

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

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>

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|--|--------------------|--------------------------|---|--|
| Facility Name MAYWOOD ACRES HEALTHCARE | | | Date of Request JULY 21, 2020 | |
| License Number CCN 055597 | | | Facility Phone 8054877840 | Facility Fax Number 8055129199 |
| Facility Address 2641 SOUTH C ST. | | | E-Mail Address [REDACTED]@MILWOODHC.COM | |
| City OXNARD | State CA | Zip Code 93033 | Contact Person's 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 **7/24/20**
End Date **10/24/20**

Program Flex Request

What regulation are you requesting program flexibility for? **CCR 22 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).

HSC 1276.65

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)

Justification for the Request

Other:

see below

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.

With the surge of cases on COVID19 in our state, especially in our county, our daily PPD will be affected since most of the skilled nursing facilities and hospitals here in Oxnard share nursing staff.

We have experienced this situation last June and July 2020 where some SNF's had an outbreak and some of the staff we shared were exposed to positive staff and patients in the said facilities. We had to remove them from the schedule for weeks until outbreak was cleared by the county public health.

We will continue do our best to meet 3.5/2.4 PPD and provide quality care as we have during the past months. Although we had those challenges, we were still able to meet the 3.5/2.4 PPD as of this date.

We will be utilizing staffing agencies to meet our daily PPD. We are contracted with the following staffing agencies:

- 1. Nurse Core
- 2. Maxim Nursing
- 3. California Health Corps

We are also offering hazard pay to our nursing staff with the overtime and night differential pay, too.

Staff who are working on the yellow zone are given an additional of \$2 per hour on top of their current rate.

We are continuously hiring licensend nurses and CNA's.

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: July 24, 2020 to October 24, 2020

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

Comments / Conditions: *The Department may revoke if licensee does not comply w/ conditions set forth in the approval or if the Department determines the proposed alternative does not adequately meet the intent of the regulation.*

CHCQ Printed Name: _____

CHCQ Staff Signature: _____

Date: 7/24/20

L&C District Office Staff Signature

HEM- II
Title

7/24/20
Date