

### 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

Heritage Gardens Health Care Center

Date of Request

License Number

055183

Facility Phone

(909) 796-0216

Facility Fax Number

(909) 799-2652

Facility Address

25271 Barton Road

E-Mail Address

progressivecarecenters.com

City

Loma Linda

State

CA

Zip Code

92354

Contact Person's Name

#### Approval Request

Complete one form total per facility

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

#### Duration of Request

Start Date July 2, 2020

End Date End of emergency

#### Program Flex Request

What regulation are you requesting program flexibility for? Title 22-section 72329.1 and 72329.2

#### 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).

Facility

License Number

Request Date

**Justification for the Request**

Other:

Day care closures and restricting staff with any Covid-19 symptoms has caused shortage.

**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.

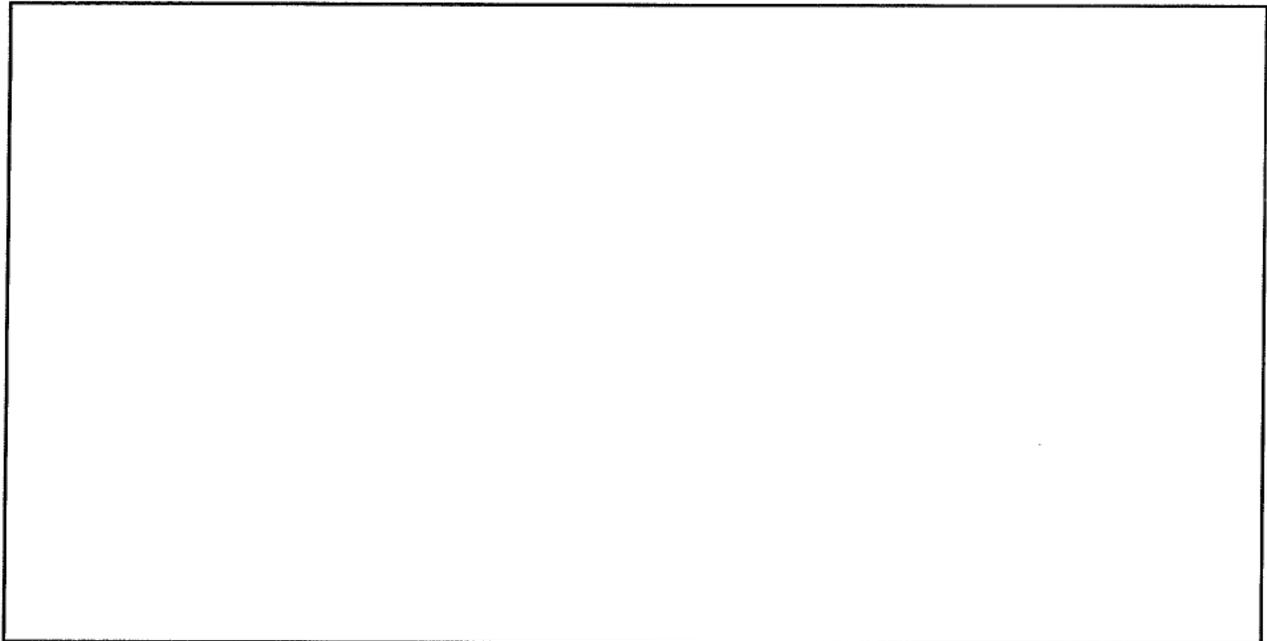
The proposed space for care of patients provides sufficient square footage to ensure access for safe care.

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.

Due to the closures of our local day cares 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 3.5/2.4 for the duration of this event or until we can maintain minimal staffing.  
-IDT and the facility medical director will communicate daily on staffing issues.  
-DON and other assigned Licensed Nurse will assess residents every shift for any change of condition and implement their change of condition policy as needed.  
-Social Service Director will communicate with residents frequently and bring any grievances or concerns to the IDT to address.  
-Call in any available non direct care staff and assign them duties to assist in resident safety, dietary, hydration, and activity needs.  
-Continue to exhaust all measure to meet 3.5 and 2.4 staffing requirements.



  
Signature of person requesting program flexibility

*Administrator*  
Title

  
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:  to

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

Comments / Conditions: 72329.1 - CANNOT FLEX. Exclude this regulation from the waiver.

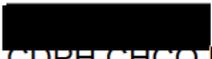
APPROVED for 72329.2(a). CONDITIONS: Minimum 3.2 DHPPD overall staffing. Subacute unit is excluded if present in the facility. Facility will continue to actively look for additional staffing. Facility must resume mandatory staffing levels as soon as feasible. Please see next page for other conditions specified in AFL 20-32.1.

CHCQ Printed Name:

CHCQ Staff Signature: \_\_\_\_\_

Date:

  
L&C District Office Staff Signature

  
HFES II  
CDPH CHCQ L&C  
San Bernardino District Office

Date