

### Temporary Permission for Program Flexibility and for Emergencies

When the Medical Health Coordination Center (MHCC) is activated, Providers and District Offices (DOs) will submit requests to [CHCQDutyOfficer@cdph.ca.gov](mailto: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 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  
CENTINELA GRAND, INC.

Date of Request  
8/24/2020

License Number  
08601902

Facility Phone  
951-657-2135

Facility Fax Number  
9516576145

Facility Address  
2225 N PERRIS BLVD

E-Mail Address  
[redacted]entgrand.com

City State Zip Code  
PERRIS CA 92571

Contact Person's Name  
[redacted]

#### Approval Request

Complete one form total per facility

- Staffing  Other
- Tent use (High patient volume)  Bed Use
- Space Conversion (other than tent use)  Over bedding

#### Duration of Request

Start Date 08/24/2020

End Date 12/31/2020

#### Program Flex Request

What regulation are you requesting program flexibility for? HSC SECTION 1276.65 (C) (1) (B) AND

#### 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).

- If you are seeking a staffing waiver, has your facility laid off any clinical staff within the previous 60 days?  
If so, please explain (**Note:** Attach supporting documentation if necessary)

No staff has been laid off for the previous 60 days.

**Justification for the Request**

- Other:

Surge in staffing due to fear in contracting COVID-19, difficulty in finding child care or staff that have COVID-19 symptoms are guaranteed at home for 14 days or until symptoms are no longer present.

**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 alternative 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.

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[Redacted signature]

Signature of person requesting program flexibility

Director of Nursing

Title

[Redacted printed name]

Printed Name

**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: August 27, 2020 to November 27, 2020

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

Comments / Conditions: Staffing waiver approved with the condition the facility maintains 3.2 staffing overall.

CHCQ Printed Name: [Redacted]

CHCQ Staff Signature: [Redacted]

Date: [Redacted]

[Redacted signature]

L&C District Office Staff Signature

Health Facilities Evaluator Supervisor

Title

August 27, 2020

Date