded in an appropriate shred container. **Immediate Measures Taken:** All Registration Staff were re-educated at a mandatory staff meeting on the facilities' HIPAA policy. Signatures were obtained. **Monitoring Process:** No further breech identified at this time. Due to the nature of this breech we were unable to determine who did the actual breech, Privacy and HIPAA will be a standing agenda item at each staff meeting for the next 4 staff meetings. This will be a verbal report out at Quality Care Committee and Board of Trustee. **Title of Person Responsible:** Facilities Privacy Officer; provided HIPAA training at staff meeting, Registration Director; Speaks at each staff meeting about Privacy and HIPAA.	10/24/14 10/17/14 11/17-11/18/14 6/30/15 6/30/15

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A 017	Continued From page 3 looked at all the documents, then brought it to the hospital's human resources department (HR), where copies were made. Rep stated an HR staff told him to shred the documents because they contained PHI, which he did. A review of a copy of a facesheet received by Rep indicated disclosure of the patients' names, addresses, dates of birth, ages, sexes, ethnicities, races, medical record numbers, guarantors' information, insurance information, medical conditions, and diagnoses. A review of a copy of a letter dated 10/24/14 from the hospital to the affected patients indicated Rep received a mailing which included the patients' PHI. A review of a copy of the hospital's 12/2012 "Volume I - management of Information" policy indicated PHI will be maintained in a manner which restricts access to those with a need-to-know.	A 017		