

State of California Health and Human Services Agency

California Department of Public Health

**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](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 (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 San Francisco Health Care and Rehab			Date of Request August 19, 2020	
License Number 22-000011			Facility Phone 415-563-0565	Facility Fax Number 415-738-0524
Facility Address 1477 Grove St.				
E-mail Address administrator@sfhcr.com				
City San Francisco	State CA	Zip Code 94117	Contact Person Name [REDACTED]	

**Approval Request**

Complete one form total per facility

- |   |   |
|---|---|
| <input type="checkbox"/> Staffing                               | <input checked="" 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: August 19, 2020  
End Date: November 20, 2020

**Program Flex Request**

What regulation are you requesting program flexibility for? Title 22, CCR secs. 72371 (c)

**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).

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Facility Name	License Number	Request Date
San Francisco Health Care and Rehab	22-0000011	8/19/20

**Justification for the Request** Other:

Facility is requesting for a moveable partition to restrict movement through two hall ways due to converting the rooms in this one long hallway into our "Observation/ Isolation rooms" for new admissions and PUIs for 14 days. This is will be easier to monitor, control the spread of germs and supervise staff.

**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: There are no alternative under current State regulation.

**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.

This facility is requesting CDPH temporarily waive for the duration of the COVID -19 pandemic of the below specified SNF licensing requirements and suspending regulatory enforcement of the following requirements:

§ 72609. Patient Rooms.

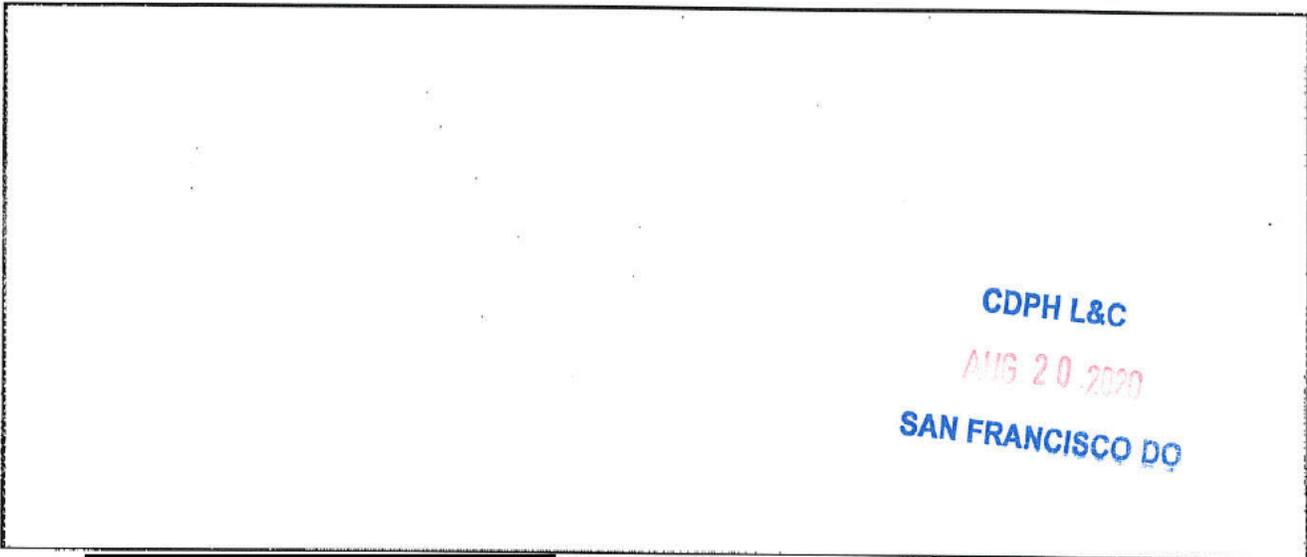
- (a) Each patient room shall be labeled with a number, letter or combination of the two for identification.
- (b) Patients' rooms shall not be kept locked when occupied except in rooms approved by the Department for seclusion of psychiatric patients.
- (c) Only upon the written approval of the Department may any exit door, corridor door, yard enclosures or perimeter fences be locked to egress.
- (d) Patient rooms approved for use by ambulatory patients only shall be identified as follows: The words " Reserved for Ambulatory Patient " in letters at least 1.25 centimeters (one-half inch) high shall be posted on the outside of the door or on the wall alongside the door where they are visible to persons entering the room.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

This database is current through 8/7/20 Register 2020, No. 32  
22 CCR § 72609, 22 CA ADC § 72609

State of California-Health and Human Services Agency

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\_\_\_\_\_  
 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 8/20/20 to 11/20/20  
 Permission Denied. Briefly describe why request was denied in comments / conditions below:  
 Comments / conditions:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 CHCQ Printed Name:  
 CHCQ Staff Signature:  
 Date:

\_\_\_\_\_  
 L&C District Office Staff Signature  
HFEM1  
 Title  
8/20/20  
 Date