STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PROGRAM AUDIT

OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HUMAN SERVICES

DECEMBER 2008

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To the Legislative Audit Commission, the Speaker and Minority Leader of the House of Representatives, the President and Minority Leader of the Senate, the members of the General Assembly, and the Governor:

This is our report of the Program Audit of the Office of the Inspector General, Department of Human Services.

The audit was conducted pursuant to Section 1-17(m) of the Department of Human Services Act (20 ILCS 1305). This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

The audit report is transmitted in conformance with Section 3-14 of the Illinois State Auditing Act.

WILLIAM G. HOLLAND
Auditor General

Springfield, Illinois
December 2008

REPORT DIGEST

PROGRAM AUDIT OF

THE DEPARTMENT OF HUMAN SERVICES

OFFICE OF THE INSPECTOR GENERAL

Released: December 2008

State of Illinois
Office of the Auditor General

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SYNOPSIS

This is our tenth audit of the Department of Human Services' Office of the Inspector General's (OIG's) effectiveness in investigating allegations of abuse or neglect. The OIG has taken significant actions toward implementing the recommendations from our previous audit. These included: capturing data for non-reportable allegations; more evenly distributing investigative caseloads; and reviewing samples of unsubstantiated and unfounded cases for consistency.

In this audit we also reported that:

- The OIG made improvements in the timeliness of investigations since our last audit. However, 40 percent of investigations were not completed within 60 calendar days in FY08. Using the more lenient working days standard established in 2002, the OIG's timeliness of case completion for FY07 and FY08 was similar to the previous audit.
- Although recommended in prior audits, the OIG has not added serious injuries to its investigative database.
- In response to a prior audit finding, the OIG revised its Checklist for Notification to Illinois State Police/Local Law Enforcement to include the date and time of the determination that credible evidence existed that would require reporting. However, in a few cases we reviewed which were reported to the State Police, this new Checklist was not used.
- In 17 of the 117 (15%) cases sampled where an assignment date could be determined, the case was not assigned to an investigator within the required one working day.
- In FY08, 7 percent of alleged incidents of abuse or neglect at facilities and 25 percent at community agencies were not being reported within the four hours required by statute and OIG's administrative rules.
- For some community agency conducted investigations in our sample, it was difficult to determine which bureau and investigator was responsible for reviewing the case.
- The Inspector General or his designee is not required to review substantiated cases of mental injury or neglect unless it is deemed "egregious" neglect.
- In 15 percent (6 of 41) of the cases sampled, more than six months passed from the date the case was completed to the date when a written response delineating the corrective actions taken was submitted by the State facility or community agency and approved by DHS.
- DHS could not document that all staff at State-operated facilities received the required training in reporting abuse and neglect.

REPORT CONCLUSIONS

The Department of Human Services Act (Act) requires the Office of the Inspector General (OIG) to investigate allegations of abuse and neglect that occur in mental health and developmental disability facilities operated by the Department of Human Services (DHS). The Act also authorizes the OIG to conduct investigations in community agencies licensed, certified, or funded by DHS to provide mental health and developmental disability services. In FY08, DHS operated 18 State facilities. There were also 346 community agencies operating 3,672 programs providing services to individuals with developmental disabilities or mental illness in community settings within Illinois that were under OIG's jurisdiction. The Act requires the Office of the Auditor General to conduct a biennial program audit of the Inspector General's effectiveness of investigations of abuse and neglect and compliance with the Act. This is the tenth audit we have conducted of the OIG since 1990.

The OIG has taken significant actions toward implementing the recommendations from our previous audit. These actions include among others:

- Capturing data for non-reportable allegations;
- Improving the timeliness of investigations;
- More evenly distributing investigator caseloads;
- Reviewing samples of unsubstantiated and unfounded cases for consistency; and
- Meeting timelines for submitting site visit reports to facility directors or hospital administrators.

Total allegations of abuse and neglect reported to the OIG have continued to increase since our 2006 audit. In FY06, 1,814 allegations were reported (1,485 abuse and 329 neglect). This compares to 2,026 in FY08 (1,631 abuse and 395 neglect) or a 12 percent increase. Although total allegations of abuse and neglect have increased, the number of allegations reported at State facilities has been decreasing. Of the 1,814 allegations reported in FY06, 921 allegations were reported at State facilities and 893 allegations were reported at community agencies. For FY08, of the total of 2,026 allegations of abuse or neglect, 798 were from State facilities and 1,228 from community agencies. FY07 and FY08 represent the first time that the number of allegations of abuse and neglect reported at community agencies was greater than the number reported at State facilities.

During our previous audit, the OIG was not capturing data related to non-reportable allegations that would enable investigators to look for patterns. Beginning in December 2006, OIG started entering non-reportable allegations into its incident database and also included a list of non-reportable complaints on subsequent calls so that a more complete past history is displayed. However, the OIG still does not collect information related to serious injuries without any allegation of abuse or neglect. In our 2004 audit, we recommended that the OIG capture data for all allegations of serious injuries in its database. In the 2006 audit, we again recommended that the OIG included serious injuries in its investigative database. As of FY08, the OIG still does not capture this data. According to OIG officials, the DHS Office of Legal Services determined that mandating agencies to report all serious injuries to OIG would first require a change in statute.

The timeliness of OIG investigations continued to improve in FY07 and FY08. In FY06, 52 percent of OIG investigations were completed in 60 calendar days. Timeliness improved in FY07 with 56 percent and in FY08 with 60 percent completed within 60 calendar days. In January 2002, the OIG amended its administrative rules to require investigations be completed within 60 ***working*** days. Using the more lenient working days standard established in 2002, the OIG's timeliness of case completion for FY07 and FY08 was similar to the previous audit.

Although there has been some improvement, timeliness of cases taking longer than 60 working days to complete continues to be a problem for some investigative bureaus for cases closed during FY08. The Central and South bureaus had the smallest percentages of cases taking longer than 60 working days with 5 percent and 6 percent respectively. The percentages for the North and Metro bureaus were much greater. The percentage of cases taking longer than 60 working days was 25 percent for the North Bureau and 64 percent for the Metro Bureau. Although the timeliness for the North Bureau is an improvement over the previous audit, the Metro Bureau's timeliness has gotten worse. The South Bureau dropped from 20 percent over 60 working days in FY06 to 6 percent in FY08.

The OIG has taken steps to address these timeliness problems by utilizing other bureaus to help complete cases for the Metro and North bureaus. This includes assigning cases to be completed by the Bureau of Domestic Abuse and the Bureau of Hotline and Intake. The OIG has also taken additional steps to increase timeliness by filling existing investigator vacancies and obtaining more computers. For the 1,929 cases closed in FY08, 219 cases were completed by other bureaus. This represents a large increase over the 19 cases that were conducted by other bureaus during the previous audit in FY06. The 219 cases included 91 assigned to clinical

coordinators which include death cases and cases that involve a medical issue. Of the remaining cases, 65 were assigned to intake investigators, and 63 were assigned to investigators from the Bureau of Domestic Abuse.

In response to our 2006 audit recommendation regarding reporting to the State Police, the OIG revised its Checklist for Notification to Illinois State Police/Local Law Enforcement to include the date and time of the determination that credible evidence existed that would require reporting. In our testing of FY08 cases, 4 cases were referred to State Police. We obtained copies of all four checklists from the investigative files. For all four cases, we determined that the incident was reported to the State Police within the required 24 hours. However, even though the OIG updated its checklist in December 2006, all four files contained the old checklist which does not include the date that it was determined that credible evidence existed. Three of the four cases occurred after the form had been revised. For one of the cases which occurred in December 2007, we could not readily determine whether it was reported in a timely manner because the old checklist was used. Therefore, OIG management cannot ensure that the allegation was reported within the 24-hour reporting requirement found in the Act.

We reviewed investigator caseloads for the different investigative bureaus at the OIG. The OIG has made significant improvement in reducing investigator caseloads since the previous audit. Investigator caseloads have decreased substantially for the North and Metro bureaus and are also more evenly distributed among bureaus. Caseloads as of August 2008 ranged from 11 in the Metro and South bureaus to 7 in the North Bureau. In August 2006, caseloads ranged from a high of 30 in the Metro Bureau to a low of 4 in the Central Bureau.

The number of interviews conducted appears to be more consistent between investigative bureaus than in our previous audit. In the previous audit we found that the number of interviews conducted by the investigative bureaus differed significantly, ranging from 3 interviews per investigation in the South Bureau to 11 per investigation in the North Bureau. The average number of interviews for FY08 cases sampled was much closer and ranged from 6 interviews in the Metro Bureau to 8 interviews in the South Bureau.

OIG directives no longer require “critical” interviews to be completed by the assigned investigator within five working days of approval of the investigative plan. However, during our case file review, we found on average it took investigators 8 days to complete interviews with the alleged victim and 20 days to complete interviews with the alleged perpetrator in each case. These are both an improvement over the

previous audit in which it took an average of 12 days to interview the alleged victim and 25 days to interview the alleged perpetrator.

The OIG needs to improve the timeliness of investigator assignment and completion of investigative plans. OIG directives require that investigations be assigned to an investigator within one working day of the OIG assuming responsibility for the investigation. For 17 of the 117 (15%) cases we sampled and could determine an assignment date, the assignment was not made within one working day. OIG directives also require assigned investigators to complete an investigative plan within three working days of assignment, except if the case is closed at intake. For 16 of the 127 (13%) of cases we sampled, we could not determine whether the plan was completed in a timely manner because there was either no date on the investigative plan or we could not determine the date assigned. For the remaining 111 cases sampled, 5 (5%) were not completed and approved within the required three working days.

Alleged incidents of abuse and neglect are not being reported to the OIG by facilities and community agencies in the time frames required by the statutes and OIG's administrative rules. In FY08, 7 percent of facility incidents and 25 percent of community agency incidents were not reported within the four-hour time requirement. Effective June 13, 2006, Public Act 94-853 added a provision that states that a required reporter who willfully fails to comply with the reporting requirements is guilty of a Class A misdemeanor.

OIG case reports generally were thorough, comprehensive, and addressed the allegation. However, we found that photographs were missing in 5 of 29 (17%) cases where there was an allegation of an injury sustained from our FY08 sample. Injury Reports were missing in 3 of 29 (10%) cases where there was an allegation of an injury sustained. Two of the 127 sample cases tested did not contain a Case Routing/Approval Form. Although all case files in our sample contained a Case Tracking Form, two of the forms were not completed. During the review of our 127 sample cases, two files did not contain pertinent medical records, treatment plans, or progress notes. One case sampled where restraints were used did not contain the appropriate documentation.

During the previous audit, we concluded that there were inconsistencies between investigative bureaus related to how the bureaus classify findings. In addition, we found inconsistencies between what is and is not accepted by the Bureau of Hotline and Intake as an allegation of abuse or neglect. Beginning in January 2007, the Deputy Inspector General and one investigative bureau chief (on a rotating basis) began quarterly reviews of unfounded and unsubstantiated cases to ensure consistency across bureaus. During our fieldwork, we reviewed the

second quarter FY08 review conducted by the Deputy Inspector General. Although the review identified problems such as cases missing an investigative plan or clinical coordinators' summary and cases in which interview statements were not numbered, the review did not find any cases involving improper findings or different interpretations of finding criteria, nor did it find any cases that might have been substantiated.

For community agency conducted investigations in our sample, it was sometimes difficult to determine which bureau and investigator was responsible for reviewing the case. For some community agency conducted investigations the OIG Bureau of Hotline and Intake was reportedly responsible for reviewing the case. For these cases that were reportedly assigned to the Bureau of Hotline and Intake, review forms were either missing or not completed.

In the previous audit we recommended that the Inspector General should clearly define what constitutes physical injury and physical harm. This has not been accomplished. According to the OIG response in the previous audit, officials agreed and stated they believed that the issue of definitions would be resolved by revisions to the statute. Until the statute is revised such a change to the OIG's administrative rules (Rule 50) would be premature. However, in the meantime, OIG would reinforce that physical "harm" is a physical "wrong or injustice."

According to 59 Ill. Adm. Code 50.90, an employee may request a hearing with the Department of Human Services and present evidence supporting why his or her finding does not warrant reporting to the Health Care Worker Registry. The percentage of cases appealed in which the Administrative Law Judge's (ALJ) decision upheld the referral of the employee to the Health Care Worker Registry has increased when compared to our previous audit. The ALJ decision was to refer the employee in 56 percent of the appeal hearings in FY08 (15 of 27) and 56 percent of those in FY07 (18 of 32), compared to 41 percent in FY06 (13 of 32) and 21 percent in FY05 (6 of 28).

We reviewed 10 substantiated cases in which the ALJ rejected the referral to the Health Care Worker Registry in FY08. In the 10 cases in which the referral was rejected, the ALJ found that the Department had not demonstrated by a preponderance of the evidence that the finding of abuse against the petitioner warranted reporting to the Registry. Several overturned cases cite the credibility of witnesses as a problem. In one case, the ALJ found the OIG investigation was unreliable. The OIG investigator in the case had been placed on leave and is no longer with the OIG. In another case, the ALJ found that the petitioner's actions were inappropriate but did not rise to the level of reporting to the Registry.

In our previous audit we recommended that the OIG revise its policies and procedures to ensure that all cases with findings that warrant reporting to the Registry are reported. The Department of Human Services Act requires physical abuse, sexual abuse, and egregious neglect to be referred to the Registry. Although the OIG has not updated the definition of egregious as it relates to neglect, the OIG directives have been updated and a process added for a stipulated motion to dismiss. This process is triggered by a 50.90 petition on certain physical abuse cases that, although the finding meets the definition of physical abuse, may not be severe enough to deserve placement on the Registry. In September 2006 the OIG implemented a new stipulation process authorized by statute for appeals hearings. The OIG did not refer a case to the Registry based on a stipulation order on six occasions in FY07 and FY08.

State facilities or community agencies are required to submit a written response to DHS for all substantiated cases of abuse or neglect, or cases with other administrative issues. In our review of written responses we found that DHS takes an excessive amount of time to receive and approve the actions taken by the agency or facility in some cases. For one case in our sample, the agency date on the written response was September 9, 2008 and the DHS approved date was also September 9, 2008. However, the case was completed in August 2007. In addition, we requested this information on August 22, 2008. Therefore, it took more than a year to get the corrective action approved from the date of completion and it was done only after auditors requested the information. Of the 41 cases in our sample for which we could determine an investigative completion date and a response date, 6 of 41 (15%) took more than six months from the date the case was completed until the written response was approved by DHS. Two of these cases took more than a year.

Even though two State-operated facilities were terminated from participation in federal programs for non-compliance with various issues, including patient safety and client protection, the OIG did not recommend a sanction against either facility. Over the past 15 years (1994 – 2008), the Inspector General has not recommended sanctions against a State-operated facility. On June 9, 2008, the OIG did utilize its authority under 20 ILCS 1305/1-17(d) to recommend sanctions and sent letters to the DHS Division of Mental Health and to the DHS Division of Developmental Disabilities related to community agencies that had not updated their abuse/neglect reporting policies. The OIG recommended a total of nine service providers for non-renewal of their DHS service provider agreements until the policies are approved by OIG. According to OIG officials, none of the issues cited by the reviewers at Tinley Park MHC were reportable to OIG under current State law. Some issues cited by the reviewers at Howe DC did meet the State law's definitions, but OIG identified no trends or

patterns in those beyond what has been typical of other facility or agency programs.

The Quality Care Board held all required quarterly meetings during FY07-08. This is a significant improvement from the previous audit. The Board continues to have difficulty maintaining seven members as required by statute. During part of FY07 (September 2006-April 2007), the Board had seven members as required; however, in April 2007, one of the Board members resigned. This left the Board with six members near the end of FY07 and all of FY08. As of June 2008, a successor had still not been appointed to fill the vacancy.

During FY07 and FY08, the Office of the Inspector General conducted annual unannounced site visits at all of the mental health and developmental centers as required by statute (20 ILCS 1305/1-17(f)). Also, during FY07 and FY08, the OIG met its established timeline for submitting site visit reports to facility directors or hospital administrators. This is an improvement since the last audit.

DHS could not document that all staff at State-operated facilities received the required Rule 50 training. In addition, the OIG identified two facilities that were deficient in training staff during its FY08 site visits. The OIG site visit for Howe Developmental Center reported that only 504 of the facility's 835 (60%) employees had been trained in OIG Rule 50 during the last year, and the OIG site visit for Tinley Park Mental Health Center reported that only 172 of the facility's 207 (83%) employees had been trained in OIG Rule 50. The OIG recommended to Howe and Tinley Park that each facility should ensure that all staff, contractual workers, and volunteers received OIG Rule 50 training at least biennially. For Tinley Park, it was the third year that the recommendation for training staff had been repeated.

BACKGROUND

The Office of the Inspector General (OIG) was initially established by Public Act 85-223 in 1987 which amended the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/1 *et seq.*). Under this Act, the Inspector General was required to conduct investigations of abuse and neglect within State-operated facilities serving the mentally ill and developmentally disabled. In 1995, the role of the Office of the Inspector General was expanded to include the authority to investigate reports of abuse or neglect at facilities or programs not only operated by the Department of Human Services (facilities), but also those licensed, certified, or funded by DHS (community agencies).

Effective August 28, 2007, Public Act 95-545 amended the Department of Human Services Act (20 ILCS 1305) and the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30) transferring all provisions concerning the Office of the Inspector General within the Department of Human Services from the Abused and Neglected Long Term Care Facility Residents Reporting Act to the Department of Human Services Act.

During FY08, the Department of Human Services operated 18 facilities Statewide that served 12,506 individuals. In addition, DHS licenses, certifies, or provides funding for approximately 346 community agencies operating 3,672 programs providing services to individuals with developmental disabilities or mental illness in community settings within Illinois. In FY08, approximately 29,500 individuals with developmental disabilities and approximately 167,456 individuals with mental illness were served in community agencies required to report to the OIG.

As of July 1, 2008, the OIG had 61 employees, including three on leave. In addition, the OIG hired two contractual employees to bring the total employees to 63. The number of investigative staff for abuse and neglect investigations is similar to the number of staff during the previous audit (21 in FY06; 20 in FY08).

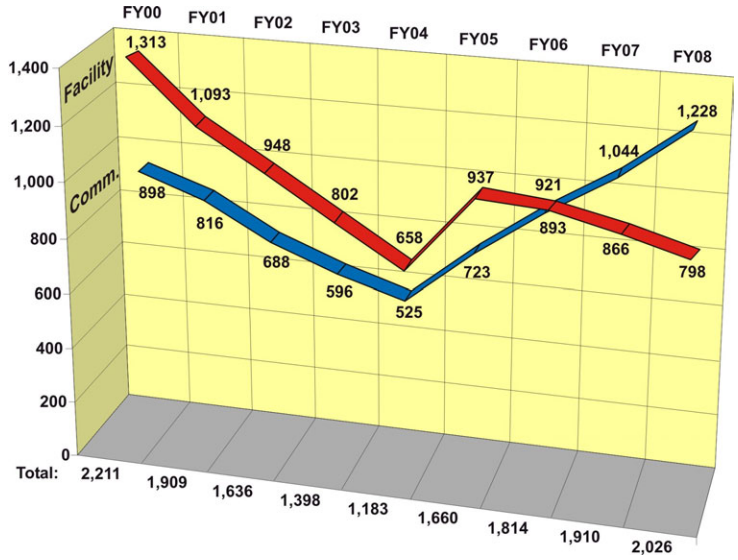
The Office of the Auditor General has conducted nine prior OIG audits to assess the effectiveness of its investigations into allegations of abuse and neglect, as required by statute. These audits were released in 1990, 1993, 1994, 1996, 1998, 2000, 2002, 2004, and 2006. (pages 6-9, 21)

FY07 represents the first time that the number of allegations of abuse and neglect reported at community agencies was greater than the number reported at State facilities.

REPORTING OF ALLEGATIONS

Total allegations of abuse and neglect reported to the OIG have continued to increase since our 2006 audit. In FY06, 1,814 allegations were reported (1,485 abuse and 329 neglect). In FY08, a total of 2,026 allegations of abuse or neglect were reported to the OIG (798 from State facilities and 1,228 from community agencies). However, the number of allegations reported at State facilities has been decreasing since FY05. FY07 represents the first time that the number of allegations of abuse and neglect reported at community agencies was greater than the number reported at State facilities (See Digest Exhibit 1).

Digest Exhibit 1
TOTAL ABUSE OR NEGLECT ALLEGATIONS REPORTED TO OIG
Fiscal Years 2000 to 2008



Note: State facilities served 2,626 individuals with developmental disabilities and 9,880 individuals with mental illness in FY08. Community agencies served approximately 29,500 individuals with developmental disabilities and approximately 167,456 individuals with mental illness in FY08.

Source: OIG data summarized by the OAG.

According to OIG officials, the most significant factor in the drop in allegations at State facilities is the comparable drop in the number of individuals served in the State facilities. OIG officials attribute the increase in community agency allegations reported to continued training efforts and increased citing of community agency failure to report or late reporting (264 cases in FY07 and 273 cases in FY08). (pages 11-12)

Beginning in December 2006, OIG started entering non-reportable allegations into its incident database.

Reporting Serious Injuries

During the previous audit, the OIG was not capturing data related to non-reportable allegations that would enable investigators to look for patterns. Beginning in December 2006, OIG started entering non-reportable allegations into its incident database and also included a list of non-reportable complaints on subsequent calls so that a more complete past history is displayed.

