

### 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

Greenfield Care Center of South Gate

Date of Request

06/29/2020

License Number

940000160

Facility Phone

323-564-7761

Facility Fax Number

323-543-8810

Facility Address

8455 State Street

E-Mail Address

admin@gccsouthgate.com

City

South Gate

State

CA

Zip Code

90280

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

End Date

#### Program Flex Request

What regulation are you requesting program flexibility for?

#### 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).

### 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 the MHCC for temporary flexibility.

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, technical 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.

Date of Request		08/28/2020		Facility Name	Greenfield Care Center of South Gate		
Facility Phone		323-564-7781		License Number	040000180		
Facility Fax Number		323-543-3810		E-Mail Address	6433 State Street		
E-Mail Address		admin@posoutgate.com		City	South Gate	State	
Contact Person's Name		Anthony Glenn Peltzman		Zip Code	90280	CA	
Duration of Request		Start Date: 08/28/2020		Approval Request			
End Date: 09/13/2020		<input checked="" type="checkbox"/> Staffing <input type="checkbox"/> Test use (high patient volume) <input type="checkbox"/> Space Conversion (clean room tent use) <input type="checkbox"/> Over bedding <input type="checkbox"/> End Use <input type="checkbox"/> Other			<input checked="" type="checkbox"/> Complete one form total per facility		

What regulation are you requesting program flexibility for? Title 22, Chapter 3, Article 3, Section 22633

A disease outbreak (ventilator through another 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 in epidemic/pandemic, a bioterrorism agent, or a declared public health emergency.

An emergency resulting in the need for increased personnel and conditions 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 mass incident or transportation accident resulting in many more mass casualties, an emergency causing the evacuation of patients or diversion of patients from another hospital (LEMSA division has been implemented).

Facility

License Number

Request Date

Greenfield Care Center of S

940000160

06/29/2020

**Justification for the Request**

Other:

We have staff testing positive weekly or are symptomatic and must be quarantined for 10 day

**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.

The facility is positive for COVID-19. We currently have 51 residents and 42 staff who are positive. Due to the closures of our local school districts and the restriction on symptomatic staff to stay away from work, we have a critical shortage of qualified direct care staff and we cannot remedy the situation through staff recall and other staffing solutions. We are asking that CDPH waive the requirement to meet 3.5/24 for the duration of this event or until we can maintain consistent minimal staffing.

The facility has limited new admissions during this time (no new admissions).

The facility is utilizing staff to work extra shifts and registry as needed.

The facility is recalling staff who are asymptomatic and C+ to work on the C+ unit (red zone).

The facility is retesting C+ patients who are asymptomatic and exhausted their observation period to determine if the resident is no longer positive and can be placed on the main nursing floor (green zone) and out of quarantine.

The facility is conducting weekly testing of staff (and residents) to determine if staff can return back to work.

Facility

Greenfield Care Center of S

License Number

04000160

Request Date

08/25/2020

Justification for the Request

Other

We have staff testing positive weekly or are symptomatic and must be quarantined for 10 days

Extending Available Alternatives  
The provider must extend 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 spaces.

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 all 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 concept, methods, procedures, technical equipment or personnel to be used, and the conditions under which this program flexibility will be used. Attach additional supporting documentation as needed.

The facility is positive for COVID-19. We currently have 31 residents and 42 staff who are positive. Due to the closure of our local school districts and the restriction on symptomatic staff to stay away from work, we have a critical shortage of qualified direct care staff and we cannot remedy the situation through staff recall and other staffing solutions. We are asking that OPH waive the requirement to meet 3.324 for the duration of the event or until we can maintain sufficient minimal staffing.  
The facility has limited new admissions during this time (no new admissions).  
The facility is utilizing staff to work extra shifts and regularly as needed.  
The facility is recalling staff who are asymptomatic and O+ to work on the O+ unit (red zone).  
The facility is testing O+ patients who are asymptomatic and extended their observation period to determine if the resident is no longer positive and can be placed on the main nursing floor (green zone) and out of quarantine.  
The facility is conducting weekly testing of staff (and residents) to determine if staff can return back to work.

The facility is using symptom based strategy in returning positive and symptomatic employees to work.

[Redacted Signature]

Administrator

Signature of person requesting program flexibility

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: 6/24/20 to 8/31/20

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

Comments / Conditions: Program Flex approved for CER 22 § 72379 only.

CHCQ Printed Name: [Redacted]

CHCQ Staff Signature: [Redacted]

Date: [Redacted]

[Redacted Signature]

Supervising HCP

8/19/20

U&C District Office Staff Signature

Title

Date

The facility is using symptom based strategy in returning positive and symptomatic employees to work.

Administrator

Title

Signature of person receiving program flexibility

Anthony Glenn Padams

Printed Name

NOTE: Approval for font size conversion, bold use and over-riding will be time limited and dependent on the facts presented that substantiate the emergency. Initial approval may be given verbally by the local DPH; however, a signed written approval must be distributed (faxed) to the facility and filed in the facility's folder.

For CDPH Use Only

Director for Health Care Quality Approval

[Signature]

[Signature]

Permission Granted from

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

Comments / Conditions

Handwritten notes and signatures in the comments section.

CHOC Printed Name

CHOC Title

Date

LAC District Office Staff Signature

Title

Date