**Section 125.170 Staff action in emerging or extraordinary circumstances**

a) Designated mandated follow-up staff shall personally observe the recipient, review individual progress and adjustment within the placement setting, and review the following considerations:

1) The recipient's rights and desires have been taken into consideration;

2) The receiving agency/facility continues to meet recipient needs;

3) The individualized services plan is being constantly updated by staff of the receiving agency;

4) Joint planning for the recipient's progress continues; and

5) On an on-going basis, the recipient has not been abused, neglected or improperly cared for.

b) As mandated follow-up or other visits are made, designated staff shall review for:

1) Prolonged understaffing;

2) Suspected abuse/neglect;

3) Inappropriate level of care;

4) Unattended medical needs;

5) Unexplained weight loss or gain;

6) Filth, dirt and odors; and

7) Inquiries from family, media or elected officials.

c) If these or other untoward or extraordinary situations such as room temperature extremes, contagious diseases and natural catastrophes are noted, the following steps shall be undertaken and fully documented:

1) Consultation with the licensed long-term care facility administrator and/or appropriate staff shall occur to discuss any deficient conditions. This consultation and any actions agreed to shall be fully documented. If resolution is achieved, further steps need not be taken. Regional offices of the Department of Public Health shall be kept informed.

2) If resolution is not reached, immediate verbal reports to the regional and central offices of the Department of Public Health, as well as to the regional administrator and appropriate associate directors of the Department must be made, followed by written confirmation within 24 hours.

3) Initiate regional interagency review with involved state agencies and formulate necessary action to resolve the situation. The right to a neutral hearing as provided for in Sections 3-703 through 3-802 of the Nursing Home Care Act [210 ILCS 45/3-703 through 3-802] and Sections 2-704, 3-207, 3-903, 4-209 and 4-709 of the Code must, however, be observed.

4) If a regional solution is not reached, the appropriate associate directors are notified and requested to facilitate resolution with the appropriate state agencies.

5) If resolution is not reached, the region will be instructed to initiate transfer by:

A) Consulting with each recipient potentially involved in the transfer and documenting the recipient's response and notifying family or legal guardian;

B) Locating and arranging for suitable alternative placement;

C) Coordinating the transfer with the Department of Public Health and applicable funding agencies;

D) Assuring that records required in this Part are maintained and personal effects are properly safeguarded; and

E) Submitting a follow-up report to the associate directors.

d) Report of abuse or neglect of a recipient by an owner, licensee, administrator, employee, or agent of a facility shall be made to local law enforcement officials as provided in the Abuse and Neglected Long Term Care Facility Residents Reporting Act [210 ILCS 30].