However, the OIG continues to consider serious injuries without an allegation of abuse or neglect to be not reportable. Until FY03, these cases were reported and were investigated by the OIG even though there was no

allegation of abuse or neglect. Serious injuries caused by neglect may not have a direct allegation associated with them, such as incidents involving resident on resident injuries. Resident on resident incidents may be a result of neglect by staff and the OIG should consider requiring that these types of cases be reported for review and/or investigation.

In our 2004 audit, we recommended that the OIG capture data for all allegations of serious injuries in its database. In the 2006 audit we again recommended that the OIG include serious injuries in its investigative database (Recommendation 3). As of our fieldwork in 2008, we determined that the OIG does not capture this data. According to OIG officials, the DHS Office of Legal Services determined that mandating agencies to report all serious injuries to OIG would first require a change in statute. (pages 15-16)

INVESTIGATION TIMELINESS

During this audit period, the OIG made improvements in its timeliness for completing investigations.

Timeliness of investigations has been an issue in all of the nine previous OIG audits. During this audit period, the OIG made improvements in its timeliness for completing investigations. In FY06, 52 percent of OIG investigations were completed in 60 calendar days. Timeliness improved in FY07 with 56 percent and in FY08 with 60 percent completed in 60 calendar days. Using the more lenient working days standard established in 2002, the OIG's timeliness of case completion for FY07 and FY08 was similar to the previous audit. Digest Exhibit 2 shows timeliness data for OIG investigations for the last six fiscal years.

Although there has been some improvement, timeliness of cases taking longer than 60 working days to complete continues to be a problem for some investigative bureaus for cases closed during FY08. The Central and South bureaus had the smallest percentages of cases taking longer than 60 working days with 5 percent and 6 percent respectively. The percentages for the North and Metro bureaus were much greater. The percentage of cases taking longer than 60 working days was 25 percent for the North Bureau and 64 percent for the Metro Bureau. Although the timeliness for the North Bureau is an improvement over the previous audit, the Metro Bureau's timeliness has gotten worse. The South Bureau dropped from 20 percent over 60 working days in FY06 to 6 percent in FY08.

The OIG has taken steps to address these timeliness problems by utilizing other bureaus to help complete cases for the Metro and North bureaus. This includes assigning cases to be completed by the Bureau of Domestic Abuse and the Bureau of Hotline and Intake. The OIG has also taken additional steps to increase timeliness by filling existing investigator

vacancies and obtaining more computers. For the 1,929 cases closed in FY08, 219 cases were completed by other bureaus. This represents a large increase over the 19 cases that were conducted by other bureaus during the previous audit in FY06. The 219 cases included 91 assigned to clinical coordinators which include death cases and cases that involve a medical issue. Of the remaining cases, 65 were assigned to intake investigators, and 63 were assigned to investigators from the Bureau of Domestic Abuse. (pages 25-27)

Digest Exhibit 2
CALENDAR DAYS TO COMPLETE ABUSE OR NEGLECT INVESTIGATIONS
Fiscal Years 2003 to 2008

Days to Complete Cases	FY03 % of Cases	FY04 % of Cases	FY05 % of Cases	FY06 % of Cases	FY07 % of Cases	FY08 % of Cases
0-60	**30%**	**39%**	**55%**	**52%**	**56%**	**60%**
61-90	16%	11%	22%	19%	15%	13%
91-120	17%	10%	11%	14%	13%	13%
121-180	23%	20%	6%	11%	11%	11%
181-200	5%	5%	1%	2%	1%	0%
>200	9%	14%	5%	2%	3%	2%
Total > 60 days	**70%**	**61%**	**45%**	**48%**	**44%**	**40%**
Total Cases by FY	1,248	1,472	1,659	1,597	1,936	1,929

Note: Analysis excludes cases investigated by the Illinois State Police. "Completed cases" shown in this Exhibit are cases where the OIG issued a Preliminary Report to the State facility or community agency in the fiscal year. "Closed cases," referred to later in this report, are cases where the OIG sent the final report to the Secretary of DHS in the fiscal year. Totals may not add due to rounding.

Source: OAG analysis of OIG data.

Reporting to the State Police

In response to our 2006 audit recommendation regarding reporting to the State Police, the OIG revised its Checklist for Notification to the Illinois State Police/Local Law Enforcement to include the date and time of the determination that credible evidence existed that would require reporting. In our testing of FY08 cases, four cases were referred to the State Police. We obtained copies of all four checklists from the investigative files. For all four cases, we determined that the incident was reported to the State Police within the required 24 hours. However, even though the OIG updated its checklist in December 2006, all four files contained the old checklist which does not include the date that it was determined that credible evidence existed. Therefore, OIG management

cannot ensure that the allegation was reported within the 24-hour reporting requirement found in the Act. (pages 29-30)

Clinical Services Cases

OIG's Clinical Coordinators handle cases that involve medical issues as well as death cases. The Coordinators work and consult with Clinical Services at DHS. During the majority of FY08, OIG had only one Clinical Coordinator to cover the entire State.

The time to conduct investigations assigned to a Clinical Coordinator increased significantly from FY06 to FY08.

The time to conduct investigations assigned to a Clinical Coordinator increased significantly from FY06 to FY08. In FY06, we reported the average completion time for cases referred to the Clinical Coordinator was 66 days. For FY08, the average completion time for cases referred to the Coordinators was 119 days. In our review of cases that took more than 200 days to complete, 5 of 40 were assigned to Clinical Coordinators. The OIG hired an additional Clinical Coordinator on a 60 day emergency basis in December 2007 and again in February 2008. In April 2008, a full-time Clinical Coordinator was finally hired.

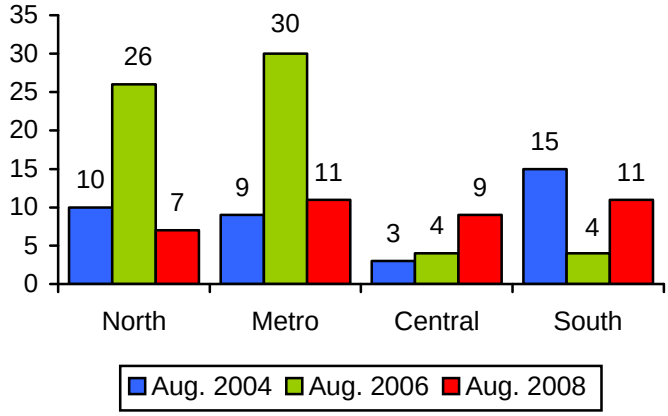
The CMS rules regarding emergency hires states that "Such appointments shall not exceed 60 days, shall not be renewed and may be made without regard to an eligible list" (80 Ill. Adm. Code 302.150 (b)). Department of Human Services' policies and procedures also do not allow for emergency appointments to exceed 60 calendar days or be renewed. In addition to the emergency hire for a Clinical Coordinator, the OIG also hired an intake investigator on an emergency basis and also renewed his appointment for an additional 60 day period. (page 30)

Investigator Caseloads

The OIG has made significant improvement in reducing investigator caseloads since the previous audit.

The OIG has made significant improvement in reducing investigator caseloads since the previous audit. Investigator caseloads have decreased substantially for the North and Metro bureaus and are also more evenly distributed among bureaus.

Digest Exhibit 3
INVESTIGATOR CASELOADS
By Bureau as of August 14, 2004, 2006, and 2008



Source: OIG data summarized by the OAG.

Digest Exhibit 3 shows the trend in caseloads by bureau from 2004 through 2008. Caseloads as of August 2008 ranged from 11 in the Metro and South bureaus to 7 in the North Bureau. In August 2006, caseloads ranged from a high of 30 in the Metro Bureau to a low of 4 in the South and Central bureaus. (page 31)

Timeliness of Assignment and Investigative Plans

The OIG needs to improve the timeliness of investigator assignment and completion of investigative plans.

The OIG needs to improve the timeliness of investigator assignment and completion of investigative plans. OIG directives require that investigations be assigned to an investigator within one working day of the OIG assuming responsibility for the investigation. More than three-quarters of the investigations we reviewed were assigned within one working day. However, for 17 of the 117 (15%) cases we sampled and could determine an assignment date, the assignment was not made within one working day. The time to assign for these cases ranged from 3 days to 10 days. For 10 cases, we could not determine the assignment date.

OIG directives also require assigned investigators to complete an investigative plan within three working days of assignment, except if the case is closed at intake. For 16 of the 127 (13%) cases we sampled, we could not determine whether the plan was completed in a timely manner because there was either no date on the investigative plan or we could not determine the date assigned. For the remaining 111 cases sampled, 5 (5%) were not completed and approved within the required three working days. (page 33)

Number of Interviews Conducted

The number of interviews conducted in FY08 is more consistent between investigative bureaus than in our previous audit. In the previous audit we found that the number of interviews conducted by the investigative bureaus differed significantly, ranging from 3 interviews per investigation in the South Bureau to 11 per investigation in the North Bureau. The average number of interviews for FY08 cases sampled was much closer and ranged from 6 interviews in the Metro Bureau to 8 interviews in the South Bureau.

The number of interviews conducted in FY08 is more consistent between investigative bureaus than in our previous audit.

OIG directives no longer require "critical" interviews to be completed by the assigned investigator within five working days of approval of the investigative plan. However, during our case file review, we found on average it took investigators 8 days to complete interviews with the alleged victim and 20 days to complete interviews with the alleged perpetrator in each case. These are both an improvement over the previous audit in which it took an average of 12 days to interview the alleged victim and 25 days to interview the alleged perpetrator. (pages 33-34)

Timeliness of Case File Reviews

Timeliness of case file review has improved since our last audit. However, the OIG continues to fall short of the timeline requirements in its directive relating to case file review. None of the bureaus are reviewing substantiated cases within the 7-day timeline delineated in the OIG directive. The Metro Bureau takes much longer to review substantiated cases than the other three bureaus. (pages 34-35)

Timely Reporting of Allegations

Alleged incidents of abuse and neglect are not being reported by facilities and community agencies in the time frames required by statutes and the OIG's administrative rules. The Department of Human Services Act requires that allegations be reported to the OIG hotline within four hours of initial discovery of the incident of alleged abuse or neglect. Community

Digest Exhibit 4
ALLEGATIONS OF ABUSE AND NEGLECT NOT REPORTED WITHIN FOUR HOURS OF DISCOVERY

Fiscal Year	Facility	Community Agency
FY05	6%	34%
FY06	6%	29%
FY07	5%	21%
FY08	7%	25%

Source: OAG analysis of OIG data.

agencies continue to have a larger percentage of untimely reports in comparison to facilities.

Digest Exhibit 4 shows allegations of abuse and neglect not reported within four hours of discovery for State facilities and community agencies from FY05 through FY08. (page 35)

INVESTIGATION THOROUGHNESS

OIG case reports generally were thorough, comprehensive, and addressed the allegation. However, we found that photographs were missing in 5 of 29 (17%) cases where there was an allegation of an injury sustained from our FY08 sample. Injury Reports were missing in 3 of 29 (10%) cases where there was an allegation of an injury sustained. Two of the 127 sample cases tested did not contain a Case Routing/Approval Form. Although all case files in our sample contained a Case Tracking Form, two of the forms were not completed. During the review of our 127 sample cases, two files did not contain pertinent medical records, treatment plans, or progress notes. One case sampled where restraints were used did not contain the appropriate documentation.

Investigation Inconsistencies

During the previous audit, we concluded that there were inconsistencies between investigative bureaus related to how the bureaus classify findings. In addition, we found inconsistencies between what is and is not accepted by the Bureau of Hotline and Intake as an allegation of abuse or neglect. Beginning in January 2007, the Deputy Inspector General and one investigative bureau chief (on a rotating basis) began quarterly reviews of unfounded and unsubstantiated cases to ensure consistency across bureaus.

Although the OIG has taken steps to try to improve in this area, consistency in what constitutes a reportable allegation and the classification of the outcome of cases as substantiated, unsubstantiated, and unfounded continue to be areas of concern at the OIG. During our testing, we identified cases that involved clients that were left unsupervised that had different outcomes.

The Inspector General or his designee is not required to review substantiated cases of mental injury or neglect unless it is deemed "egregious" neglect.

The Inspector General or his designee is not required to review substantiated cases of mental injury or neglect unless it is deemed "egregious" neglect. Conducting case file reviews is critical to the investigations process. These reviews not only ensure an effective investigation, but also help ensure the integrity and quality of the investigatory process. (pages 39-44)

Definition of Physical Harm

In the previous audit we recommended that the Inspector General should clearly define what constitutes physical injury and physical harm. This has not been accomplished. According to the OIG response in the previous audit, officials agreed and stated they believed that the issue of definitions would be resolved by revisions to the statute. Until the statute is revised, such a change to Rule 50 would be premature. However, in the meantime, OIG would reinforce that physical "harm" is a physical "wrong or injustice."

Auditors noted that effective August 28, 2007, Public Act 95-545 amended the Department of Human Services Act (20 ILCS 1305) by transferring to it all provisions concerning the Office of the Inspector General within the Department of Human Services from the Abused and Neglected Long Term Care Facility Residents Reporting Act. According to OIG officials, since the law was not substantially altered, Rule 50 was not revised. (page 45)

OIG SUBSTANTIATED CASE WRITTEN RESPONSES

The Department of Human Services Act requires that each completed case where abuse or neglect is substantiated or administrative action is recommended, contain a written response from the agency or facility that addresses the actions that will be taken. The Secretary of DHS is required by the Act to accept or reject the written response.

In our review of written responses, we found that DHS takes an excessive amount of time to receive and approve the actions taken by the agency or facility in some cases.

In our review of written responses, we found that DHS takes an excessive amount of time to receive and approve the actions taken by the agency or facility in some cases. For one case in our sample, the written response from the agency was dated November 9, 2007 but was not approved by DHS for over nine months (August 29, 2008). In another case, the agency date on the written response was September 9, 2008 and the DHS approved date was also September 9, 2008. However, the case was completed in August 2007. We requested this information on August 22, 2008. Therefore, more than a year after the case was completed, and only after auditors requested the information, was a written response prepared and approved by DHS.

Overall there were 43 cases in our sample that required a written response. Of the 41 cases in our sample for which we could determine an investigative completion date and a response date, 6 of 41 (15%) took more than six months from the date the case was completed until the written response was approved by DHS. Two of these cases took more

than a year. For two cases, we could not determine the date the case was completed.

According to OIG officials, the Developmental Disabilities Division at DHS had been falling behind in approvals partly due to staffing issues. During the later part of FY08 the Division increased its efforts to approve written responses in timely manner. If DHS does not approve written responses in a timely manner, the OIG cannot effectively monitor the implementation of actions by State-operated facilities and community agencies. In addition, not ensuring that appropriate actions are taken may put client safety at risk. (pages 53-55)

HEALTH CARE WORKER REGISTRY

According to 59 Ill. Adm. Code 50.90, an employee may request a hearing with the Department of Human Services and present evidence supporting why his or her finding does not warrant reporting to the Health Care Worker Registry. The percentage of cases appealed in which the Administrative Law Judge's (ALJ) decision upheld the referral of the employee to the Health Care Worker Registry has increased when compared to our previous audit. The ALJ decision was to refer the employee in 56 percent of the appeal hearings in FY08 (15 of 27) and 56 percent of those in FY07 (18 of 32), compared to 41 percent in FY06 (13 of 32) and 21 percent in FY05 (6 of 28).

We reviewed 10 substantiated cases in which the ALJ rejected the referral to the Health Care Worker Registry in FY08. In the 10 cases in which the referral was rejected, the ALJ found that the Department had not demonstrated by a preponderance of the evidence that the finding of abuse against the petitioner warranted reporting to the Registry. Several overturned cases cite the credibility of witnesses as a problem. In one case, the ALJ found the OIG investigation was unreliable. The OIG investigator in the case had been placed on leave and is no longer with the OIG. In another case, the ALJ found that the petitioner's actions were inappropriate but did not rise to the level of reporting to the Registry.

In our previous audit we recommended that the OIG revise its policies and procedures to ensure that all cases with findings that warrant reporting to the Registry are reported. The Department of Human Services Act requires physical abuse, sexual abuse, and egregious neglect to be referred to the Registry. Although the OIG has not updated the definition of egregious as it relates to neglect, the OIG directives have been updated and a process added for a stipulated motion to dismiss. This process is triggered by a Rule 50.90 petition on certain physical abuse cases that, although the finding meets the definition of physical abuse, may not be

severe enough to deserve placement on the Registry. In September 2006 the OIG implemented a new stipulation process authorized by statute for appeals hearings. The OIG did not refer a case to the Registry based on a stipulation order on six occasions in FY07 and FY08. (pages 56-60)

SANCTIONS

During FY07, two State-operated facilities failed to comply with requirements to remain certified as eligible Medicare or Medicaid service providers. As a result, Tinley Park Mental Health Center's Medicare provider agreement was terminated effective February 23, 2007 and Howe Developmental Center was terminated from the program effective March 8, 2007.

Even though these two State-operated facilities were terminated from participation in federal programs for non-compliance with issues related to patient safety and client protection, the OIG did not recommend a sanction against either facility. Over the past 15 years (1994 – 2008), the Inspector General has not recommended sanctions against a State-operated facility.

According to OIG officials, none of the issues cited by the reviewers at Tinley Park MHC were reportable to OIG under current State law. Some issues cited by the reviewers at Howe DC did meet the State law's definitions, but OIG identified no trends or patterns in those beyond what has been typical of other facility or agency programs. According to OIG officials, the OIG cannot recommend sanctions without identifying a pattern of uncorrected problems with abuse/neglect as defined in current law.

On June 9, 2008, the OIG did utilize its authority under 20 ILCS 1305/1-17(d) to recommend sanctions and sent letters to the DHS Division of Mental Health and to the DHS Division of Developmental Disabilities related to community agencies that had not updated their abuse/neglect reporting policies. The OIG recommended a total of nine service providers for non-renewal of their DHS service provider agreements until the policies are approved by OIG. (pages 61-62)

OTHER ISSUES

Other issues identified in the audit included:

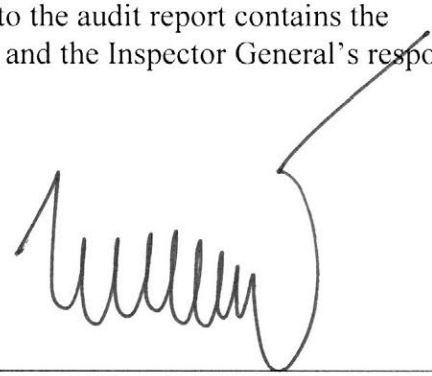
- The Quality Care Board held all required quarterly meetings during FY07-08.

- During FY07 and FY08, the Office of the Inspector General conducted annual unannounced site visits at all of the mental health and developmental centers and met established timelines for submitting site visit reports to facility directors or hospital administrators.

- DHS could not document that all staff at State-operated facilities received the required Rule 50 training in reporting abuse and neglect. In addition, the OIG identified two facilities that were deficient in training staff during its FY08 site visits. The OIG site visit for Howe Developmental Center reported that only 504 of the facility's 835 (60%) employees had been trained in OIG Rule 50 during the last year, and the OIG site visit for Tinley Park Mental Health Center reported that only 172 of the facility's 207 (83%) employees had been trained in OIG Rule 50. (pages 63-67)

RECOMMENDATIONS

The audit report contains 10 recommendations: 7 recommendations to the Office of the Inspector General and 3 recommendations to the Department of Human Services. The Inspector General and the Department of Human Services generally agreed with all 10 recommendations. Appendix E to the audit report contains the Department of Human Services' and the Inspector General's responses.



WILLIAM G. HOLLAND
Auditor General

WGH\MSP

December 2008

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Chapter One

INTRODUCTION AND BACKGROUND

REPORT CONCLUSIONS

The Department of Human Services Act (Act) requires the Office of the Inspector General (OIG) to investigate allegations of abuse and neglect that occur in mental health and developmental disability facilities operated by the Department of Human Services (DHS). The Act also authorizes the OIG to conduct investigations in community agencies licensed, certified, or funded by DHS to provide mental health and developmental disability services. In FY08, DHS operated 18 State facilities. There were also 346 community agencies operating 3,672 programs providing services to individuals with developmental disabilities or mental illness in community settings within Illinois that were under OIG's jurisdiction. The Act requires the Office of the Auditor General to conduct a biennial program audit of the Inspector General's effectiveness of investigations of abuse and neglect and compliance with the Act. This is the tenth audit we have conducted of the OIG since 1990.

The OIG has taken significant actions toward implementing the recommendations from our previous audit. These actions include among others:

- Capturing data for non-reportable allegations;
- Improving the timeliness of investigations;
- More evenly distributing investigator caseloads;
- Reviewing samples of unsubstantiated and unfounded cases for consistency; and
- Meeting timelines for submitting site visit reports to facility directors or hospital administrators.

Total allegations of abuse and neglect reported to the OIG have continued to increase since our 2006 audit. In FY06, 1,814 allegations were reported (1,485 abuse and 329 neglect). This compares to 2,026 in FY08 (1,631 abuse and 395 neglect) or a 12 percent increase. Although total allegations of abuse and neglect have increased, the number of allegations reported at State facilities has been decreasing. Of the 1,814 allegations reported in FY06, 921 allegations were reported at State facilities and 893 allegations were reported at community agencies. For FY08, of the total of 2,026 allegations of abuse or neglect, 798 were from State facilities and 1,228 from community agencies. FY07 and FY08 represent the first time that the number of allegations of abuse and neglect reported at community agencies was greater than the number reported at State facilities.

