



 Signature of person requesting program flexibility


 Printed name

Administrator

 Title

Note: Approval for tent use, space conversion, bed use and over-bedding will be time limited and dependent on the facts presented that substantiate the emergency. Initial approval may be given verbally by the local DO; however, a signed written approval must be distributed (faxed) to the facility and filed in the facility's folder.

For CDPH Use Only:

Center for Health Care Quality Approval:

Permission Granted from: 07/06/2020 to 10/06/2020

Permission Denied: Briefly describe why request was denied in comments / conditions below.

Comments / conditions:
This is approved with the condition that the facility implements its' Mitigation Plan and use registry (staffing agencies) before flexing staffing regulations. The facility must meet a NHPPD of 3.2.

CHCQ Printed Name:
 CHCQ Staff Signature: _____
 Date: _____



 L&C District Office Staff Signature

Program Manager

 Title

07/30/2020

 Date

Facility Name California Post Acute Care	License Number 940000113	Request Date 7-6-20
--	------------------------------------	-------------------------------

Justification for the Request

Other:

Exhausting Available Alternatives

The provider must exhaust available alternatives before requesting increased patient accommodations.

Check all that apply:

- Rescheduling non-emergent surgeries and diagnostic procedures.
- Transferring patients to other beds or discharge as appropriate.
- Setting clinics for non-emergency cases (if possible).
- Requesting ambulance diversion from LEMSA, if appropriate.
- Other:

Adequate Staff, Equipment and Space

The provider must make arrangements for adequate staffing, equipment and space for increased patient accommodations. Check all that apply:

- A plan is in place for staff if the request is for use of alternate space.
- A plan is in place for equipment if the request is for use of alternate space.
- The proposed space for care of patients provides sufficient square footage to ensure access for safe care.
- Other:

Additional Information

Provide a brief description of your conditions and explain the need for program flexibility. Provide a brief description of the alternative concepts, methods, procedures, techniques, equipment or personnel to be used, and the conditions under which this program flexibility will be used. Attach additional supporting documentation as needed.

Due to the ongoing Covid pandemic it is difficult to maintain requested staffing levels. The facility will maintain an acceptable PPD level to meet the residents' needs while understanding that certain days may fall below the requested CDPH PPD thresholds. The facility will ensure adequate care is provided by monitoring each residents' vitals, daily room rounds, and resident council meetings.

Temporary Permission for Program Flexibility and for Emergencies

When the MHCC is activated, Providers and DO's will submit requests to CHCQDutyOfficer@cdph.ca.gov.

This form is to be used **ONLY** for program flexibility requests when providers temporarily need to comply with licensing requirements by using alternative concepts, methods, procedures, techniques, equipment, or personnel.

Providers are required to submit a program flexibility request to the California Department of Public Health (CDPH), Center for Health Care Quality (CHCQ) for approval. This form is a mechanism to expedite the request directly to the Medical Health Coordination Center (MHCC) for approval in emergency situations.

<https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/DistrictOffices.aspx>

Facility Name California Post Acute Care			Date of Request 7-6-20	
License Number 940000113			Facility Phone 310-639-4623	Facility Fax Number 310-763-0993
Facility Address 3615 E. Imperial Hwy				
City Lynwood	State CA	Zip Code 90262	E-mail Address administrator@californiapostacute.com	
Contact Person Name [REDACTED]				

Approval Request

Complete one form total per facility

- | | |
|---|---------------------------------------|
| <input checked="" type="checkbox"/> Staffing | <input type="checkbox"/> Other |
| <input type="checkbox"/> Tent use (High patient volume) | <input type="checkbox"/> Bed use |
| <input type="checkbox"/> Space conversion (other than tent use) | <input type="checkbox"/> Over bedding |

Duration of Request

Start Date:	7-6-20
End Date:	10-6-20

Program Flex Request

What regulation are you requesting program flexibility for? Title 22 20.32 72329.lcfg Section 3 A-D/ 72329.2 and 72329.1.

Justification for the Request

- A disease outbreak (verifiable through sources such as the local emergency medical service agency (LEMSA), local Public Health Officer, CDPH Division of Communicable Disease Control, the Centers for Disease Control and Prevention) is present in the community where the hospital is located or in a contiguous area(s) causing a rapid influx (surge) of patients to the hospital. Examples of this type of surge include: Increased cases of seasonal influenza, onset of a severe acute respiratory syndrome-type or other highly contagious virus requiring acute care, an epidemic/pandemic, a bioterrorism agent, or a declared public health emergency.
- An emergency resulting in the need for increased patient accommodations has occurred in the community where the hospital is located or in a contiguous area(s) causing a rapid influx (surge) of patients to the hospital. Examples of this type of surge include: A natural or human-caused disaster, a crime incident or transportation accident resulting in numerous mass casualties, an emergency causing the evacuation of patients or diversions from another hospital (LEMSA diversion has been implemented).