

### 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>

<p>Facility Name</p> <input type="text" value="Windsor Gardens Convalescent Center of Lo"/> <p>License Number</p> <input type="text" value="940000067"/> <p>Facility Address</p> <input type="text" value="3232 E Artesia Boulevard"/> <p>City                      State                      Zip Code</p> <input type="text" value="Long Beach"/> <input type="text" value="CA"/> <input type="text" value="90805"/>	<p>Date of Request</p> <input type="text" value="07/10/2020"/> <p>Facility Phone                      Facility Fax Number</p> <input type="text" value="562-422-9219"/> <input type="text" value="562-428-0280"/> <p>E-Mail Address</p> <input type="text" value="[REDACTED]"/> <p>Contact Person's Name</p> <input type="text" value="[REDACTED]"/>
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**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

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).

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:

On March 04, 2020 Gov. Gavin Newsom declared a State of Emergency to make additional resources available, formalize emergency actions already underway across multiple state agencies and departments, and help the state prepare for broader spread of COVID-19.

**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: See below

**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**

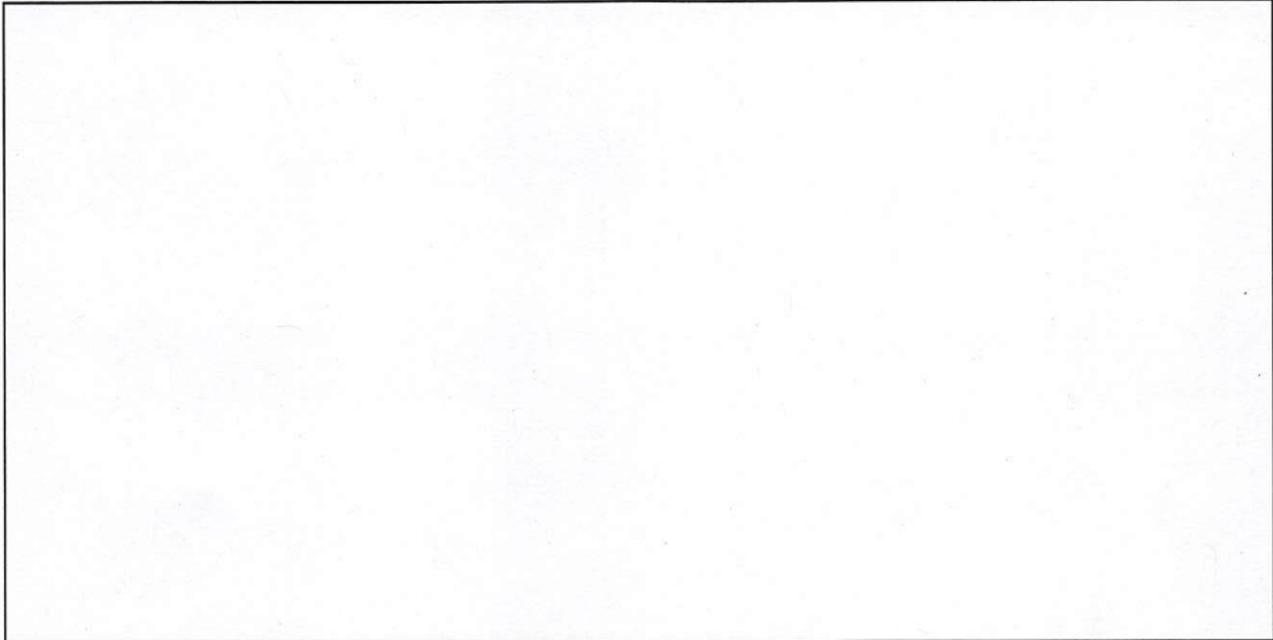
Provide a brief description of your conditions and explain the need for program flexibility. Provide a brief description of the alternative concepts, methods, procedures, techniques, equipment or personnel to be used, and the conditions under which this program flexibility will be used. Attach additional supporting documentation as needed.

CCR 22 §72329; §72329.2; H&S Code §1599.1(a)

Our facility is experiencing COVID-19 related issues that is directly impacting our staffing levels. (as described below/facility specific). We have difficulties meeting the 3.5NHPPD and 2.4 CNA HPPD due to CNA recruitment and CNA retention challenges. Currently, we are utilizing the licensed nurses hours to meet the 3.5 but unable to CNA 2.4 ratios due to high number of CNA open positions (24 CNA). In this regard, the facility is not meeting the minimum ratios and currently at the 3.2 NHPPD and 2.0 CNA HPPD ratios at the minimum.

Steps the facility has taken (and continues to take) include: (facility specific)

1. Implementing the facility's Staff Recall Policy and staffing contingency plans.



[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:  to

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

Comments / Conditions:

*For Title 22 92329(a), approved with the condition of minimum 3:2 DHPAD overall staffing. Excludes sub-Acute if any.*

CHCQ Printed Name:

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

Date:

[Redacted Signature]

*HF Program Manager Nursing*

*9-15-2020*

L&C District Office Staff Signature

Title

Date