During our previous audit, the OIG was not capturing data related to non-reportable allegations that would enable investigators to look for patterns. Beginning in December 2006, OIG started entering non-reportable allegations into its incident database and also included a list of non-reportable complaints on subsequent calls so that a more complete past history is displayed. However, the OIG still does not collect information related to serious injuries without any allegation of abuse or neglect. In our 2004 audit, we recommended that the OIG capture data for all allegations of serious injuries in its database. In the 2006 audit, we again recommended that the OIG included serious injuries in its investigative database. As of FY08, the OIG still does not capture this data. According to OIG officials, the DHS Office of Legal Services determined that mandating agencies to report all serious injuries to OIG would first require a change in statute.

The timeliness of OIG investigations continued to improve in FY07 and FY08. In FY06, 52 percent of OIG investigations were completed in 60 calendar days. Timeliness improved in FY07 with 56 percent and in FY08 with 60 percent completed within 60 calendar days. In January 2002, the OIG amended its administrative rules to require investigations be completed within 60 ***working*** days. Using the more lenient working days standard established in 2002, the OIG's timeliness of case completion for FY07 and FY08 was similar to the previous audit.

Although there has been some improvement, timeliness of cases taking longer than 60 working days to complete continues to be a problem for some investigative bureaus for cases closed during FY08. The Central and South bureaus had the smallest percentages of cases taking longer than 60 working days with 5 percent and 6 percent respectively. The percentages for the North and Metro bureaus were much greater. The percentage of cases taking longer than 60 working days was 25 percent for the North Bureau and 64 percent for the Metro Bureau. Although the timeliness for the North Bureau is an improvement over the previous audit, the Metro Bureau's timeliness has gotten worse. The South Bureau dropped from 20 percent over 60 working days in FY06 to 6 percent in FY08.

The OIG has taken steps to address these timeliness problems by utilizing other bureaus to help complete cases for the Metro and North bureaus. This includes assigning cases to be completed by the Bureau of Domestic Abuse and the Bureau of Hotline and Intake. The OIG has also taken additional steps to increase timeliness by filling existing investigator vacancies and obtaining more computers. For the 1,929 cases closed in FY08, 219 cases were completed by other bureaus. This represents a large increase over the 19 cases that were conducted by other bureaus during the previous audit in FY06. The 219 cases included 91 assigned to clinical coordinators which include death cases and cases that involve a medical issue. Of the remaining cases, 65 were assigned to intake investigators, and 63 were assigned to investigators from the Bureau of Domestic Abuse.

In response to our 2006 audit recommendation regarding reporting to the State Police, the OIG revised its Checklist for Notification to Illinois State Police/Local Law Enforcement to include the date and time of the determination that credible evidence existed that would require reporting. In our testing of FY08 cases, 4 cases were referred to the State Police. We obtained copies of all four checklists from the investigative files. For all four cases, we determined that the incident was reported to the State Police within the required 24 hours. However, even though

the OIG updated its checklist in December 2006, all four files contained the old checklist which does not include the date that it was determined that credible evidence existed. Three of the four cases occurred after the form had been revised. For one of the cases which occurred in December 2007, we could not readily determine whether it was reported in a timely manner because the old checklist was used. Therefore, OIG management cannot ensure that the allegation was reported within the 24-hour reporting requirement found in the Act.

We reviewed investigator caseloads for the different investigative bureaus at the OIG. The OIG has made significant improvement in reducing investigator caseloads since the previous audit. Investigator caseloads have decreased substantially for the North and Metro bureaus and are also more evenly distributed among bureaus. Caseloads as of August 2008 ranged from 11 in the Metro and South bureaus to 7 in the North Bureau. In August 2006, caseloads ranged from a high of 30 in the Metro Bureau to a low of 4 in the Central Bureau.

The number of interviews conducted appears to be more consistent between investigative bureaus than in our previous audit. In the previous audit we found that the number of interviews conducted by the investigative bureaus differed significantly, ranging from 3 interviews per investigation in the South Bureau to 11 per investigation in the North Bureau. The average number of interviews for FY08 cases sampled was much closer and ranged from 6 interviews in the Metro Bureau to 8 interviews in the South Bureau.

OIG directives no longer require "critical" interviews to be completed by the assigned investigator within five working days of approval of the investigative plan. However, during our case file review, we found on average it took investigators 8 days to complete interviews with the alleged victim and 20 days to complete interviews with the alleged perpetrator in each case. These are both an improvement over the previous audit in which it took an average of 12 days to interview the alleged victim and 25 days to interview the alleged perpetrator.

The OIG needs to improve the timeliness of investigator assignment and completion of investigative plans. OIG directives require that investigations be assigned to an investigator within one working day of the OIG assuming responsibility for the investigation. For 17 of the 117 (15%) cases we sampled and could determine an assignment date, the assignment was not made within one working day. OIG directives also require assigned investigators to complete an investigative plan within three working days of assignment, except if the case is closed at intake. For 16 of the 127 (13 %) cases we sampled, we could not determine whether the plan was completed in a timely manner because there was either no date on the investigative plan or we could not determine the date assigned. For the remaining 111 cases sampled, 5 (5%) were not completed and approved within the required three working days.

Alleged incidents of abuse and neglect are not being reported to the OIG by facilities and community agencies in the time frames required by the statutes and OIG's administrative rules. In FY08, 7 percent of facility incidents and 25 percent of community agency incidents were not reported within the four-hour time requirement. Effective June 13, 2006, Public Act 94-853 added a provision that states that a required reporter who willfully fails to comply with the reporting requirements is guilty of a Class A misdemeanor.

OIG case reports generally were thorough, comprehensive, and addressed the allegation. However, we found that photographs were missing in 5 of 29 (17%) cases where there was an allegation of an injury sustained from our FY08 sample. Injury Reports were missing in 3 of 29 (10%) cases where there was an allegation of an injury sustained. Two of the 127 sample cases tested did not contain a Case Routing/Approval Form. Although all case files in our sample contained a Case Tracking Form, two of the forms were not completed. During the review of our 127 sample cases, two files did not contain pertinent medical records, treatment plans, or progress notes. One case sampled where restraints were used did not contain the appropriate documentation.

During the previous audit, we concluded that there were inconsistencies between investigative bureaus related to how the bureaus classify findings. In addition, we found inconsistencies between what is and is not accepted by the Bureau of Hotline and Intake as an allegation of abuse or neglect. Beginning in January 2007, the Deputy Inspector General and one investigative bureau chief (on a rotating basis) began quarterly reviews of unfounded and unsubstantiated cases to ensure consistency across bureaus. During our fieldwork, we reviewed the second quarter FY08 review conducted by the Deputy Inspector General. Although the review identified problems such as cases missing an investigative plan or clinical coordinators' summary and cases in which interview statements were not numbered, the review did not find any cases involving improper findings or different interpretations of finding criteria, nor did it find any cases that might have been substantiated.

For community agency conducted investigations in our sample, it was sometimes difficult to determine which bureau and investigator was responsible for reviewing the case. For some community agency conducted investigations the OIG Bureau of Hotline and Intake was reportedly responsible for reviewing the case. For these cases that were reportedly assigned to the Bureau of Hotline and Intake, review forms were either missing or not completed.

In the previous audit we recommended that the Inspector General should clearly define what constitutes physical injury and physical harm. This has not been accomplished. According to the OIG response in the previous audit, officials agreed and stated they believed that the issue of definitions would be resolved by revisions to the statute. Until the statute is revised such a change to Rule 50 would be premature. However, in the meantime, OIG would reinforce that physical "harm" is a physical "wrong or injustice."

According to 59 Ill. Adm. Code 50.90, an employee may request a hearing with the Department of Human Services and present evidence supporting why his or her finding does not warrant reporting to the Health Care Worker Registry. The percentage of cases appealed in which the Administrative Law Judge's (ALJ) decision upheld the referral of the employee to the Health Care Worker Registry has increased when compared to our previous audit. The ALJ decision was to refer the employee in 56 percent of the appeal hearings in FY08 (15 of 27) and 56 percent of those in FY07 (18 of 32), compared to 41 percent in FY06 (13 of 32) and 21 percent in FY05 (6 of 28).

We reviewed 10 substantiated cases in which the ALJ rejected the referral to the Health Care Worker Registry in FY08. In the 10 cases in which the referral was rejected, the ALJ found that the Department had not demonstrated by a preponderance of the evidence that the finding of

abuse against the petitioner warranted reporting to the Registry. Several overturned cases cite the credibility of witnesses as a problem. In one case, the ALJ found the OIG investigation was unreliable. The OIG investigator in the case had been placed on leave and is no longer with the OIG. In another case, the ALJ found that the petitioner's actions were inappropriate but did not rise to the level of reporting to the Registry.

In our previous audit we recommended that the OIG revise its policies and procedures to ensure that all cases with findings that warrant reporting to the Registry are reported. The Department of Human Services Act requires physical abuse, sexual abuse, and egregious neglect to be referred to the Registry. Although the OIG has not updated the definition of egregious as it relates to neglect, the OIG directives have been updated and a process added for a Stipulated Motion to Dismiss. This process is triggered by a 50.90 petition on certain physical abuse cases that, although the finding meets the definition of physical abuse, may not be severe enough to deserve placement on the Registry. In September 2006 the OIG implemented a new stipulation process authorized by statute for appeals hearings. The OIG did not refer a case to the Registry based on a stipulation order on six occasions in FY07 and FY08.

State facilities or community agencies are required to submit a written response to DHS for all substantiated cases of abuse or neglect, or cases with other administrative issues. In our review of written responses we found that DHS takes an excessive amount of time to receive and approve the actions taken by the agency or facility in some cases. For one case in our sample, the agency date on the written response was September 9, 2008 and the DHS approved date was also September 9, 2008. However, the case was completed in August 2007. In addition, we requested this information on August 22, 2008. Therefore, it took more than a year to get the corrective action approved from the date of completion and it was done only after auditors requested the information. Of the 41 cases in our sample for which we could determine an investigative completion date and a response date, 6 of 41 (15%) took more than six months from the date the case was completed until the written response was approved by DHS. Two of these cases took more than a year.

Even though two State-operated facilities were terminated from participation in federal programs for non-compliance with various issues, including patient safety and client protection, the OIG did not recommend a sanction against either facility. Over the past 15 years (1994 – 2008), the Inspector General has not recommended sanctions against a State-operated facility. On June 9, 2008, the OIG did utilize its authority under 20 ILCS 1305/1-17(d) to recommend sanctions and sent letters to the DHS Division of Mental Health and to the DHS Division of Developmental Disabilities related to community agencies that had not updated their abuse/neglect reporting policies. The OIG recommended a total of nine service providers for non-renewal of their DHS service provider agreements until the policies are approved by OIG. According to OIG officials, none of the issues cited by the reviewers at Tinley Park MHC were reportable to OIG under current State law. Some issues cited by the reviewers at Howe DC did meet the State law's definitions, but OIG identified no trends or patterns in those beyond what has been typical of other facility or agency programs.

The Quality Care Board held all required quarterly meetings during FY07-08. This is a significant improvement from the previous audit. The Board continues to have difficulty

maintaining seven members as required by statute. During part of FY07 (September 2006-April 2007), the Board had seven members as required; however, in April 2007, one of the Board members resigned. This left the Board with six members near the end of FY07 and all of FY08. As of June 2008, a successor had still not been appointed to fill the vacancy.

During FY07 and FY08, the Office of the Inspector General conducted annual unannounced site visits at all of the mental health and developmental centers as required by statute (20 ILCS 1305/1-17(f)). Also, during FY07 and FY08, the OIG met its established timeline for submitting site visit reports to facility directors or hospital administrators. This is an improvement since the last audit.

DHS could not document that all staff at State-operated facilities received the required Rule 50 training. In addition, the OIG identified two facilities that were deficient in training staff during its FY08 site visits. The OIG site visit for Howe Developmental Center reported that only 504 of the facility's 835 (60%) employees had been trained in OIG Rule 50 during the last year, and the OIG site visit for Tinley Park Mental Health Center reported that only 172 of the facility's 207 (83%) employees had been trained in OIG Rule 50. The OIG recommended to Howe and Tinley Park that each facility should ensure that all staff, contractual workers, and volunteers received OIG Rule 50 training at least biennially. For Tinley Park, it was the third year that the recommendation for training staff had been repeated.

BACKGROUND

The Department of Human Services Act (Act) requires the Office of the Inspector General (OIG) to investigate allegations of abuse and neglect that occur in mental health and developmental disability facilities operated by the Department of Human Services (DHS). The Act also authorizes the OIG to conduct investigations in community agencies licensed, certified, or funded by DHS to provide mental health and developmental disability services.

The OIG was initially established by Public Act 85-223 in 1987 which amended the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/1 *et seq*.). Under this Act, the Inspector General was required to conduct investigations of abuse and neglect within State-operated facilities serving the mentally ill and developmentally disabled. In 1995, the role of the Office of the Inspector General was expanded to include the authority to investigate reports of abuse or neglect at facilities or programs not only operated by the Department of Human Services (facilities), but also those licensed, certified, or funded by DHS (community agencies). This includes State-operated mental health centers and developmental centers, Community Integrated Living Arrangements (CILAs), developmental training programs, and outpatient mental health services.

In 1995, amendments were enacted that required the OIG to promulgate rules to establish requirements for investigations that delineate how the OIG would interact with the licensing unit of DHS. These amended administrative rules (59 Ill. Adm. Code 50) were adopted October 19, 1998. The rules require that facilities and community agencies report incidents of alleged abuse

or neglect to the OIG. The administrative rules were revised with an emergency rule and then a final rule effective May 24, 2002.

Effective August 28, 2007, Public Act 95-545 amended the Department of Human Services Act (20 ILCS 1305) and the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30) transferring all provisions concerning the Office of the Inspector General within the Department of Human Services from the Abused and Neglected Long Term Care Facility Residents Reporting Act to the Department of Human Services Act. The OIG also amended its administrative rules effective May 16, 2008, to take into account the changes made by Public Act 95-545.

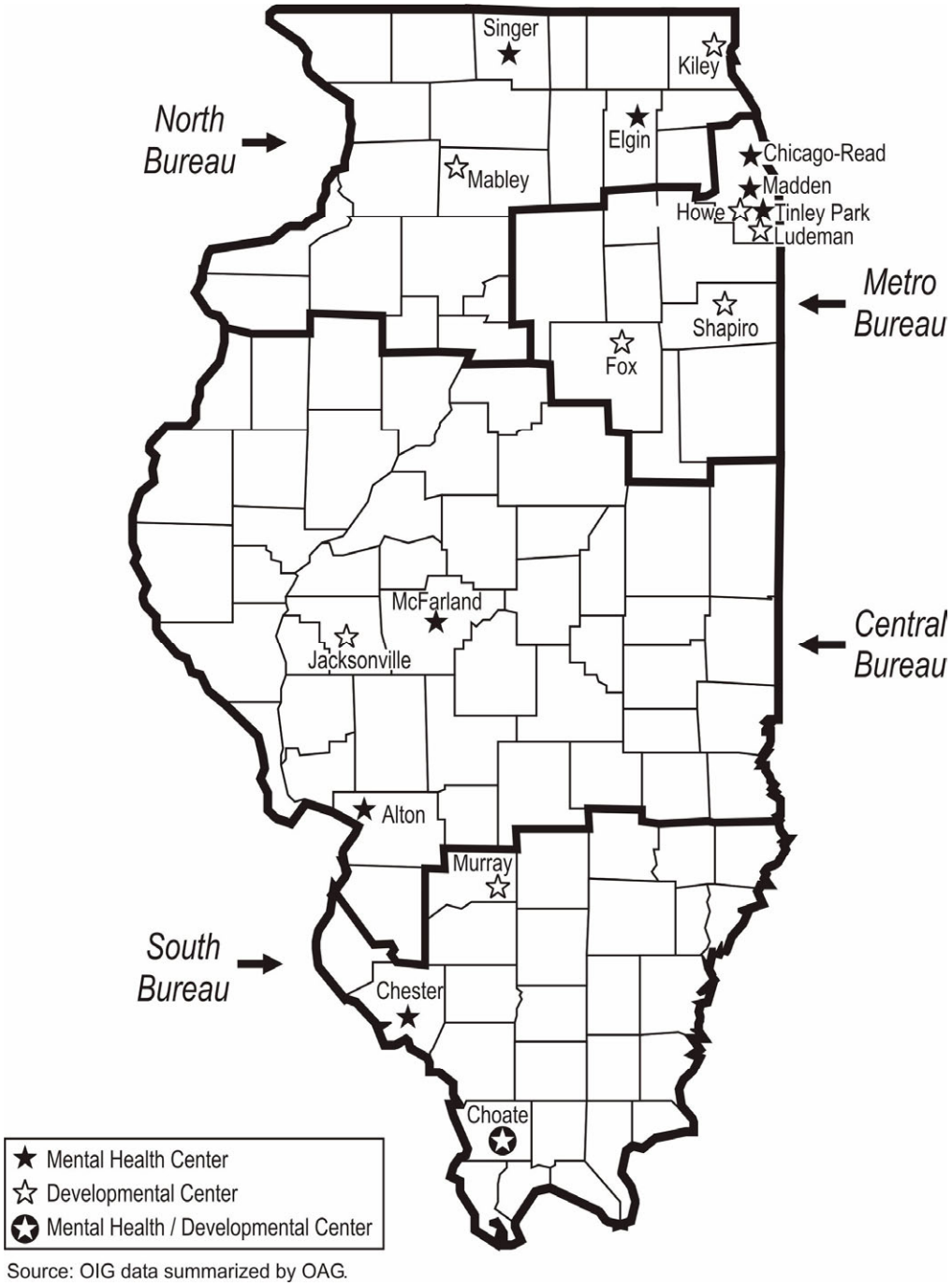
The Office of the Inspector General is located within the Department of Human Services and is appointed by the Governor and confirmed by the Senate for a four-year term. The current Inspector General was appointed in February 2006.

The Department of Human Services Act directs the Auditor General to conduct a biennial program audit of the Department of Human Services, Office of the Inspector General. The Act specifically requires the audit to include the Inspector General's effectiveness in investigating reports of alleged neglect or abuse of residents in any facility operated by the Department of Human Services and in making any recommendations for sanctions to DHS and to the Department of Public Health. The Act also requires that the audit be released no later than January 1 of each odd-numbered year.

During FY08, the Department of Human Services operated 18 facilities statewide that served 12,506 individuals. Eight facilities served the developmentally disabled only, eight facilities served the mentally ill, and a dual facility which served both (Choate MHC and Choate DC). Exhibit 1-1 shows the location of the DHS operated facilities, and indicates whether the facilities are part of the OIG's North, Metro, Central, or South bureau.

In addition, DHS licenses, certifies, or provides funding for 346 community agencies operating 3,672 programs providing services to individuals with developmental disabilities or mental illness in community settings within Illinois. These community agency programs provide transportation services, workshops, or community living arrangements. In FY08, approximately 29,500 individuals with developmental disabilities and approximately 167,456 individuals with mental illness were served in community agencies required to report to the OIG.

Exhibit 1-1
DHS OPERATED RESIDENT FACILITIES AND OIG INVESTIGATIVE BUREAUS



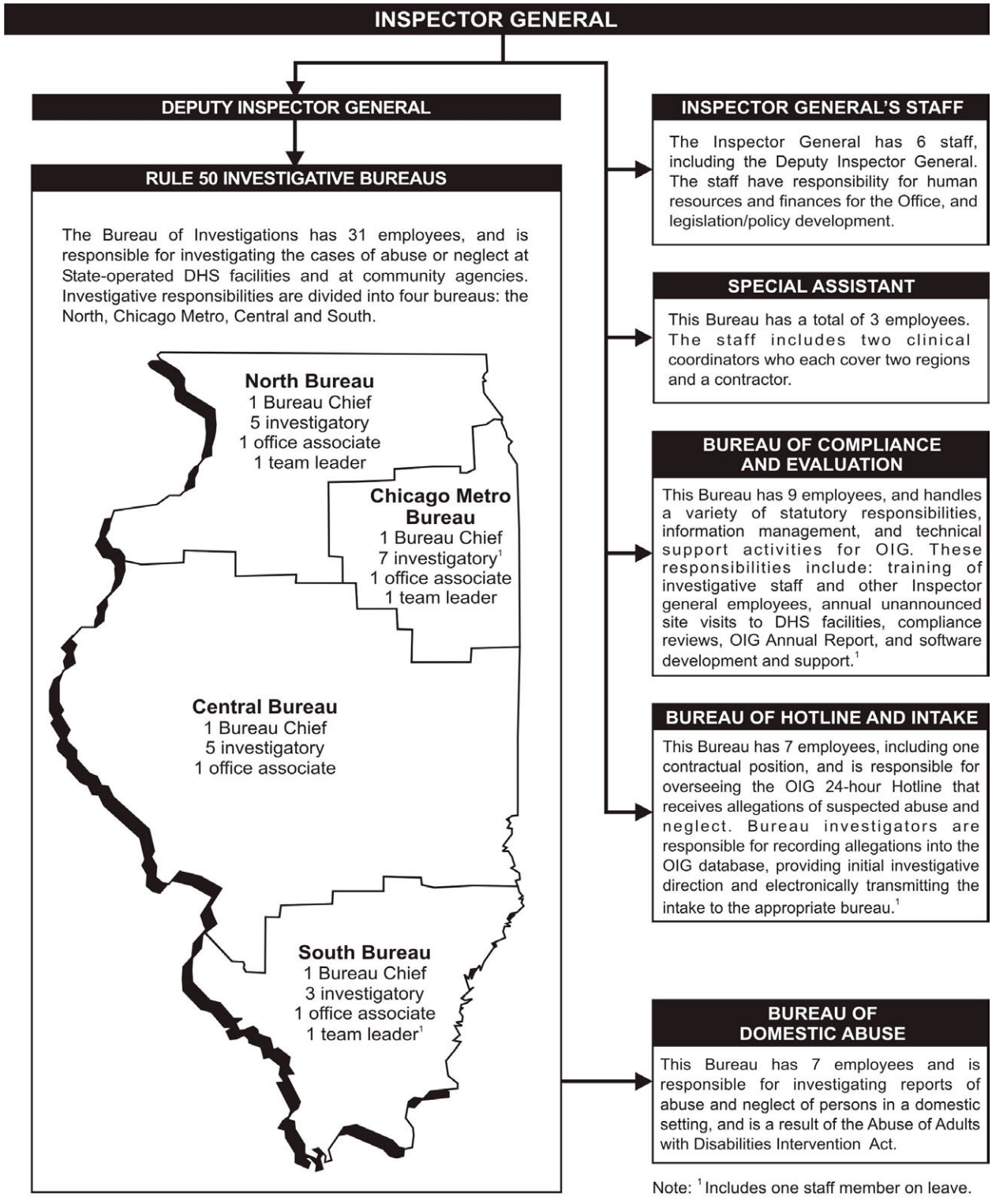
Source: OIG data summarized by OAG.

OIG Organization

The OIG's organizational structure has not changed significantly since the previous audit. Exhibit 1-2 shows the organizational structure of the OIG and the number of staff in each of the regions. As of July 1, 2008, the OIG had 61 employees, including three on leave. In addition the OIG hired two contractual employees to bring the total employees to 63. This represents an increase of four positions from staffing levels reported in our 2006 OIG audit. The number of investigative staff for abuse and neglect investigations is similar to the number of staff during the previous audit (21 in FY06; 20 in FY08). The OIG had an appropriation of $4.4 million for FY06. In FY07, the OIG's appropriation increased to $4.5 million and for FY08 the appropriation increased to $4.7 million. This is still well below the $5.8 million appropriation the OIG received for FY04.

The largest organizational unit within the OIG is the Bureau of Investigations. The Bureau of Investigations is responsible for conducting investigations of allegations of abuse or neglect at State-operated facilities and community agencies. As shown in Exhibit 1-2, the OIG has established four regions or bureaus within the Bureau of Investigations. Each region has a bureau chief and investigative staff. The North, Metro, and South Bureaus have an investigative team leader (ITL) who is responsible primarily for case file review. The ITL from the South Bureau, however, has been on military leave since September 2002 and will not return until at least August 2009.

Exhibit 1-2
OIG ORGANIZATIONAL CHART
As of July 1, 2008



Source: OIG data summarized by OAG.

Trends in Allegations of Abuse or Neglect

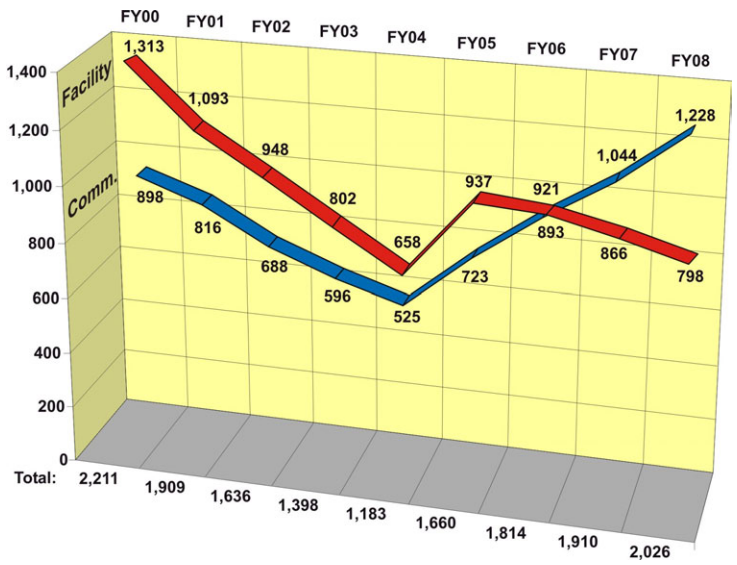
Overall, allegations of abuse and neglect reported to the OIG have been increasing since FY04. However, the number of allegations reported at State facilities has been decreasing since FY05. FY07 represents the first time that the number of allegations of abuse and neglect reported at community agencies was greater than the number reported at State facilities. This trend continued for FY08. In FY08, a total of 2,026 allegations of abuse or neglect were reported to the OIG (798 from State facilities and 1,228 from community agencies).

Exhibit 1-3 summarizes abuse or neglect allegations reported to the OIG from the two sources for Fiscal Years 2000 to 2008. State facilities served 2,626 individuals with developmental disabilities and 9,880 individuals with mental illness in FY08. Community agencies served approximately 29,500 individuals with developmental disabilities and 167,456 individuals with mental illness in FY08.

Allegations of abuse reported to the OIG have increased 10 percent since FY06. In FY06, there were 1,485 abuse allegations reported to the OIG. This compares to 1,631 in FY08.

Allegations of neglect have increased 20 percent since FY06. In FY06, there were 329 neglect allegations reported to the OIG.

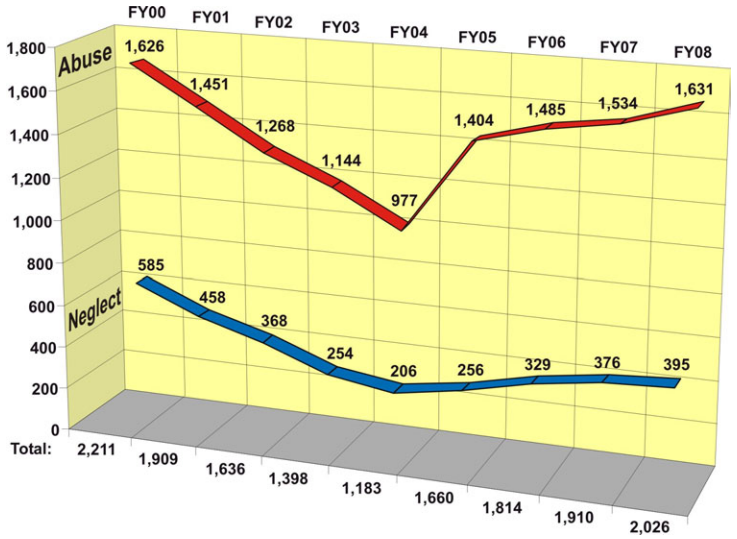
Exhibit 1-3
TOTAL ABUSE OR NEGLECT ALLEGATIONS REPORTED TO OIG
Fiscal Years 2000 to 2008



Note: State facilities served 2,626 individuals with developmental disabilities and 9,880 individuals with mental illness in FY08. Community agencies served approximately 29,500 individuals with developmental disabilities and approximately 167,456 individuals with mental illness in FY08.

Source: OIG data summarized by OAG.

Exhibit 1-4
TRENDS IN REPORTING ABUSE & NEGLECT
Fiscal Years 2000 to 2008



Source: OIG data summarized by OAG.

This compares to 395 in FY08. Exhibit 1-4 shows the trends in reporting of abuse and neglect to the OIG.

We asked OIG officials about the trends in the reporting of allegations. According to OIG officials, the most significant factor in the drop in allegations at State facilities is the comparable drop in the number of individuals served in the State facilities. Allegations from State facilities fell from 948 in FY02 to 798 in FY08, a drop of 16 percent. According to the OIG, individuals served in the facilities fell from 4,606 on June 30, 2002, to 3,735 on June 30, 2008, a drop of 19 percent. The numbers presented above represent the patient "census" on June 30 of each year which is an actual count of inpatients on that day. The number of clients served presented elsewhere in this chapter represent the number of clients served for the entire year. OIG officials attribute the increase in community agency allegations reported to continued training efforts and increased citing of community agency failure to report or late reporting (264 cases in FY07 and 273 cases in FY08).

OIG INVESTIGATION PROCESS

The investigation process begins when an allegation is reported to the OIG Hotline. The OIG Hotline investigator determines whether the allegation meets the definition of abuse or neglect. If abuse or neglect is suspected, the case is then assigned to the investigative bureau responsible for that facility or region (for community agencies). Depending on the allegation and the direction given by the OIG investigator, the facility or community agency personnel collects physical evidence and takes initial statements from those involved in the incident about the alleged abuse or neglect.

OIG directives require investigators to complete an investigative plan within three working days of assignment. When the investigator completes an investigation, an investigative report is developed in accordance with OIG directives and is forwarded via e-mail to the investigative team leader (if applicable) and the bureau chief for initial review and approval. According to OIG directives, the case is required to be reviewed, absent extenuating circumstances, within seven working days of receipt. Once the bureau chief reviews and approves a substantiated case of physical abuse, sexual abuse, or egregious neglect, it will then be sent to the Inspector General or his/her designee for review. According to Rule 50 (59 Ill. Adm. Code Part 50), the investigative report shall be submitted to the Inspector General within 60 working days of the assignment unless there are extenuating circumstances.

Abuse

Any physical injury, sexual abuse, or mental injury inflicted on an individual other than by accidental means.

Neglect

A failure to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to an individual or in the deterioration of an individual's physical or mental condition.

Physical Injury

Physical harm to an individual caused by any non-accidental act or omission.

Source: 59 Ill. Adm. Code Part 50.

The responsibility for death investigations is shared between the OIG Clinical Coordinators and the

Bureau of Investigations. If the Clinical Coordinator determines the death was attributed to abuse or neglect, the bureau chief is notified and an OIG investigator is assigned. The Clinical Coordinator assists with the investigation, but the standard OIG investigation process is followed.

If the Clinical Coordinator determines that a death is not due to abuse or neglect, she will notify the bureau chief and will assume primary responsibility for the investigation. This includes conducting necessary interviews, collecting relevant documentation and completing the death report.

For cases that involve medical issues, the OIG directives require that an OIG investigator contact the Clinical Coordinator via e-mail for a consultation. The OIG investigator must also contact the Clinical Coordinator prior to rendering a conclusion in a case involving a medical issue. Finally, the OIG investigator must cite the findings of the Clinical Coordinator in the preliminary report when an opinion is rendered as to whether the medical issue did or did not contribute to the allegation.

The OIG sends notice of the outcome of the investigation to the complainant, the individual who was allegedly abused or neglected or his or her legal guardian, and the person alleged to have committed the offense. If any of these parties disagree with the findings or wants more information, they may submit in writing a request for reconsideration or clarification. Requests for reconsideration or clarification must be submitted within 15 working days after the receipt of the report or notification of the finding(s). All requests must include new information that could change the finding.

The OIG also sends the community agency or facility a copy of the investigative report that includes the OIG's finding in the case. If the OIG assumes primary responsibility for the investigation and the case contains substantiated findings or recommendations, the community agency or facility is required to submit a written response within 30 calendar days. If reconsideration is requested and denied or after clarification has been provided, the community agency or facility shall submit a written response to the Inspector General within 15 working days after the receipt of the clarification or denial of reconsideration. The Inspector General shall provide a complete investigative report within 10 calendar days to the Secretary of Human Services when abuse or neglect is substantiated or administrative action is recommended.

REPORTING OF ALLEGATIONS

Total allegations of abuse and neglect reported to the OIG have increased significantly since FY04. In FY04, 1,183 allegations were reported (977 abuse, 206 neglect). In FY06, 1,814 allegations were reported (1,485 abuse and 329 neglect). In FY08, 2,026 allegations were reported (1,631 abuse and 395 neglect). This increase is attributable to the increase in allegations being reported at community agencies.

Direct Reporting to the OIG Hotline

DHS facilities and community agencies are required to report allegations of abuse and neglect by calling into the OIG Hotline. The OIG Hotline investigator makes an assessment as to whether the allegation is abuse or neglect, the intent being to reduce the number of inappropriate cases from being investigated. Hotline investigators directly enter the information into a database and the case is then forwarded to the bureaus to begin the investigation.

Facility and community agency employees are required to report to the OIG if they: witness, are told of, or have reason to believe an incident of abuse, neglect, or death has occurred. Rule 50 requires that the following allegations be reported:

- any allegation of abuse by an employee;
- any allegation of neglect by an employee, community agency, or facility; and
- any injury or death of an individual that occurs within a facility or community agency program when abuse or neglect is suspected.

Non-Reportable Cases

During the previous audit we determined there were allegations reported that were deemed non-reportable by Hotline investigators that may have met the necessary criteria to be reported. We recommended that the OIG should ensure that all allegations reported to the Hotline are investigated appropriately as required by 59 Ill. Adm. Code 50. Additionally, we recommended that the OIG should consider revising its investigative directives and administrative rules to ensure that all potential allegations of abuse and neglect are investigated.

OIG current administrative rules (Rule 50) define abuse, neglect, and mental injury as:

- **Abuse** - Any physical injury, sexual abuse, or mental injury inflicted on an individual other than by accidental means.
- **Neglect** - The failure to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to an individual or in the deterioration of an individual's physical or mental condition.
- **Mental Injury** - Harm caused by an act or omission that precipitates emotional distress or maladaptive behavior in the individual, or could precipitate emotional distress or maladaptive behavior, including the use of words, signs, gestures or other actions toward or about and in the presence of individuals.

Since the last audit, the OIG has revised its directives and non-reportable allegations are now recorded in the database which includes much of the same information included for a reportable incident such as a narrative of the case. In February 2007, the directives regarding hotline coverage were also revised to include a new process for non-reportable cases which requires intake staff to complete a Non-Reportable Report for calls that do not meet the Rule 50

or Rule 51 criteria. According to data received from the OIG, for FY08 there were 1,032 non-reportable cases recorded.

During this audit, we reviewed a list of non-reportable cases for FY07 and selected cases to determine if there were allegations made that should have been investigated by the OIG. The list included 507 non-reportable cases that were recorded between December 2006 and June 30, 2007. We reviewed these cases and selected 14 for which we questioned why the cases did not rise to the level of reportable and asked the OIG to respond. In many of the cases, the OIG responded that there was no harm, therefore it was not reportable. Rule 50 requires that there must be some harm or deterioration that results or is reasonably presumed to have resulted. Although we questioned several of the non-reportable allegations, in some cases the alleged perpetrator and issue were already being investigated. In other cases the allegation was under the jurisdiction of another State agency (The Department of Public Health).

Reporting Criminal Acts

State law requires the OIG to report any suspected abuse or neglect that indicates a possible criminal act has been committed to the Illinois State Police within 24 hours. The State Police shall investigate any report from a facility indicating a murder, rape, or other felony.

During the previous audit we found an instance where an alleged criminal act was reported to the OIG but was closed by Hotline investigators as a non-reportable allegation. While OIG officials noted it was reported to local law enforcement, it was not reported to the Illinois State Police as required by State law. We recommended that the Office of the Inspector General should ensure that all allegations of suspected abuse or neglect that indicate any possible criminal act has been committed are reported to the Illinois State Police as was required by 210 ILCS 30/6.2(b). Public Act 95-545 moved this requirement to the Department of Human Services Act (20 ILCS 1305/1-17(b)).

In February 2007, OIG merged and revised its law enforcement reporting directives. In our review of 507 non-reportables for FY07, we did not identify any cases which should have been reported to the Illinois State Police.

Reporting Serious Injuries

During the previous audit, the OIG was not capturing data related to non-reportable allegations that would enable investigators to look for patterns. Beginning in December 2006, OIG started entering non-reportable allegations into its incident database and also included a list of non-reportable complaints on subsequent calls so that a more complete past history is displayed.

However, the OIG continues to consider serious injuries without an allegation of abuse or neglect to be not reportable. Until FY03, these cases were reported and were investigated by the OIG even though there was no allegation of abuse or neglect. The legal interpretation OIG was given by the DHS Office of General Counsel was that OIG is not required to investigate these serious injury cases and has taken the necessary steps to ensure that these cases are no longer

reported or investigated. We concluded that it should be up to the OIG to determine if an injury was caused by abuse or neglect, and not up to the facility or community agency. Serious injuries caused by neglect may not have a direct allegation associated with them, such as incidents involving resident on resident injuries. Resident on resident incidents may be a result of neglect by staff and the OIG should consider requiring that these types of cases be reported for review and/or investigation.

In our 2004 audit, we recommended that the OIG capture data for all allegations of serious injuries in its database. In the 2006 audit we again recommended that the OIG include serious injuries in its investigative database (Recommendation 3). As of our fieldwork in 2008, we determined that the OIG does not capture this data. According to OIG officials, the DHS Office of Legal Services determined that mandating agencies to report all serious injuries to OIG would first require a change in statute.

OIG INVESTIGATIVE DATABASE AND SERIOUS INJURIES	
RECOMMENDATION 1	***The Office of the Inspector General should continue to consider adding serious injuries to its investigative database.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	OIG agrees in part. Rule 50 requires reporting of serious injuries when they are alleged or suspected to have resulted from abuse or neglect by staff. These serious injuries are already being added to our investigative database. Requiring agencies and facilities to report even accidental serious injuries to OIG would require a change in the statute.

OTHER STATE AGENCIES

While the Department of Human Services Act requires the OIG to investigate abuse and neglect, other State agencies, including the Illinois State Police, the Department of Children and Family Services, and the Department of Public Health, also have statutory responsibility to investigate potential instances of abuse and neglect. The Act requires the OIG to promulgate rules that set forth instances where two or more State agencies could investigate an allegation so that OIG investigations do not duplicate other investigations. Since 1998, the OIG's administrative rules have stipulated that *"when two or more State agencies could investigate an allegation of abuse or neglect at a community agency or facility, OIG shall not conduct an investigation that is redundant to an investigation conducted by another State agency unless another State agency has requested that OIG participate in the investigation."* A finding in our 2000 OIG audit recommended that the Inspector General clarify the investigatory role of each agency through signed interagency agreements.

Illinois State Police

Effective August 2, 2005, Public Act 094-0428 was passed that amended the OIG's reporting timeline to the Illinois State Police. As a result of the new legislation, the OIG now shall within 24 hours after determining that a reported allegation of suspected abuse or neglect indicates that any possible criminal act has been committed or that special expertise is required in the investigation, immediately notify the Department of State Police or the appropriate law enforcement entity. The Department of State Police shall investigate any report from a State-operated facility indicating a possible murder, rape, or other felony.

The most recent agreement between the OIG and the Illinois State Police was signed in July 2005. When allegations are investigated by the Illinois State Police, the OIG may conduct a separate investigation after the State Police investigation is completed. The State Police only look at the criminal aspects of the incident; it is up to the OIG to examine any administrative issues relating to the incident.

Department of Public Health

Public Health conducts investigations at any long-term care institution participating in the Medicare or Medicaid programs, including facilities operated by DHS. The Act requires all persons who provide direct care services or have direct contact with residents to report all incidents of suspected abuse or neglect to Public Health immediately. According to Public Health officials, its investigations are not duplicative of OIG investigations because its investigations focus on regulatory and licensure/certification issues, which include State Administrative Code, Medicare, and Medicaid. The OIG investigation findings and recommended actions are centered more toward administrative issues rather than certification. The OIG currently has an interagency agreement with Public Health that was signed in January 2001.

Department of Children and Family Services

The Abused and Neglected Child Reporting Act (325 ILCS 5/1 *et seq*.) mandates that many persons, including State employees, immediately report incidents of suspected abuse or neglect of all persons under the age of 18 to the Department of Children and Family Services (DCFS). DCFS then has 14 days to determine whether there is a "good faith" indication of potential child abuse or neglect. DCFS has 60 days to complete the investigation and make a final disposition. According to documentation provided to us by the OIG, an interagency agreement was executed by DCFS and the OIG on November 20, 2000. The agreement has no provision for annual review and is therefore still effective at this time. This agreement specifically states that the OIG is only to investigate those cases where a recipient is under the age of 18 if DCFS and Illinois State Police decline to investigate. In addition, the agreement requires the OIG to notify DCFS upon completion of these investigations and provide a copy of the investigation upon request.

PRIOR AUDIT FINDINGS

The audit of the OIG released in December 2006 contained 14 recommendations to the OIG. The Inspector General fully or partially implemented 11 of the recommendations from the 2006 audit. The following summarizes what the OIG has done to implement the previous audit recommendations.

- **Non-Reportables (Implemented)** – In December 2006, the OIG revised its directives and non-reportable allegations are now recorded in the database (See previous discussion in this chapter regarding non-reportable cases).

- **Reporting Criminal Acts (Implemented)** – In December 2006, OIG revised its reporting form for law enforcement to include the date and time that credible evidence was determined. In February 2007 OIG merged and revised its law enforcement reporting directives. In our review of 507 non-reportables for FY07, we did not identify any cases which should have been reported to the Illinois State Police.

- **OIG Investigative Database (Partially Implemented)** – As previously discussed, OIG revised its database to capture non-reportable complaints. However, the OIG has not addressed the serious injuries part of the recommendation. According to the OIG, the DHS Office of Legal Services determined that mandating agencies to report all serious injuries to OIG would first require a change in statute. That office requested that any revisions to Rule 50 be put on hold, pending statutory changes. Although Public Act 95-545 recently amended the OIG's statutes, no changes were made regarding serious injuries.

- **Timeliness of Case Completion (Not Implemented) –** The OIG continues to make improvements in the timeliness of investigations of abuse and neglect. However, the OIG still has yet to meet the 60 working day requirement contained in its rules and directives for all cases absent extenuating circumstances. Using the working days requirement in Rule 50 established in 2002, the OIG completed 71 percent and 72 percent of its cases in FY07 and FY08, respectively, within 60 working days.

- **Reporting to State Police (Partially Implemented)** – The OIG has revised its Checklist for Notification to ISP/Local Law Enforcement to include the date and time of the determination that credible evidence existed that would require reporting. In our testing of FY08 cases, four cases were referred to State Police. We obtained copies of all four checklists from the investigative files. For all four cases, we determined that the incident was reported to the State Police within the required 24 hours. However, even though the OIG updated its checklist in December 2006, all four files contained the old checklist which does not include the date that it was determined that credible evidence existed. For one of the cases which occurred in December 2007, we could not readily determine whether it was reported in a timely manner. After follow-up with the OIG, we determined that it was reported within the time requirement.

- **Investigator Caseloads (Implemented)** – The OIG has been proactive in trying to improve the timeliness of investigations. During FY07 and FY08 OIG hired 11 new investigators. Caseloads were also redistributed among bureaus. This included using the Bureau of Hotline and Intake to conduct investigations of allegations recanted at intake and also to investigate some allegations of mental injury. Some cases were also redistributed to Bureau of Domestic Abuse investigators.

- **Interviews Conducted (Implemented)** – In February 2007 the requirement for critical interviews was deleted from the OIG directives, along with doing these interviews within 5 days of the case being assigned. Since our previous audit, the number of interviews appears to be more consistent between investigative bureaus, ranging from 6 to 8 per case. In the previous audit we found that the number of interviews conducted by the investigative bureaus differed significantly.

- **Case Management System (Implemented)** – The OIG has made several changes to its electronic tracking system since the previous audit. OIG now requires case reviewers to enter review dates into the database. OIG has also made changes that allow investigators to enter actions more quickly and has received or replaced 13 laptop computers and 28 desktop computers for use by staff to facilitate investigative efforts.

- **Allegation Reporting (Not Implemented)** – Alleged incidents of abuse and neglect are still not being reported by facilities and community agencies in the time frames required by OIG's administrative rules. Reporting of allegations at community agencies improved slightly while reporting at facilities got worse.

- **Documentation of Interviews (Not Implemented)** – In the previous audit we found that OIG investigators were inconsistent in regard to the format used to document investigative interviews. In addition, we found five examples from five different investigations where interview write-ups were almost verbatim for multiple individuals interviewed. In many of these write-ups, the investigator used the same summary write-up and changed the time and names of the other witnesses. According to the OIG's responses, the OIG did not accept the recommendation because the Inspector General felt that there were directives already in place regarding documenting interviews and the interviewer should rely on professional judgment. We reviewed interviews as part of our sample of FY08 cases and the interviews were generally consistent. We also did not find instances of verbatim interviews for multiple parties as was found in the previous audit.

- **Investigative Consistency (Partially Implemented)** – The OIG has established a central review process in which the Deputy Inspector General and one of the bureau chiefs (on a rotating basis) review unfounded and unsubstantiated cases on a quarterly basis to ensure consistency of investigation approach and findings across the bureaus. However, the OIG has not defined what constitutes physical injury and physical harm in the statutes, rules or directives. OIG officials responded that since the law was not substantially altered, Rule 50 was not revised.

- **Nurse Aid Registry (now the Health Care Worker Registry) (Implemented) –** In September 2006 the OIG implemented a new stipulation process authorized by statute for appeals hearings. The process is triggered by a 50.90 petition (requesting a hearing with the Department of Human Services to present evidence supporting why the finding does not warrant reporting to the Health Care Worker Registry) on certain physical abuse cases that, although they meet the broad definition of physical abuse, may not be severe enough to deserve placement on the Registry. The process involves input from OIG and DHS legal. The final decision is made by the Secretary of DHS upon a recommendation by the Administrative Law Judge.

- **Quality Care Board (Implemented)** – The Quality Care Board held all required quarterly meetings during FY07 and FY08. This is a significant improvement from the previous audit. The Board continues to have difficulty maintaining seven members as required by statute. During part of FY07 (September 2006-April 2007), the Board had seven members as required; however, in April 2007, one of the Board members resigned. This left the Board with six members near the end of FY07 and all of FY08. As of June 2008, a successor had still not been appointed to fill the vacancy.

- **OIG Site Visits (Implemented)** – During FY07 and FY08, the OIG conducted annual unannounced site visits at all of the mental health and developmental centers as required by statute (20 ILCS 1305/1-17(f)). Also, during FY07 and FY08, the OIG met its established timeline for submitting site visit reports to facility directors or hospital administrators. This is an improvement since the last audit.

AUDIT SCOPE AND METHODOLOGY

This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. The objective of this audit was to evaluate the Inspector General's effectiveness in investigating reports of alleged abuse or neglect of residents in any facility operated, licensed, certified, or funded by the Department of Human Services and in making any recommendations for sanctions to DHS and the Department of Public Health. Detailed audit objectives are outlined in Appendix B of this report.

Initial work began on this audit in March 2008 and fieldwork was concluded in September 2008. We interviewed representatives from the Inspector General's Office, the Illinois State Police, the Department of Public Health, and the Department of Children and Family Services. We reviewed documents and data from the Inspector General's Office and the

State Police. We examined the current OIG organizational structure, policies and procedures, investigations process, case review process, and documentation requirements. We also reviewed internal controls over the investigation process. We reviewed backgrounds for investigators hired since our last OIG audit and reviewed investigator training records. We tested a sample of cases closed from FY08 and analyzed electronic data for Fiscal Years 2007 and 2008. Additionally, our audit work included follow-up on previous OIG audit recommendations. A more complete description of our testing and analyses is in Appendix B of this report.

We assessed risk by reviewing recommendations from previous OIG audits, OIG internal documents, policies and procedures, management controls, and the OIG's administrative rules. We reviewed management controls relating to the audit objectives that were identified in section 1-17(m) of the Department of Human Services Act (20 ILCS 1305/1-17(m)) (see Appendix A). The audit reports on any weaknesses in those controls and includes them as recommendations.

In conducting the audit, we reviewed applicable State statutes, administrative rules, and OIG policies. We reviewed compliance with these laws, rules, and policies to the extent necessary to meet the audit's objectives. Any instances of non-compliance we identified are noted as recommendations in this report.

The Office of the Auditor General has conducted nine prior OIG audits to assess the effectiveness of its investigations into allegations of abuse and neglect, as required by statute. These audits were released in 1990, 1993, 1994, 1996, 1998, 2000, 2002, 2004, and 2006.

REPORT ORGANIZATION

The remainder of this report is organized into the following chapters:

- **Chapter Two** examines the timeliness of abuse or neglect investigations.
- **Chapter Three** discusses the thoroughness of abuse or neglect investigations.
- **Chapter Four** reviews actions, recommendations, written responses, appeals, the Health Care Worker Registry, and sanctions.
- **Chapter Five** discusses the Quality Care Board, site visits, and training.

Chapter Two

TIMELINESS OF ABUSE OR NEGLECT INVESTIGATIONS

CHAPTER CONCLUSIONS

The timeliness of OIG investigations continued to improve in FY07 and FY08. In FY06, 52 percent of OIG investigations were completed in 60 calendar days. Timeliness improved in FY07 with 56 percent and in FY08 with 60 percent completed within 60 calendar days. In January 2002, the OIG amended its administrative rules to require investigations be completed within 60 *working* days. Using the more lenient working days standard established in 2002, the OIG's timeliness of case completion for FY07 and FY08 was similar to the previous audit.

Although there has been some improvement, timeliness of cases taking longer than 60 working days to complete continues to be a problem for some investigative bureaus for cases closed during FY08. The Central and South bureaus had the smallest percentages of cases taking longer than 60 working days with 5 percent and 6 percent respectively. The percentages for the North and Metro bureaus were much greater. The percentage of cases taking longer than 60 working days was 25 percent for the North Bureau and 64 percent for the Metro Bureau. Although the timeliness for the North Bureau is an improvement over the previous audit, the Metro Bureau's timeliness has gotten worse. The South Bureau dropped from 20 percent over 60 working days in FY06 to 6 percent in FY08.

The OIG has taken steps to address these timeliness problems by utilizing other bureaus to help complete cases for the Metro and North bureaus. This includes assigning cases to be completed by the Bureau of Domestic Abuse and the Bureau of Hotline and Intake. The OIG has also taken additional steps to increase timeliness by filling existing investigator vacancies and obtaining more computers. For the 1,929 cases closed in FY08, 219 cases were completed by other bureaus. This represents a large increase over the 19 cases that were conducted by other bureaus during the previous audit in FY06. The 219 cases included 91 assigned to clinical coordinators which include death cases and cases that involve a medical issue. Of the remaining cases, 65 were assigned to intake investigators, and 63 were assigned to investigators from the Bureau of Domestic Abuse.

In response to our 2006 audit recommendation regarding reporting to the State Police, the OIG revised its Checklist for Notification to Illinois State Police/Local Law Enforcement to include the date and time of the determination that credible evidence existed that would require reporting. In our testing of FY08 cases, four cases were referred to the State Police. We obtained copies of all four checklists from the investigative files. For all four cases, we determined that the incident was reported to the State Police within the required 24 hours. However, even though the OIG updated their checklist in December 2006, all four files contained the old checklist which does not include the date that it was determined that credible evidence

existed. Three of the four cases occurred after the form had been revised. For one of the cases which occurred in December 2007, we could not readily determine whether it was reported in a timely manner because the old checklist was used. Therefore, OIG management cannot ensure that the allegation was reported within the 24-hour reporting requirement found in the Act.

We reviewed investigator caseloads for the different investigative bureaus at the OIG. The OIG has made significant improvement in reducing investigator caseloads since the previous audit. Investigator caseloads have decreased substantially for the North and Metro bureaus and are also more evenly distributed among bureaus. Caseloads as of August 2008 ranged from 11 in the Metro and South bureaus to 7 in the North Bureau. In August 2006, caseloads ranged from a high of 30 in the Metro Bureau to a low of 4 in the Central Bureau.

The number of interviews conducted is more consistent between investigative bureaus than in our previous audit. In the previous audit, we found that the number of interviews conducted by the investigative bureaus differed significantly, ranging from 3 interviews per investigation in the South Bureau to 11 per investigation in the North Bureau. The average number of interviews for FY08 cases sampled was much closer and ranged from 6 interviews in the Metro Bureau to 8 interviews in the South Bureau.

OIG directives no longer require "critical" interviews to be completed by the assigned investigator within five working days of approval of the investigative plan. However, during our case file review, we found on average it took investigators 8 days to complete interviews with the alleged victim and 20 days to complete interviews with the alleged perpetrator in each case. These are both an improvement over the previous audit in which it took an average of 12 days to interview the alleged victim and 25 days to interview the alleged perpetrator.

The OIG needs to improve the timeliness of investigator assignment and completion of investigative plans. OIG directives require that investigations be assigned to an investigator within one working day of the OIG assuming responsibility for the investigation. For 17 of the 117 (15%) cases we sampled and could determine an assignment date, the assignment was not made within one working day. OIG directives also require assigned investigators to complete an investigative plan within three working days of assignment, except if the case is closed at intake. For 16 of the 127 (13%) cases we sampled, we could not determine whether the plan was completed in a timely manner because there was either no date on the investigative plan or we could not determine the date assigned. For the remaining 111 cases sampled, 5 (5%) were not completed and approved within the required three working days.

Alleged incidents of abuse and neglect are not being reported to the OIG by facilities and community agencies in the time frames required by the statutes and OIG's administrative rules. In FY08, 7 percent of facility incidents and 25 percent of community agency incidents were not reported within the four-hour time requirement. Effective June 13, 2006, Public Act 94-853 added a provision that states that a required reporter who willfully fails to comply with the reporting requirements is guilty of a Class A misdemeanor.

INVESTIGATION TIMELINESS

The effectiveness of an investigation is diminished if it is not conducted in a timely manner. In several of our prior OIG audits, we noted that timely completion of investigations is critical for an effective investigation, because as time passes, injuries heal, memories fade, or witnesses may not be located. Prior OIG investigative guidance required that investigations be completed as expeditiously as possible and should not exceed 60 calendar days absent extenuating circumstances.

The OIG changed the definition of days in its administrative rules in January 2002 to be **working** rather than **calendar** days. Sixty working days generally works out to over 80 calendar days. Although we will consider working days in our discussions, we will also continue to use calendar days in our analyses so that comparisons can be made over time to our prior audits.

Timeliness of investigations has been an issue in all of the nine previous OIG audits. During this audit period, the OIG made improvements in its timeliness for completing investigations. In FY06, 52 percent of OIG investigations were completed in 60 calendar days. Timeliness improved in FY07 with 56 percent and in FY08 with 60 percent completed in 60 calendar days.

In FY05, the average was 70 calendar days and the median was 54 days. In FY06, the average was 69 days and the median was 57 days. In FY07, the average was 67 days and the median was 50 days. In FY08, the average was 63 days and the median was 43 days.

Exhibit 2-1
CALENDAR DAYS TO COMPLETE ABUSE OR NEGLECT INVESTIGATIONS
Fiscal Years 2003 to 2008

Days to Complete Cases	FY03 % of Cases	FY04 % of Cases	FY05 % of Cases	FY06 % of Cases	FY07 % of Cases	FY08 % of Cases
0-60	**30%**	**39%**	**55%**	**52%**	**56%**	**60%**
61-90	16%	11%	22%	19%	15%	13%
91-120	17%	10%	11%	14%	13%	13%
121-180	23%	20%	6%	11%	11%	11%
181-200	5%	5%	1%	2%	1%	0%
>200	9%	14%	5%	2%	3%	2%
Total > 60 days	**70%**	**61%**	**45%**	**48%**	**44%**	**40%**
Total Cases	1,248	1,472	1,659	1,597	1,936	1,929

Note: Analysis excludes cases investigated by the Illinois State Police. "Completed cases" shown in this Exhibit are cases where the OIG issued a Preliminary Report to the State facility or community agency in the fiscal year. "Closed cases," referred to later in this report, are cases where the OIG sent the final report to the Secretary of DHS in the fiscal year. Totals may not add due to rounding.

Source: OAG analysis of OIG data.

Exhibit 2-1 shows the percentage of cases completed in terms of ranges of the number of days to completion for Fiscal Years 2003 to 2008. Case completion is measured from the date the allegation of abuse or neglect is reported to the OIG to the date the investigative report is sent to the facility or community agency notifying them of the investigation outcome. Data analysis was conducted on the entire population of cases closed in each of the fiscal years.

Since the OIG changed the definition of days from calendar to the more lenient working days in Rule 50 in January 2002, we also looked at the percent of cases completed within 60 working days. With the more lenient working day standard, the OIG completed 76 percent of its FY05 cases and 71 percent of its FY06 cases within 60 working days. For FY07 and FY08, this remained steady as the OIG completed 71 percent and 72 percent of cases, respectively, when using the 60 working day standard.

Although there has been some improvement, timeliness of cases taking longer than 60 working days to complete continues to be a problem for some investigative bureaus for cases closed during FY08. Exhibit 2-2 shows that the Central and South bureaus had the smallest percentages of cases taking longer than 60 working days, with 5 percent and 6 percent respectively. The percentages for the North and Metro bureaus were much greater. The percentage of cases taking longer than 60 working days was 25 percent for the North Bureau and 64 percent for the Metro Bureau. Although the timeliness for the North Bureau is an improvement over the previous audit, the Metro Bureau's timeliness has gotten worse. The South Bureau dropped from 20 percent over 60 working days in FY06 to 6 percent in FY08.

The OIG has taken steps to address these timeliness problems by utilizing other bureaus to help complete cases for the Metro and North bureaus. This includes assigning cases to be completed by the Bureau of Domestic Abuse and the Bureau of Hotline and Intake. The OIG has also taken additional steps to increase timeliness by filling existing investigator vacancies and obtaining more computers. For the 1,929 cases closed in FY08, 219 cases were completed by other bureaus. This represents a large increase over the 19 cases that were conducted by other bureaus during the previous audit in FY06. The 219 cases included 91 assigned to clinical coordinators which include death cases and cases that involve a medical issue. Of the remaining cases, 65 were assigned to intake investigators, and 63 were assigned to investigators from DAP. According to OIG officials, caseloads were redistributed among other bureaus to increase timeliness.

Exhibit 2-2
CASES WITH INVESTIGATIONS GREATER THAN 60 WORKING DAYS
Cases Closed During FY08

OIG Bureaus	Number of Cases Greater Than 60 Working Days	Total Cases Closed	Percent Greater Than 60 Working Days
North	102	401	25%
Metro	327	508	64%
Central	25	493	5%
South	17	308	6%
Other [1]	69	219	32%
Total	**540**	**1,929**	**28%**

Note:

[1] Other includes cases assigned to the Bureau of Domestic Abuse, Bureau of Hotline and Intake, or Clinical Coordinators.

Source: OIG data summarized by OAG.

Cases Over 200 Days

Exhibit 2-3 shows the types of allegations taking more than 200 calendar days to complete from FY06 through FY08. The number of OIG investigations taking more than 200 calendar days to complete between FY06 and FY08 has varied from 38 in FY06 to 66 in FY07 to 40 in FY08. However, the number of allegations over 200 days involving physical or sexual abuse dropped considerably between FY07 and FY08.

Exhibit 2-3
TYPES OF ALLEGATIONS IN CLOSED CASES OVER 200 CALENDAR DAYS TO COMPLETE
Fiscal Years 2006 to 2008

Type of Allegation	FY06	FY07	FY08
Physical Abuse	16	26	9
Neglect	16	22	20
Verbal Abuse	2	3	5
Death	0	2	3
Sexual Abuse	3	10	3
Psychological Abuse	1	3	0
Total	**38**	**66**	**40**

Note: Analysis excludes cases investigated by the Illinois State Police.

Source: OAG analysis of OIG data.

In FY06, the Metro Bureau continued to have the largest percent of investigations taking longer than 200 days with 68 percent, while the North Bureau had 26 percent, and both the Central Bureau and South Bureau had 3 percent. For FY08, the Metro Bureau again had the most with 53 percent (21 of 40 cases). The other three bureaus ranged from 17.5 percent in the Central Bureau and 15 percent in the North Bureau to 2.5 percent in the South Bureau. For 5 of the 40 cases, a Clinical Coordinator was assigned primary investigative responsibility.

Unlike in previous audits, State operated facilities did not account for a large percentage of case that took more than 200 days. Of the 40 cases that took more than 200 days to complete, 5 of 40 (12.5%) were State operated facilities, while 35 (87.5%) were investigations of allegations at community agencies.

TIMELINESS OF CASE COMPLETION	
RECOMMENDATION 2	***The Office of the Inspector General should continue to work to improve the timeliness of investigations of abuse and neglect.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	OIG agrees and will work to continue to improve. However, OIG is gratified that, as the audit report recognizes, we have significantly reduced our time for completing abuse/neglect investigations, from an average of 53 days/case in FY06 to an average of 44 days/case in FY08, despite the ongoing increase in allegations and decrease in investigators.

OTHER TIMELINESS ISSUES

There are several factors that may affect timeliness of case completion. These factors are discussed below. Cases referred to either the Illinois State Police or to OIG's Clinical Coordinators may add to the overall time it takes the OIG to complete cases. In addition, investigator caseloads, timeliness of investigative interviews, and timeliness of case file review may also increase the time it takes to complete cases.

Illinois State Police

The Department of Human Services Act (20 ILCS 1305/1-17(b)) requires that:

The Inspector General shall, within 24 hours after determining that a reported allegation of suspected abuse or neglect indicates that any possible criminal act has been committed or that special expertise is required in the investigation, immediately notify the Department of State Police or the appropriate law enforcement entity. The Department of State Police shall investigate any report from a State-operated facility indicating a possible murder, rape, or other felony.

The State Police either conducts an investigation or refers the case back to OIG. In some instances, the OIG will conduct an investigation in a case even if the State Police conducted an investigation. The State Police investigation is a criminal investigation and the OIG investigation is administrative. According to OIG's investigative guidance, the OIG conducts no further investigative activity when the State Police accepts a case unless requested to do so by the State Police. Exhibit 2-4 shows the number of cases referred to the State Police and the disposition of those cases. According to information provided by the State Police, the total number of cases referred has decreased over the last two years. During this same time period, the number of allegations reported at State facilities also declined.

Exhibit 2-4
DISPOSITION OF CASES REFERRED TO STATE POLICE
Fiscal Years 2005 to 2008

Disposition	Number of Cases			
	FY05	FY06	FY07	FY08
Referred back to OIG without investigation	63	57	43	44
Declined by Prosecutor	15	5	10	2
Not Sustained	21	10	13	8
Conviction	6	0	6	0
Unfounded	2	1	1	0
Dismissed	1	1	1	1
Total	**108**	**74**	**74**	**55**

Source: OAG analysis of Illinois State Police data.

In response to our 2006 audit recommendation regarding reporting to the State Police, the OIG revised its Checklist for Notification to the Illinois State Police/Local Law Enforcement to include the date and time of the determination that credible evidence existed that would require

reporting. In our testing of FY08 cases, four cases were referred to State Police. We obtained copies of all four checklists from the investigative files. For all four cases, we determined that the incident was reported to the State Police within the required 24 hours. However, even though the OIG updated their checklist in December 2006, all four files contained the old checklist which does not include the date that it was determined that credible evidence existed. Three of the four cases occurred after the form had been revised. For one of the cases which occurred in December 2007, we could not readily determine whether it was reported in a timely manner because the old checklist was used. Therefore, OIG management cannot ensure that the allegation was reported within the 24-hour reporting requirement found in the Act. After follow-up with the OIG, we determined that it was reported within the time requirement.

REPORTING TO THE STATE POLICE	
RECOMMENDATION 3	***The Office of the Inspector General should maintain the necessary documentation to monitor referrals to the Illinois State Police. Monitoring should be in place to ensure that the referrals are timely as required by State law.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	OIG agrees. The investigative bureaus have been reminded to use the current version of the form. The bureau chiefs will continue to be responsible to monitor this form.

Clinical Services Cases

OIG's Clinical Coordinators handle cases that involve medical issues as well as death cases. The Coordinators work and consult with Clinical Services at DHS. During the majority of FY08, OIG had only one Clinical Coordinator to cover the entire State.

The time to conduct investigations assigned to a Clinical Coordinator increased significantly from FY06 to FY08. In FY06, we reported the average completion time for cases referred to the Clinical Coordinator was 66 days. For FY08, the average completion time for cases referred to the Coordinators was 119 days. In our review of cases that took more than 200 days to complete, 5 of 40 were assigned to Clinical Coordinators.

The OIG hired an additional Clinical Coordinator on a 60 day emergency basis in December 2007 and again in February 2008. In April 2008, a full-time Clinical Coordinator was finally hired.

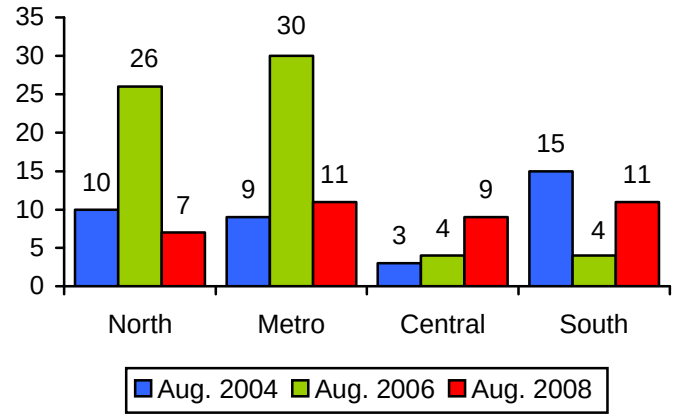
The CMS rules regarding emergency hires states that "Such appointments shall not exceed 60 days, shall not be renewed and may be made without regard to an eligible list" (80 Ill. Adm. Code 302.150 (b)). Department of Human Services' policies and procedures also do not allow for emergency appointments to exceed 60 calendar days or be renewed. In addition to the emergency hire for a Clinical Coordinator, the OIG also hired an intake investigator on an emergency basis and also renewed his appointment for an additional 60 day period.

EMERGENCY HIRES	
RECOMMENDATION 4	***The Department of Human Services should comply with CMS rules and DHS policy by not renewing emergency appointments.***
DEPARTMENT OF HUMAN SERVICES RESPONSE	Agree. The agency has now ceased all consecutive emergency appointments.

Investigator Caseloads

The OIG has made significant improvement in reducing investigator caseloads since the previous audit. Investigator caseloads have decreased substantially for the North and Metro bureaus and are also more evenly distributed among bureaus. Exhibit 2-5 shows the trend in caseloads by bureau from 2004 through 2008. Caseloads as of August 2008 ranged from 11 in the Metro and South bureaus to 7 in the North Bureau. In August 2006, caseloads ranged from a high of 30 in the Metro Bureau to a low of 4 in the South and Central bureaus.

Exhibit 2-5
INVESTIGATOR CASELOADS
By Bureau as of August 14, 2004, 2006, and 2008



Source: OIG data summarized by OAG.

Exhibit 2-6 shows that in FY08, the highest average cases completed per month by investigator and bureau was 10.2 in the Central Bureau. The lowest monthly average cases completed per investigator was 4.6 in the South Bureau. The average days to complete a case in FY08 decreased for three of the four bureaus and ranged from 36 in the Central Bureau to 103 days in the Metro Bureau. The 103 average days for the Metro Bureau is a significant improvement over the 124 days in the previous audit. The North Bureau average dropped from an average of 114 days to 67 days and the South Bureau dropped from an average of 62 days to complete investigations to 43 days.

Exhibit 2-6
INVESTIGATIONS COMPLETED AND INVESTIGATION TIMELINESS BY BUREAU
Fiscal Years 2006 and 2008

	Cases Reported		Investigations Completed		Investigations Open at End of Fiscal Year		Monthly Cases Completed Per Investigator		Avg. Calendar Days to Complete	
	FY06	FY08	FY06	FY08	FY06	FY08	FY06	FY08	FY06	FY08
North	341	308	308	393	100	64	5.1	9.2	114	67
Metro	524	625	537	559	120	118	6.4	7.5	124	103
Central	459	588	489	522	14	73	10.3	10.2	33	36
South	378	354	438	312	8	52	7.4	4.6	62	43
Totals	**1,702**	**1,875**	**1,772**	**1,786**	**242**	**307**	**7.2**	**7.1**	**79**	**65**

Source: OIG data summarized by OAG.

As seen in Exhibit 2-6, there has been an increase in the number of allegations of abuse or neglect reported since FY06. From FY06 to FY08, allegations increased by 173 (10%), not including death investigations or State Police investigations. The Metro Bureau had a 19 percent increase and the Central Bureau had a 28 percent increase.

The OIG has been proactive in trying to improve the timeliness of investigations. During FY07 and FY08, OIG hired 11 new investigators to fill vacancies as they occurred. In addition, the OIG has received or replaced 13 laptop computers and 28 replacement desktop computers for use by staff to facilitate investigative efforts. Caseloads were also redistributed among bureaus. For instance, the North Bureau completed 104 investigations for the Metro Bureau. The redistribution also included using the Intake Bureau to conduct investigations of allegations that were recanted at intake and also to investigate some allegations of mental injury. Some cases were also redistributed to Bureau of Domestic Abuse investigators (see Exhibit 2-7).

Exhibit 2-7
BUREAU OF INCIDENT VS. INVESTIGATIVE BUREAU
Abuse or Neglect Cases Closed in FY08

Investigating Bureau	Bureau of Incident			
	North	Metro	Central	South
North	301	104	1	0
Metro	0	540	0	0
Central	0	2	486	11
South	0	0	0	312
Intake	14	13	17	21
Clinical	0	0	0	3
DAP	10	6	48	0
Totals	325	665	552	347

Note: This exhibit presents cases closed for FY08, not including death investigations. Numbers presented in Exhibit 2-6 represent investigations completed which may include cases not yet closed.

Source: OAG analysis of OIG data.

Timeliness of Investigative Interviews

Timely interviews of alleged victims and perpetrators are necessary because as time passes, recollection of events is not as clear, or witnesses may not be available for follow-up interviews. Even though initial statements are often taken at the time of the incident, delays in getting detailed interviews from those involved, especially from the alleged victim, increase the risk of losing information and weakening the evidence obtained.

Since the last audit, the OIG directives were amended to delete a required timeline for conducting interviews with those involved. During the previous audit, the directives required that all "critical" interviews were to be completed by the assigned investigator within five working days of approval of the investigative plan. For our FY08 case files reviewed, it took investigators an average of 8 days to complete interviews with the alleged victim, which was 4 fewer days than the 12 days it took in FY06. For FY08 case files reviewed, it took investigators an average of 20 days to complete interviews with the alleged perpetrator in each case, which is 5 days fewer than the 25 days it took in FY06.

We recommended during the previous audit that the OIG define in the OIG directives what is considered to be a critical interview in order to provide additional guidance to investigators. Since the previous audit, the OIG has deleted the requirement for critical interviews from its directives. Even though the OIG no longer requires critical interviews, we continue to look at the amount of time it takes investigators to interview the alleged victim and the alleged perpetrator.

Timeliness of Assignment and Investigative Plans

The OIG needs to improve the timeliness of investigator assignment and completion of investigative plans. OIG directives require that investigations be assigned to an investigator within one working day of the OIG assuming responsibility for the investigation. More than three-quarters of the investigations we reviewed were assigned within one working day. However, for 17 of the 117 (15%) cases we sampled and could determine an assignment date, the assignment was not made within one working day. The time to assign for these cases ranged from 3 days to 10 days. For 10 cases, we could not determine the assignment date.

OIG directives also require assigned investigators to complete an investigative plan within three working days of assignment, except if the case is closed at intake. For 16 of the 127 (13%) cases we sampled, we could not determine whether the plan was completed in a timely manner because there was either no date on the investigative plan or we could not determine the date assigned. For the remaining 111 cases sampled, 5 (5%) were not completed and approved within the required three working days.

INVESTIGATOR ASSIGNMENT AND INVESTIGATIVE PLANS	
RECOMMENDATION 5	***The Office of the Inspector General should assign all allegations to an investigator within one working day and complete all investigative plans within three working days as is required by OIG directives.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	OIG agrees. The investigative bureaus have been reminded to assign investigations and complete investigative plans timely.

Number of Interviews Conducted

The number of interviews conducted in FY08 is more consistent between investigative bureaus than in our previous audit. In the previous audit, we found that the number of interviews conducted by the investigative bureaus differed significantly, ranging from 3 interviews per investigation in the South Bureau to 11 per investigation in the North Bureau.

Exhibit 2-8 shows the average number of interviews for FY08 cases sampled ranged from 6 in the Metro Bureau to 8 in the South Bureau.

Exhibit 2-8
AVERAGE NUMBER OF INTERVIEWS PER INVESTIGATION BY BUREAU

Bureau	FY06	FY08
North	10.8	7.2
Central	5.3	7.1
Metro	5.2	5.9
South	2.9	7.8

Source: OAG sample of closed investigations from FY08 and FY06 OAG audit.

Timeliness of Case File Reviews

Timeliness of case file review has improved since our last audit. However, the OIG continues to fall short of the timeline requirements in its directive relating to case file review. Data from the OIG database shows that none of the four investigative bureaus are reviewing substantiated cases within the timelines delineated in the OIG directives. OIG directives require the Investigative Team Leader (ITL) and Bureau Chief to review cases within seven working days of receipt. If the case is substantiated physical abuse, sexual abuse or egregious neglect, the case is reviewed by the Inspector General or his designee.

The ITL or the Bureau Chief may send the case back to the investigator for further investigation. The directive states that the investigator will complete the additional work and ensure that the case is returned to the ITL or Bureau Chief within seven working days of the receipt of the returned case. Once the Bureau Chief reviews and approves a substantiated case,

directives require that it be forwarded to the Deputy Inspector General for review and approval. The Inspector General shall review all Health Care Worker Registry cases. OIG's database does not track cases that were sent back for additional investigation. Therefore, our analysis only shows the total calendar days from date submitted for review until the Bureau Chief signs the case as reviewed. Without tracking cases sent back for additional investigations, OIG management cannot effectively monitor how long it takes for cases to be reviewed.

Exhibit 2-9
AVERAGE CALENDAR DAYS FROM DATE SUBMITTED FOR REVIEW UNTIL FINAL REVIEW BY BUREAU CHIEF
Fiscal Years 2006 to 2008

	Cases Substantiated [1]			Cases Not Substantiated [1]		
	FY06	**FY07**	**FY08**	**FY06**	**FY07**	**FY08**
North	35	18	17	8	5	7
Metro	68	38	44	19	19	14
Central	21	18	19	9	8	13
South	28	16	29	7	5	8
Total Avg.	**36**	**23**	**26**	**11**	**10**	**11**

Note:
[1] Days may include time when the Bureau Chief sends the case back to the investigator for further investigation.

Source: OAG analysis of OIG data.

Exhibit 2-9 shows that none of the bureaus are reviewing substantiated cases within the 7-day timeline delineated in the OIG directive. The Metro Bureau takes much longer to review substantiated cases than the other three bureaus. The review of substantiated cases is taking a large percent of the 60-day time requirement that the OIG has to complete its investigations. Improvements in the time it takes to review substantiated cases could have a substantial effect on the overall timeliness of case completions at the OIG.

TIMELY REPORTING OF ALLEGATIONS

Alleged incidents of abuse and neglect are not being reported by facilities and community agencies in the time frames required by statutes and the OIG's administrative rules. The Department of Human Services Act requires that allegations be reported to the OIG hotline within four hours of initial discovery of the incident of alleged abuse or neglect. Community agencies continue to have a larger percentage of untimely reports in comparison to facilities. Exhibit 2-10 shows allegations of abuse and neglect not reported within four hours of discovery for State facilities and community agencies from FY05 through FY08.

Exhibit 2-10
ALLEGATIONS OF ABUSE AND NEGLECT NOT REPORTED WITHIN FOUR HOURS OF DISCOVERY

Fiscal Year	Facility	Community Agency
FY05	6%	34%
FY06	6%	29%
FY07	5%	21%
FY08	7%	25%

Source: OAG analysis of OIG data.

- **Facility** - 7 percent of facility incidents were not reported within the four-hour time requirement in FY08 compared to 6 percent in FY06.

- **Community Agency** - 25 percent of community agency incidents were not reported within the four-hour time requirement in FY08 compared to 29 percent in FY06.

Several steps have been taken since the previous audit in order to improve the timeliness of reporting allegations of abuse and neglect. Effective June 13, 2006, Public Act 94-853 added a provision that states that a required reporter who willfully fails to comply with the reporting requirements is guilty of a Class A misdemeanor. According to OIG officials, the OIG is also citing late reporting more often when it does happen. OIG officials cited late reporting in 34 cases in FY06, 68 cases in FY07, and 175 cases in FY08.

ALLEGATION REPORTING	
RECOMMENDATION 6	***The Office of the Inspector General should continue to work with State facilities and community agencies to ensure that allegations of abuse or neglect are reported within the time frame specified in Department of Human Services Act and OIG's administrative rules.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	OIG agrees. OIG has taken the following steps to reinforce timeliness of reporting: - Notified the facilities and community agencies of the new law (P.A. 94-853) making intentional late reporting or failure to report a Class A misdemeanor; - Re-issued to all facilities and community agencies a handbook, "Reporting and Investigating Abuse and Neglect of Adults with Disabilities," which emphasizes timely reporting; - Ensured the DHS contracts with community providers includes the requirement for reporting and a mandate for at least biennial training of all staff in Rule 50; - Reviewed all community agency internal policies on reporting to ensure that every one includes the time requirements in Rule 50; - Maintained the database-generated "flags" on all new intakes, so investigators are notified of identified or potential late reporting when it occurs; - Routinely cites late reporting in investigative reports, which requires the facility or community agency to submit a Written Response listing actions that will be taken to prevent recurrence and address problems identified;

	- On a monthly basis, notifies the DHS divisions of facilities and community agencies that reported late; and - Continues to conduct trainings of community agency staff, conducting 26 trainings with a total of 681 participants in Rule 50 during FY 2008 alone.

Chapter Three

THOROUGHNESS OF ABUSE OR NEGLECT INVESTIGATIONS

CHAPTER CONCLUSIONS

OIG case reports generally were thorough, comprehensive, and addressed the allegation. However, we found that photographs were missing in 5 of 29 (17%) cases where there was an allegation of an injury sustained from our FY08 sample. Injury Reports were missing in 3 of 29 (10%) cases where there was an allegation of an injury sustained. Two of the 127 sample cases tested did not contain a Case Routing/Approval Form. Although all case files in our sample contained a Case Tracking Form, two of the forms were not completed. During the review of our 127 sample cases, two files did not contain pertinent medical records, treatment plans, or progress notes. One case sampled where restraints were used did not contain the appropriate documentation.

During the previous audit, we concluded that there were inconsistencies between investigative bureaus related to how the bureaus classify findings. In addition, we found inconsistencies between what is and is not accepted by the Bureau of Hotline and Intake as an allegation of abuse or neglect. Beginning in January 2007, the Deputy Inspector General and one investigative bureau chief (on a rotating basis) began quarterly reviews of unfounded and unsubstantiated cases to ensure consistency across bureaus. During our fieldwork, we reviewed the second quarter FY08 review conducted by the Deputy Inspector General. Although the review identified problems such as cases missing an investigative plan or clinical coordinators' summary and cases in which interview statements were not numbered, the review did not find any cases involving improper findings or different interpretations of finding criteria, nor did it find any cases that might have been substantiated.

For community agency conducted investigations in our sample, it was sometimes difficult to determine which bureau and investigator was responsible for reviewing the case. For some community agency conducted investigations the OIG Bureau of Hotline and Intake was reportedly responsible for reviewing the case. For these cases that were reportedly completed by the Bureau of Hotline and Intake, review forms were either missing or not completed.

In the previous audit we recommended that the Inspector General should clearly define what constitutes physical injury and physical harm. This has not been accomplished. According to the OIG response in the previous audit, officials agreed and stated they believed that the issue of definitions would be resolved by revisions to the statute. Until the statute is revised, such a change to Rule 50 would be premature. However, in the meantime, OIG would reinforce that physical "harm" is a physical "wrong or injustice."

INVESTIGATION THOROUGHNESS

In addition to timeliness, essential components of an abuse or neglect investigation include thoroughness in the collection of evidence, adequate supervisory review, and a clear and comprehensive final case report.

Collection of Evidence

Evidence for OIG investigations includes items such as signed witness statements, interview summaries, documents, photographs, and other physical evidence. OIG investigative directives also require investigators to complete an investigative plan within three days of assignment and send the plan to the Bureau Chief prior to the start of the investigation.

The directives also require photographs to be taken whenever an allegation of abuse or neglect is received alleging an injury, whether or not the injury is visible. However, the directives also state that when there is no visible injury consistent with the allegation, the OIG investigator can exercise discretion in determining whether photographs are necessary. The case files we sampled from FY08 were generally thorough and contained the appropriate documentation. However, some files were missing documentation that should have been gathered during the investigation.

During our testing, we checked for evidence including: interviews, photographs, medical records/treatment plans/progress notes, injury reports (including documentation that no injury occurred), and restraint/seclusion records. In our testing we found:

- **Photographs:** Photographs were missing in 5 of 29 (17%) cases from our sample where there was an allegation of an injury sustained. In one of these cases, the OIG cited the facility for not taking photos. According to OIG officials, in a few other cases photos were taken, but no photos were in the file.

- **Injury Report:** Injury Reports were missing in 3 of 29 (10%) cases where there was an allegation of an injury sustained.

- **Medical Records/Treatment Plans/Progress Notes:** During the review of our 127 sample cases, 2 files did not contain pertinent medical records, treatment plans, or progress notes.

- **Restraint/Seclusion Records:** For one case sampled where restraints were used, the file did not contain the appropriate documentation.

Interview Thoroughness

Investigative interviews conducted during the investigation are essential fact finding instruments used by the investigators to determine what happened related to an allegation. Interviews often identify the involved parties (i.e., victims, perpetrators, witnesses). At the completion of the investigation, the OIG investigators produce an investigative report that is

based on the information obtained during the course of the investigation, including interviews and statements given by the victim, perpetrator, or witnesses.

We reviewed FY08 cases to see if they included a statement or interview with the alleged victim and the alleged perpetrator. Of the 127 cases we reviewed, 99 cases involved a victim that was verbal. Although 4 of the 99 cases did not contain a written statement or interview with the victim, in most cases there were extenuating circumstances. For instance, in one case the victim refused to be interviewed. In another case, the victim was released two days after the allegation and the OIG made multiple unsuccessful attempts to contact the victim. The alleged perpetrator was not interviewed in six cases.

The previous audit contained a recommendation that the OIG should develop criteria for documenting investigative interviews. During the FY06 audit we found instances of inconsistent documentation of interviews and verbatim write-ups for multiple individuals. The OIG did not accept the recommendation because management felt that there were directives already in place regarding documenting interviews and the interviewer should rely on professional judgment. We reviewed interviews as part of our sample of FY08 cases and the interviews were generally consistent. We did not find instances of verbatim interviews for multiple parties as was found in the previous audit.

CASE MONITORING AND SUPERVISORY REVIEW

Supervisory review is another essential element in an effective investigation. It is the responsibility of the OIG's supervisory staff to ensure that criteria for effective investigations are being met. Without adequate supervisory review and feedback, the quality of the investigations may suffer, and as a result, the effectiveness may be diminished.

According to the OIG investigative directives, it is the policy of the OIG to enhance the integrity and quality of investigations by conducting case reviews in a timely and consistent manner. A typical case will move through at least one level of review, and at least two levels for substantiated physical abuse, sexual abuse, or egregious neglect cases, before being sent to the facility or community agency.

Documentation of Case Monitoring and Review

The OIG requires that case files contain case monitoring and review documentation. These are the Case Tracking Form and the Case Routing/Approval Form.

- **Case Tracking Form** - All case files in our sample contained a Case Tracking Form as required by investigative directives. However, for two cases, although the tracking form was in the file, it had not been completed. The Case Tracking Form identifies information such as the case number, investigative agency, bureau, and allegation. This form's main purpose is to track OIG's actions throughout the investigation. Dates for when the investigative report was received, when it was reviewed, and when

it was closed are all tracked on this form. It is also used to document the case finding and recommendations for action.

- **Case Routing/Approval Form -** After a case is submitted for review, the review progress is documented through the Case Routing/Approval Form. After each level of review, the reviewer signs and dates the form to indicate that the review has taken place and sends the case to the next level of review. On these forms, the reviewer can note when the case was sent to special review, clinical, legal, a consultant, or another office. Two of the 127 cases tested did not contain a Case Routing/Approval Form. Both of these cases were conducted by a community agency and the OIG Bureau of Hotline and Intake was responsible for the case review. In two other cases sampled the person assigned as the primary investigator to conduct the investigation also reviewed and approved the investigation on the Case Routing/Approval Form as the team leader and because these cases were not substantiated, there was no review or approval by the Bureau Chief.

Investigative Reports

The OIG investigative reports that we tested from FY08 were generally thorough, comprehensive, and addressed the allegation. A well-written investigative report is also essential to an effective investigation because it often provides a basis for management's decision on the action warranted in the case. Once the investigator completes the investigative report, it is reviewed by management who must "sign off" on the case before a recommendation is sent to the facility or community agency. Therefore, it is important that the investigative report be clear and convincing to anyone who reads it. The report should address all relevant aspects of the investigation and reveal what the investigation accomplished. All of the cases we reviewed contained an investigative report.

Case Review

The case file review process can vary depending on the type of case (facility or agency), whether the allegation is substantiated, and even what type of abuse or neglect was substantiated. For community agency conducted investigations in our sample it was sometimes difficult to determine which bureau and investigator was responsible for reviewing the case. For some community agency conducted investigations, the OIG Bureau of Hotline and Intake was reportedly responsible for reviewing the case. For these cases that were completed by the Bureau of Hotline and Intake, review forms were either missing or not completed.

For example, in one case we sampled the case was missing the Case Routing/Approval Form, the Case Tracking Form was in the file but not completed, and the OIG could not provide a copy of the Case Review Form for Facility/Agency Conducted Investigations. The database does not show which OIG bureau or investigator was assigned responsibility for the case. However, according to OIG officials this case was reportedly completed by the Bureau of Hotline and Intake. This case was substantiated abuse (mental injury); however, according to OIG directives was not required to be reviewed by the Inspector General or his designee. Therefore, we could find little evidence that the case was reviewed. According to OIG officials, the Bureau

of Hotline and Intake was assigned to help conduct investigations of some mental injury cases in the North and Metro bureaus when there was a backlog of cases. In another case which appeared to be completed by the Bureau of Hotline and Intake, the Case Tracking Form was only partially completed and we could not obtain a copy of the Case Review Form.

The Inspector General or his designee is not required to review substantiated cases of mental injury or neglect unless it is deemed "egregious" neglect. Conducting case file reviews is critical to the investigations process. These reviews not only ensure an effective investigation, but also help ensure the integrity and quality of the investigatory process.

CASE FILE REVIEWS	
RECOMMENDATION **7**	***The Office of the Inspector General should:*** • ***ensure that review responsibility for all cases is clearly assigned and that all forms are completed and contained in the case file; and*** • ***consider requiring that the Inspector General or his designee review all substantiated cases of abuse or neglect.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	OIG agrees. OIG has required all reviewing staff to ensure that the database reflects all receipt and completion dates for reviews. OIG is also developing new and more detailed database reports to monitor and evaluate review time. In addition, OIG will consider requiring that the Inspector General or his/her designee review all substantiated cases of abuse or neglect.

CONSISTENCY AMONG INVESTIGATIVE BUREAUS

During the previous audit, we concluded that there were inconsistencies between investigative bureaus related to how the bureaus classify findings. In addition, we found inconsistencies between what is and is not accepted by the Bureau of Hotline and Intake as an allegation of abuse or neglect.

OIG's four investigative bureaus (South, Central, Metro, and North) are decentralized. The investigative bureaus use standard forms including an investigative plan, the Case Tracking Form, the Case Routing/Approval Form, and the Case Closure Checklist. While substantiated cases of physical abuse, sexual abuse, or egregious neglect are reviewed by the Inspector General or his designee to ensure consistency, cases closed as substantiated mental injury, substantiated neglect, unfounded, or unsubstantiated are closed by the Investigative Team Leader (ITL) or Bureau Chief from each bureau and are not reviewed centrally.

Beginning in January 2007, the Deputy Inspector General and one investigative bureau chief (on a rotating basis) began quarterly reviews of unfounded and unsubstantiated cases to ensure consistency across bureaus. During our fieldwork, we reviewed the second quarter FY08

review conducted by the Deputy Inspector General. The review contained a summary of each case and a short review of any issues or problems found during the review for 18 unsubstantiated or unfounded cases sampled. The review identified problems such as cases missing an investigative plan or clinical coordinators' summary. It also identified cases in which interview statements were not numbered. However, the OIG review did not find any cases involving improper findings or different interpretations of finding criteria, nor did it find any cases that might have been substantiated.

Although the OIG has taken steps to try to improve in this area, consistency in what constitutes a reportable allegation, and the classification of the outcome of cases as substantiated, unsubstantiated, and unfounded continues to be an area of concern at the OIG. During our testing, we identified cases that involved clients that were left unsupervised that had different outcomes. Below is a discussion of three of these cases.

Case #1 involves an individual served at a community agency, in which the individual was left alone at a day outing. Staff did not discover that the individual was missing until they had returned to the residence approximately 30 minutes later. The employee at the location of the day outing called the police upon discovering that the individual was separated from the group. The individual was taken to the police station, where she was picked up by agency staff. According to the intake narrative it was non reportable because "this incident did not rise to the level of neglect as described in Rule 50 (client suffered no harm or injury), and can be handled internally by the agency." There was no information in the incident narrative regarding the individual's level of functioning. The final outcome of the case was **Non Reportable**.

Case #2 involves an individual served at a community agency that was left alone for approximately three hours. The individual was at a day work program location for approximately two hours waiting for either a staff member to pick him up, or for a staff member to let him know that they had called a cab. Staff never picked him up or called a cab. The manager of his workplace called a cab after the individual had been waiting for approximately two hours. When the cab took the individual to his residence no one was there because the residents had all been moved to a different location due to staffing issues that day. The individual waited for an additional hour outside of his residence until another resident asked where he was. Then a staff member picked him up and took him to where the residents in his house were located. According to the intake narrative "due to the length of time [the individual] was left alone… and his inability to comprehend that he could have gone to the neighbors for help," this was an acceptable allegation of abuse. According to documentation found in the case file, this individual functioned at a severely mentally retarded level. The final outcome of the case was **Unfounded with issues**.

Case #3 occurred at a State facility, and involved an individual who was found sleeping in her bed when she was supposed to be at her day training center. Upon medical examination she was found to have no signs of visible injury. The person reporting the allegation stated that the individual is assigned to same room supervision during bathing, toileting, and meals, and should not be left unsupervised because of her profoundly mentally retarded functioning level. The final outcome of the case was **Substantiated Neglect** because according to the case file report "it could have resulted in an injury."

Definition of Physical Harm

In our previous audit we found that there may have been different interpretations for the definition of physical harm. The OIG's definition of abuse and neglect in its administrative rules include the term "physical injury." As seen in Exhibit 3-1, 59 Ill. Adm. Code 50.10 (Rule 50) defines physical injury as physical harm. Physical harm is not defined in the Department of Human Services Act (20 ILCS 1305/1-17) or in Rule 50.

Exhibit 3-1
DEFINITION OF PHYSICAL INJURY AND PHYSICAL HARM

Physical Injury

Defined as **physical harm** to an individual caused by any non-accidental act or omission.

Physical Harm

- Not defined in the Department of Human Services Act (20 ILCS 1305/1-17)
- Not defined in 59 Ill. Adm. Code 50.10
- Only defined in OIG Training Manual as a **WRONG OR INJUSTICE**

Source: OAG analysis of statutes, administrative rules, and training manual.

In the previous audit we recommended that the Inspector General should clearly define what constitutes physical injury and physical harm. This has not been accomplished. According to the OIG response in the previous audit, officials agreed and stated they believed that the issue of definitions would be resolved by revisions to the statute. Until the statute is revised, such a change to Rule 50 would be premature. However, in the meantime, OIG would reinforce that physical "harm" is a physical "wrong or injustice."

Effective August 28, 2007, Public Act 95-545 amended the Department of Human Services Act (20 ILCS 1305) and the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30) transferring all provisions concerning the Office of the Inspector General within the Department of Human Services from the Abused and Neglected Long Term Care Facility Residents Reporting Act to the Department of Human Services Act. According to OIG officials, since the law was not substantially altered, Rule 50 was not revised.

INVESTIGATIVE CONSISTENCY	
RECOMMENDATION **8**	***The Office of the Inspector General should:*** • ***continue to work to ensure consistency of investigations and recommendations; and*** • ***consider clearly defining what constitutes physical injury and physical harm.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	OIG agrees in part. OIG will continue efforts to ensure consistency of investigative findings. OIG has defined physical injury in Rule 50 but maintains that the issue of defining physical harm would be resolved by revisions to the statute. Until the statute is revised, however, any change to Rule 50 would be premature. In the meantime, OIG will continue to reinforce that physical "harm" is a physical "wrong or injustice."

Chapter Four

ACTIONS, SANCTIONS, AND RECOMMENDATIONS

CHAPTER CONCLUSIONS

According to 59 Ill. Adm. Code 50.90, an employee may request a hearing with the Department of Human Services and present evidence supporting why his or her finding does not warrant reporting to the Health Care Worker Registry. The percentage of cases appealed in which the Administrative Law Judge's (ALJ) decision upheld the referral of the employee to the Health Care Worker Registry has increased when compared to our previous audit. The ALJ decision was to refer the employee in 56 percent of the appeal hearings in FY08 (15 of 27) and 56 percent of those in FY07 (18 of 32), compared to 41 percent in FY06 (13 of 32) and 21 percent in FY05 (6 of 28).

We reviewed 10 substantiated cases in which the ALJ rejected the referral to the Health Care Worker Registry in FY08. In the 10 cases in which the referral was rejected, the ALJ found that the Department had not demonstrated by a preponderance of the evidence that the finding of abuse against the petitioner warranted reporting to the Registry. Several overturned cases cite the credibility of witnesses as a problem. In one case, the ALJ found the OIG investigation was unreliable. The OIG investigator in the case had been placed on leave and is no longer with the OIG. In another case, the ALJ found that the petitioner's actions were extremely inappropriate but did not rise to the level of reporting to the Registry.

In our previous audit, we recommended that the OIG revise its policies and procedures to ensure that all cases with findings that warrant reporting to the Registry are reported. The Department of Human Services Act requires physical abuse, sexual abuse, and egregious neglect to be referred to the Registry. Although the OIG has not updated the definition of egregious as it relates to neglect, the OIG directives have been updated and a process added for a Stipulated Motion to Dismiss. This process is triggered by a 50.90 petition on certain physical abuse cases that, although the finding meets the definition of physical abuse, may not be severe enough to deserve placement on the Registry. In September 2006 the OIG implemented a new stipulation process authorized by statute for appeals hearings. The OIG did not refer a case to the Registry based on a stipulation order on six occasions in FY07 and FY08.

State facilities or community agencies are required to submit a written response to DHS for all substantiated cases of abuse or neglect, or cases with other administrative issues. In our review of written responses we found that DHS takes an excessive amount of time to receive and approve the actions taken by the agency or facility in some cases. For one case in our sample, the agency date on the written response was September 9, 2008 and the DHS approved date was also September 9, 2008. However, the case was completed in August 2007. In addition, we requested this information on August 22, 2008. Therefore, it took more than a year to get the

corrective action approved from the date of completion and it was done only after auditors requested the information. Of the 41 cases in our sample for which we could determine an investigative completion date and a response date, 6 of 41 (15%) took more than six months from the date the case was completed until the written response was approved by DHS. Two of these cases took more than a year.

Even though two State-operated facilities were terminated from participation in federal programs for non-compliance with various issues, including patient safety and client protection, the OIG did not recommend a sanction against either facility. Over the past 15 years (1994 – 2008), the Inspector General has not recommended sanctions against a State-operated facility. On June 9, 2008, the OIG did utilize its authority under 20 ILCS 1305/1-17(d) to recommend sanctions and sent letters to the DHS Division of Mental Health and to the DHS Division of Developmental Disabilities related to community agencies that had not updated their abuse/neglect reporting policies. The OIG recommended a total of nine service providers for non-renewal of their DHS service provider agreement until the policy is approved by OIG. According to OIG officials, none of the issues cited by the reviewers at Tinley Park MHC were reportable to OIG under current State law. Some issues cited by the reviewers at Howe DC did meet the State law's definitions, but OIG identified no trends or patterns in those beyond what has been typical of other facility or agency programs.

Exhibit 4-1
ABUSE AND NEGLECT CASES CLOSED AND SUBSTANTIATED
(Allegations Categorized as Abuse or Neglect at Intake)
Fiscal Years 2000 to 2008

	Individuals Served[1]	Closed Cases	Substantiated Cases	Substantiated %
FY00 Facility	12,858	1,426	129	9%
FY00 Community	160,378	939	321	34%
FY 2000 Total	**173,236**	**2,365**	**450**	**19%**
FY01 Facility	13,048	1,293	65	5%
FY01 Community	180,026	959	274	29%
FY 2001 Total	**193,074**	**2,252**	**339**	**15%**
FY02 Facility	13,680	874	55	6%
FY02 Community	192,131	629	198	31%
FY 2002 Total	**205,811**	**1,503**	**253**	**17%**
FY03 Facility	12,285	701	40	6%
FY03 Community	194,884	522	85	16%
FY 2003 Total	**207,169**	**1,223**	**125**	**10%**
FY04 Facility	12,167	846	63	7%
FY04 Community	192,532	609	134	22%
FY 2004 Total	**204,699**	**1,455**	**197**	**14%**
FY05 Facility	12,679	904	43	5%
FY05 Community	193,279	724	147	20%
FY 2005 Total	**205,958**	**1,628**	**190**	**12%**
FY06 Facility	13,417	876	57	7%
FY06 Community	196,427	781	153	20%
FY 2006 Total	**209,844**	**1,657**	**210**	**13%**
FY07 Facility	12,751	983	58	6%
FY07 Community[2]	193,840	1,102	177	16%
FY 2007 Total	**206,591**	**2,085**	**235**	**11%**
FY08 Facility	12,506	825	48	6%
FY08 Community[2]	196,956	1,282	209	16%
FY 2008 Total	**209,462**	**2,107**	**257**	**12%**

[1] Individuals served is the sum of mental health clients served and developmentally disabled clients served in facilities or in community agencies.

[2] FY07 and FY08 DD individuals served data included in the community category represents the entire population served during the fiscal year. For previous years, this data was captured as a snapshot of clients being served as of that day during the fiscal year.

Source: OIG information summarized by OAG.

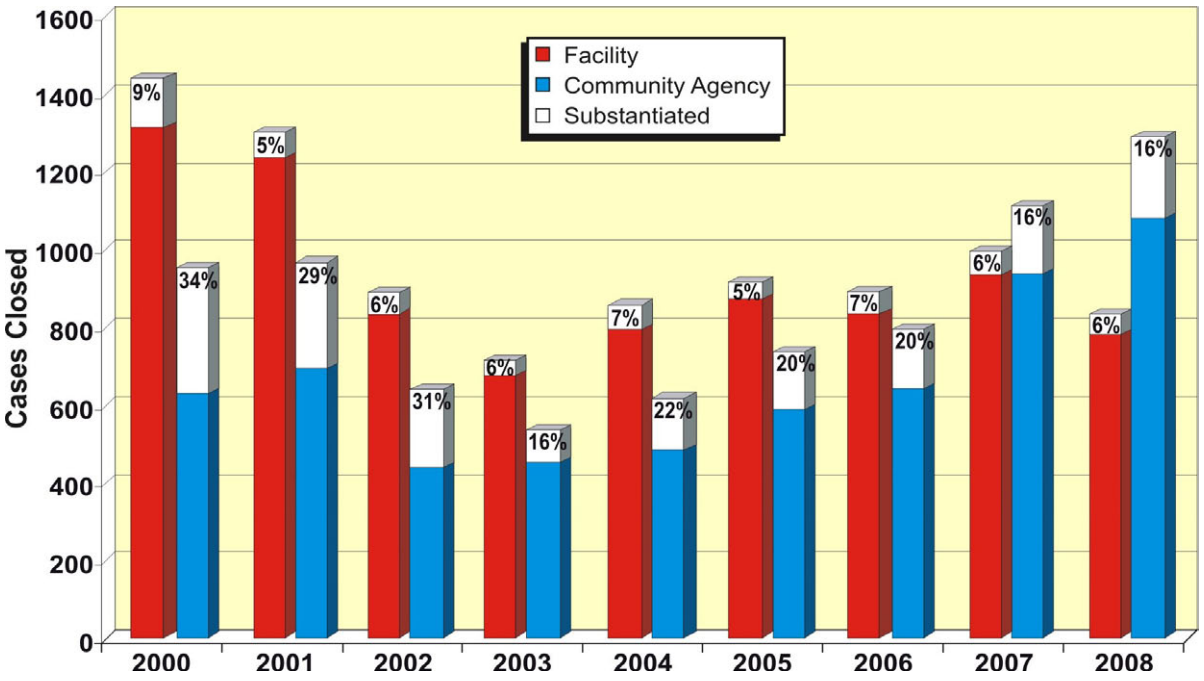
SUBSTANTIATED ABUSE AND NEGLECT CASES

In FY08, the OIG closed a total of 2,107 investigations of allegations of abuse or neglect. The OIG substantiated 257 of the abuse or neglect allegations, resulting in a 12 percent substantiation rate. Exhibits 4-1 and 4-2 both show the past nine years' closed cases and substantiation rates for allegations classified as abuse and neglect. The exhibits break out both facility and community agency allegations and substantiated cases of abuse and neglect. Exhibit 4-1 shows the data in a table and Exhibit 4-2 shows that data graphically. These numbers and percentages include substantiated cases that were classified as abuse or neglect at intake.

Although the annual number of substantiated abuse and neglect cases has increased over the past four years, the substantiation rate has remained fairly consistent. From FY04 to FY08 the overall substantiation rate has ranged from 11 percent to 14 percent overall.

For FY07 and FY08, the number of cases closed and substantiated allegations at community agencies has grown significantly and now outnumbers those at State facilities. Although the number of allegations substantiated at community agencies has been increasing since FY03, as a percentage of community allegations the substantiation rate has remained fairly steady.

Exhibit 4-2
ABUSE AND NEGLECT CASES CLOSED AND SUBSTANTIATED FOR STATE FACILITIES AND COMMUNITY AGENCIES
(Allegations Categorized as Abuse or Neglect at Intake)
Fiscal Years 2000 to 2008



Note: State facilities served 2,626 individuals with developmental disabilities and 9,880 individuals with mental illness in FY08. Community agencies served approximately 29,500 individuals with developmental disabilities and approximately 167,456 individuals with mental illness in FY08.

Source: OIG information summarized by OAG.

RECOMMENDATIONS AND ACTIONS

At the conclusion of an investigation, the OIG investigative team leader or bureau chief determines whether the evidence in the case supports the finding that the allegation of abuse or neglect is substantiated, unsubstantiated, or unfounded. The case is reviewed and a preliminary report is sent to the facility or community agency notifying it of the results of the investigation.

If the allegation is substantiated or the OIG had other recommendations, the report recommends what type of action the OIG thinks should be taken. Some examples of recommendations for actions in substantiated cases include retraining, policy creation or revision, and reporting to the Health Care Worker Registry.

After the recommendation is sent, the facility or community agency generally takes some action to resolve the issues related to the case. Exhibit 4-3 shows the substantiated cases in FY08 by the type of recommended action and by the investigating agency. The number of recommended actions has increased from the 212 in our FY06 audit to 262 for FY08 or about 24 percent.

In our 2006 audit, administrative action was recommended in 31 percent of the cases. In FY08, administrative action was the recommended action in 40 percent of the cases and was the most frequently used action in both the OIG and community agency investigations. Administrative actions include, but are not limited to, suspension, termination, and reprimand. In FY08, recommended actions of "no action" and "retraining" were similar to those in the previous audit. Also, the number of cases in which the recommended action was referral to the Health Care Worker Registry (formerly known as the Nurse Aide Registry) increased from 47 in FY06 to 65 in FY08 or about 38 percent.

Exhibit 4-3
RECOMMENDED ACTIONS FOR SUBSTANTIATED CASES
(All Allegations Regardless of Category at Intake) [2]
Fiscal Year 2008

RECOMMENDED ACTION	INVESTIGATED BY			TOTAL
	OIG	Community Agency	State Police	
No Action	35	4	3	42
Retraining	31	9	0	40
Policy Creation or Revision	7	0	1	8
Other Administrative Action	82	20	2	104
Referral to Other Agency	1	0	0	1
Health Care Worker Registry	57	0	8	65
Unknown [1]	1	1	0	2
Total Substantiated	**214**	**34**	**14**	**262**

Notes:
[1] Recommended action data missing from OIG's database.
[2] Data in Exhibit 4-3 includes 5 death cases that were not included in Exhibits 4-1 and 4-2 since they were not categorized as abuse or neglect at intake.

Source: OAG analysis of OIG data.

Exhibit 4-4
SUBSTANTIATED CASES BY TYPE OF ALLEGATION AND ACTIONS TAKEN
(All Allegations Regardless of Category at Intake)
Fiscal Year 2008

TYPE OF ALLEGATION	INVESTIGATED BY				ACTIONS TAKEN AGAINST EMPLOYEE(S)[2]
	OIG	Agency	[1]DII	Total	
A-2 -Physical abuse with serious harm alleged	1	0	1	2	Discharge, Suspension, Written Reprimand, Counseling, Re-Training, Policy Change, Group Staff Training
A-3 -Physical abuse without serious harm alleged	70	0	7	77	Discharge, Resignation, Suspension, Written Reprimand, Oral Reprimand, Counseling, Reassignment, Re-Training, Administrative Change, Habilitation/Treatment Plan Change, Policy Change, Procedural Change, Group Staff Training
A-4 -Sexual abuse alleged	15	0	0	15	Discharge, Resignation, Suspension, Re-Training, Performance Evaluation Objective, Administrative Change, Group Staff Training
A-5 -Mental injury (verbal) alleged	30	14	0	44	Discharge, Resignation, Suspension, Reassignment, Written Reprimand, Oral Reprimand, Counseling, Supervision, Re-Training, Administrative Change, Group Staff Training, Habilitation/Treatment Plan Change, Policy Change, Structural Upgrade
A-6 -Mental injury (psychological) alleged	24	8	0	32	Discharge, Resignation, Suspension, Reassignment, Written Reprimand, Supervision, Re-Training, Counseling, Performance Evaluation Objective, Administrative Change, Group Staff Training
Total Abuse Cases	**140**	**22**	**8**	**170**	
N-2 -Neglect in any serious injury	12	0	1	13	Discharge, Resignation, Suspension, Supervision, Written Reprimand, Counseling, Re-Training, Administrative Change, Group Staff Training, Policy Change, Procedural Change
N-3 -Neglect in any non-serious injury	32	10	3	45	Discharge, Resignation, Suspension, Reassignment, Written Reprimand, Oral Reprimand, Re-Training, Administrative Change, Group Staff Training, Habilitation/Treatment Plan Change, Policy Change, Procedural Change
N-4 -Neglect in an individual's absence	4	0	0	4	Suspension, Oral Reprimand, Re-Training
N-5 -Neglect in sexual activity between residents	3	0	0	3	Suspension
N-7 -Neglect with risk of harm or injury	20	2	0	22	Discharge, Resignation, Suspension, Reassignment, Written Reprimand, Counseling, Re-Training, Supervision, Administrative Change, Group Staff Training, Habilitation/Treatment Plan Change, Policy Change, Procedural Change
Total Neglect Cases	**71**	**12**	**4**	**87**	
D-1 -Suicide in residential program (or after transfer)	0	0	1	1	Discharge, Resignation, Administrative Change, Policy Change, Procedural Change
D-4 - Death in residential program (not suicide or natural)	2	0	1	3	Discharge, Re-Training, Administrative Change, Group Staff Training, Policy Change
D-5 -Death not in residential program (not suicide or other)	1	0	0	1	Procedural Change
Total Death Cases	**3**	**0**	**2**	**5**	
Total Substantiated	**214**	**34**	**14**	**262**	

Note: [1] DII is the Division of Internal Investigation at the Illinois State Police.
[2] Each case may involve multiple employees or multiple actions against a single employee.

Source: OAG analysis of OIG data.

Exhibit 4-4 shows the type of allegation and the actions taken in the 262 substantiated cases closed in FY08. Appropriate administrative actions to be taken are left to the discretion of the facility or community agency management. Appendix C shows the number of cases closed and a substantiation rate by facility from FY06 through FY08.

OIG SUBSTANTIATED CASE WRITTEN RESPONSES

The Department of Human Services Act (20 ILCS 1305/1-17) requires the Inspector General to require a facility or community agency to submit a written response for all substantiated cases of abuse or neglect, or cases with other administrative issues. The statute states:

> *For cases where the allegation of abuse or neglect is substantiated, the Inspector General shall require the facility or agency to submit a written response. The written response from a facility or agency shall address in a concise and reasoned manner the actions that the agency or facility will take or has taken to protect the resident or patient from abuse or neglect, prevent reoccurrences, and eliminate problems identified and shall include implementation and completion dates for all such action (20 ILCS 1305/1-17 (b-5)).*

According to OIG directives, the facility or agency is directed to submit a written response to either the Division of Mental Health or Division of Developmental Disabilities for approval. Substantiated cases as well as those where OIG recommends administrative action are reported to the Secretary of the Department of Human Services. The Secretary has the authority to accept or reject the written response and establish how DHS will determine if the facility or agency followed the written response.

The OIG is required by the Department of Human Services Act to monitor compliance through a random review of completed corrective actions. The Inspector General is also required to review any implementation that takes more than 120 days. The OIG conducts monthly compliance reviews on a random 20 percent sample of approved written responses received. For the time period May 2007 through April 2008, DHS received a total of 652 written responses (480 from community agencies and 172 from State facilities). For the period May 2007 through April 2008, the OIG conducted reviews of 130 written responses (96 from community agencies and 34 from State facilities). The OIG conducted on-site reviews in 27 cases, phone interviews in 18 cases, and reviewed documentation for the remaining 85 cases. As a result of the reviews conducted, the OIG returned four written responses to their respective DHS divisions because of concerns with the division's approval of the planned actions.

Exhibit 4-5 shows that for FY07 and FY08, the number of reviews of written responses has been increasing. During our previous audit for FY06, the Office of Inspector General conducted compliance reviews of 73 written responses (44 community agency and 29 facility cases). The number of reviews has increased to 130 for FY08.

Exhibit 4-5
WRITTEN RESPONSE COMPLIANCE REVIEWS CONDUCTED
Fiscal Years 2006-2008

	FY06	FY07	FY08
Agency	44	75	96
Facility	29	34	34
Total	**73**	**109**	**130**

Source: OIG compliance review data.

DHS Approval of Written Responses Untimely

The Department of Human Services Act requires that each completed case where abuse or neglect is substantiated, or administrative action is recommended, contain a written response from the agency or facility that addresses the actions that will be taken. The Secretary of DHS is required by the Act to accept or reject the written response.

It is the policy of the OIG to obtain, track, review, and monitor written responses for substantiated cases and for unsubstantiated or unfounded cases with recommendations. The Act requires that the OIG monitor any written response that takes more than 120 days to implement. However, this can only begin after the respective DHS division has approved the written response.

In our review of 127 case files, we identified 15 files that did not contain the required written response. Even though it was not contained in the case file, we were able to obtain a copy of the written response from the OIG for all 15 files. In our review of written responses, we found that DHS takes an excessive amount of time to receive and approve the actions taken by the agency or facility in some cases. For one case in our sample, the written response from the agency was dated November 9, 2007 but was not approved by DHS for over nine months on August 29, 2008. In another case, the agency date on the written response was September 9, 2008 and the DHS approved date was also September 9, 2008. However, the case was completed in August 2007. We requested this information on August 22, 2008. Therefore, it took more than a year to receive the written response and for DHS to approve it from the date the case was completed and it was done only after auditors requested the information.

Overall there were 43 cases in our sample that required a written response. Of the 41 cases in our sample for which we could determine an investigative completion date and a response date, 6 of 41 (15%) took more than six months from the date the case was completed until the written response was approved by DHS. Two of these cases took more than a year. For two cases, we could not determine the date the case was completed.

According to OIG officials, the Developmental Disabilities Division at DHS had been falling behind in approvals partly due to staffing issues. During the later part of FY08 the

Division increased its efforts to approve written responses in timely manner. If DHS does not approve written responses in a timely manner, the OIG cannot effectively monitor the implementation of actions by State-operated facilities and community agencies. In addition, not ensuring that appropriate actions are taken may put client safety at risk.

DHS APPROVAL OF WRITTEN RESPONSES	
RECOMMENDATION 9	***The Department of Human Services should ensure that written responses from facilities and community agencies are received and approved in a timely manner.***
DEPARTMENT OF HUMAN SERVICES RESPONSE	Agree. Beginning July 2008, an improved process was established which has significantly reduced the number of past due written responses and will continue to result in more timely receipt and review of written responses from community agencies. The receipt of written responses is being tracked and monitored, weekly review meetings are held and bi-monthly reports are used to ensure prompt review of all responses received. Reminder notices are being sent to developmental disabilities service providers to remind them of the written response development and submission expectations.

APPEALS PROCESS IN SUBSTANTIATED CASES

After the investigative report review process is completed and the report has been accepted by the Inspector General, the facility or community agency is notified of the investigation results and finding. A notice of the finding is also sent to the complainant, the individual who was allegedly abused or neglected or his or her legal guardian, and the person alleged to have committed the offense. When the OIG substantiates a finding of abuse or neglect against an individual at a facility or community agency, there are several distinct levels of appeals that can be made. A substantiated finding can be appealed to the Inspector General for reconsideration; an appeal can also be made based on the actions taken; and finally, an appeal can be made to DHS that the finding does not warrant reporting to the Health Care Worker Registry.

Reconsideration or Clarification

The OIG directives and administrative rules (59 Ill. Adm. Code 50.60) establish a detailed reconsideration or clarification process that allows the notified parties 15 days to submit a reconsideration request. If the facility or community agency disagrees with the outcome of the investigation, they may either request that the Inspector General further explain the findings, or request the Inspector General to reconsider the findings based on additional information submitted by the community agency or facility. After a community agency or facility request for reconsideration or clarification is received, the Inspector General will notify the community agency or facility of the decision to either accept or deny the request. The reconsideration of a finding is the only appeal process where an OIG substantiated finding against a person can be changed.

According to data provided by the OIG, the OIG received at least one request for reconsideration or clarification in 82 cases for FY07 and 90 cases in FY08. In FY07, 12 of 82 (15%) and in FY08, 30 of 90 (33%) requests for reconsideration or clarification were granted by the OIG. In FY07, OIG revised the investigative report in 12 cases. In FY08, 25 investigative reports were revised as a result of a reconsideration or clarification request. Of the 37 investigative reports that were revised, 12 resulted in a changed finding. After the investigative report is sent, and if no response for reconsideration or clarification is submitted to the OIG, the case is closed after 30 days and the case is considered final.

Appeal of Action Taken

According to 59 Ill. Adm. Code 50.80, a person or community agency can appeal an administrative action taken against them, based on the finding of an OIG investigation. An appeal may be requested from a DHS administrative law judge. The purpose of the appeal is to review the type or severity of discipline or the administrative action taken against an employee. The request for the appeal hearing must be made no later than 30 calendar days after the action occurred. At the hearing, the community agency, facility or DHS will be required to prove that its action was fair and supported by a preponderance of credible evidence.

According to DHS officials, 73 appeals were filed during FY07 and FY08. Of the 73 appeals filed, 41 were dismissed due to the filing of the appeal before the OIG investigation was closed or other reasons, 5 were dismissed based on petitioners' failure to appear at the hearing, 1 was withdrawn by the petitioner, 20 hearings found in favor of the community agency, and 3 hearings found in favor of the petitioner.

HEALTH CARE WORKER REGISTRY

The Department of Public Health maintains the Health Care Worker Registry (formerly the Nurse Aide Registry). The Registry lists individuals with a background check conducted pursuant to the Health Care Worker Background Check Act (225 ILCS 46). It shows training information for certified nursing assistants and other health care workers. Additionally, it displays administrative findings of abuse, neglect or misappropriations of property.

The Health Care Worker Background Check Act applies to all unlicensed individuals employed or retained by a health care employer as home health care aides, nurse aides, personal care assistants, private duty nurse aides, day training personnel, or an individual working in any similar health-related occupation where he or she provides direct care (e.g., resident attendants, child care/habilitation aides/developmental disabilities aides, and psychiatric rehabilitation services aides) or has access to long-term care residents or the living quarters or financial, medical or personal records of long-term care residents. It also applies to all employees of licensed or certified long-term care facilities who have or may have contact with residents or access to the living quarters or the financial, medical or personal records of residents. Individuals with disqualifying convictions as listed in this act are generally prohibited from working in any of the above positions.

The Department of Human Services Act requires the OIG to report individuals with substantiated findings of physical or sexual abuse or egregious neglect to the Health Care Worker Registry. The purpose of the mandate is to ensure that there is a public record of such findings. Agencies and facilities must verify registry status before hiring an employee to look for prior findings of physical or sexual abuse or egregious neglect. These individuals are barred from working with people who have mental disabilities. IDPH has a waiver process, but it does not apply to OIG findings, which are administrative and have a separate hearing process.

Health Care Worker Registry Appeals

According to 59 Ill. Adm. Code 50.90, an employee may request a hearing with the Department of Human Services and present evidence supporting why his or her finding does not warrant reporting to the Health Care Worker Registry. The purpose of the hearing is to determine whether or not the adverse finding against an employee will be reported on the Registry. The hearing does not overturn the substantiated finding at the OIG. The hearing must be requested no later than 30 calendar days from receipt of notice.

The OIG made 66 referrals for substantiated cases to the Health Care Worker Registry in FY07 and 73 referrals in FY08. Of these 139 referrals, 7 (5%) were sent for substantiated egregious neglect while the other 132 were for substantiated physical or sexual abuse.

Exhibit 4-6 shows the number of appeals won and lost by petitioners for FY07 and FY08. In our review of Health Care Worker Registry appeals requested, 38 substantiated cases were appealed in FY07 and 29 cases were appealed in FY08.

Exhibit 4-6
HEALTH CARE WORKER REGISTRY APPEALS
Fiscal Years 2007 and 2008

	FY07	**FY08**[1]
Petitioner **Lost** Appeal (Referred to Registry)	18	15
Petitioner **Won** Appeal (Not Referred)	14	12
Stipulation Order (Not Referred)	4	2
Other Reason (Not Referred)	2	0
Total Decisions	**38**	**29**

Note:
[1] For FY08 there were also 10 cases in which the appeal was dismissed or the appeal or petition was withdrawn.

Source: OIG data summarized by OAG.

The percentage of cases appealed in which the Administrative Law Judge's (ALJ) decision upheld the referral of the employee to the Health Care Worker Registry has increased when compared to our previous audit. The ALJ decision was to refer the employee in 56 percent of the appeal hearings in FY08 (15 of 27) and 56 percent of those in FY07 (18 of 32), compared to 41 percent in FY06 (13 of 32) and 21 percent in FY05 (6 of 28).

Stipulated Motions to Dismiss Process

In September 2006, the OIG implemented a stipulation process for Health Care Worker Registry appeals hearings. This process is triggered by a Rule 50.90 (Health Care Worker Registry Appeal) petition on certain physical abuse cases that, although they meet the definition of physical abuse, may not be severe enough to deserve placement on the Registry. The OIG

created a directive to implement the new stipulated motions to dismiss process in February 2007. As is shown in Exhibit 4-6, the OIG chose not to refer a case to the Registry based on a stipulation order on six occasions in FY07 and FY08.

Review of Health Care Worker Registry Appeals Won

By rule, DHS is required, in the event an employee appeals an OIG substantiated finding, to demonstrate by a preponderance of the evidence that the finding warrants reporting to the Registry. Rule 50 defines preponderance of the evidence as proof sufficient to persuade the finder of fact that a proposition is more likely true than not true. A preponderance of the evidence is also the standard of evidence used by the OIG to substantiate an allegation of abuse or neglect.

According to the Mental Health and Developmental Disabilities Administrative Act (20 ILCS 1705/7.3), "…no facility, service agency, or support agency providing mental health or developmental disability services that is licensed, certified, operated, or funded by the Department shall employ a person, in any capacity, who is identified by the Health Care Worker Registry as having been subject of a substantiated finding of abuse or neglect of a services recipient."

We reviewed 10 substantiated cases eligible for referral to the Health Care Worker Registry that were rejected by the DHS ALJ in FY08. We also reviewed 10 cases in which the ALJ upheld the referral to the Health Care Worker Registry in FY08.

All of these cases were investigated by the OIG during our audit period (FY07 or FY08). In the 10 referrals that were rejected, the ALJ found that the Department had not demonstrated by a preponderance of the evidence that the finding of abuse against the petitioner warranted reporting to the Registry. In the 10 referrals presented in Exhibit 4-7, the ALJ also concluded that the evidence presented at the hearing was conflicting or insufficient to determine that the Petitioner committed the act. In one case, the ALJ found the OIG investigation was unreliable. The OIG investigator in the case had been placed on leave and is no longer with the OIG. In another case, the ALJ stated that the petitioner's actions were extremely inappropriate but did not rise to the level of reporting to the Health Care Worker Registry.

Several cases we reviewed cited that witnesses were not credible. We developed questions for the OIG based on our review of these 10 cases. The OIG's responses show that there are challenges to OIG prevailing at these hearing. According to the OIG:

- The testimonial evidence that OIG obtains during its investigations is very fragile as the hearing process can be and often is a very long process and over time; witnesses' memories fade or change. The ability of individuals with disabilities to testify upwards of one year after an incident is problematic and can compromise OIG's case at the hearing.

Exhibit 4-7
SUMMARY OF DHS ADMINISTRATIVE LAW JUDGE'S FY08 RULINGS ON PETITIONER'S NURSE AIDE REGISTRY APPEALS WON BY PETITIONER
For Cases Investigated during FY07 or FY08

1	Administrative Law Judge's Ruling: The three people who accused Petitioner of abuse have been the subject of complaints from other staff for their unkind behavior and at least one of them has made false accusations against other staff in the past. The Department's witnesses were not sufficiently credible to outweigh the evidence that the Petitioner acted appropriately.
2	Administrative Law Judge's Ruling: Petitioner had worked twenty hours and was scheduled to work another ten. He was required to complete a task that most likely should have been completed by two R.N.s. No evidence was presented that Petitioner did not do the very best he could in a situation in which he should not have been placed.
3	Administrative Law Judge's Ruling: The Department's witnesses were not credible. An R.N.'s physical examination of the alleged victim on the date of the alleged incident revealed no injury.
4	Administrative Law Judge's Ruling: The Department's witness was subpoenaed to appear and testify but failed to appear at the hearing. Without the witnesses' testimony and identification of Petitioner as the person in charge of the restrained patient, it is impossible to conclude that the incident happened.
5	Administrative Law Judge's Ruling: Although Petitioner's actions were extremely inappropriate, the Department failed to demonstrate that they warrant placement on the Health Care Worker Registry.
6	Administrative Law Judge's Ruling: Although Petitioner engaged in what the OIG has termed "dragging," and it is recognized that this is not an acceptable technique, no alternative was suggested by anyone at the hearing, nor was it suggested that petitioner should have done nothing.
7	Administrative Law Judge's Ruling: The hearsay versions of events from recipients do not entirely agree with each other or with the hearsay version told by the alleged victim. Further, they do not agree with the nearly uniform evidence presented by nursing notes, the Petitioner's testimony, and the testimony of two staff eyewitnesses.
8	Administrative Law Judge's Ruling: Petitioner was required to balance many competing claims for her attention on the morning of the incident, and according to testimony she did not breach the standard of care expected of her by her own supervisors. No evidence was presented that Petitioner committed any deliberate act that contributed to the death, or even that Petitioner's absence in the home resulted in the death.
9	Administrative Law Judge's Ruling: The OIG report in this matter was unreliable. The OIG investigator who completed the investigation had been placed on administrative leave.
10	Administrative Law Judge's Ruling: The investigation appears to have been tainted from the beginning by a staff member who interviewed the alleged victims herself. Facts uncovered during the investigation were confusing and conflicting. No date was ever established for the alleged incident, no injury was ever observed, and no concrete evidence was presented to support the Department's hearsay case.

Source: OAG summary of DHS Administrative Law Judge Rulings.

- The victims in OIG's cases often have compromised memories due to their disabilities and medications they are taking.

- Even when a victim remembers the incident, the victim must testify in front of the abuser and consequently, may be unable to adequately communicate what happened.

In the previous audit, we recommended that the OIG review ALJ opinions to determine whether changes to the investigative process are warranted. According to OIG officials, they have been reviewing all of the ALJ decisions since FY05 and no problems have been found with the investigations process.

We also recommended that the OIG make appropriate revisions to its administrative rules, policies and procedures (which may include revising the definition of egregious) to ensure that all cases with findings that warrant reporting to the Registry are reported. Cases of substantiated neglect do not get referred to the Health Care Worker Registry unless the OIG deems the neglect as egregious. Although the OIG has not updated the definition of egregious, the OIG directives have been updated and, as was discussed earlier in this section, a process was added for a stipulated motion to dismiss. The OIG also conducted internal training for testifying at court hearings in March and April 2007.

SANCTIONS

The Department of Human Services Act gives the Inspector General the authority to recommend sanctions:

> *(d) Sanctions. The Inspector General may recommend to the Departments of Public Health and Human Services sanctions to be imposed against mental health and developmental disabilities facilities under the jurisdiction of the Department of Human Services for the protection of residents, including appointment of on-site monitors or receivers, transfer or relocation of residents, and closure of units. The Inspector General may seek the assistance of the Attorney General or any of the several State's Attorneys in imposing such sanctions. Whenever the Inspector General issues any recommendations to the Secretary of Human Services, the Secretary shall provide a written response (20 ILCS 1305/1-17(d)).*

In December 2002, the Inspector General developed a directive that specifies criteria regarding when to recommend sanctions against mental health and developmental disability facilities. The directive includes procedures the OIG is to follow when imposing sanctions against an entity under the jurisdiction of the OIG. These procedures state that:

The Inspector General shall utilize the following criteria to make determinations about when to recommend sanctions to the Illinois Department of Public Health (IDPH) and/or the Department of Human Services (DHS):

1.) A determination of imminent risk to the well being of the individual(s);
2.) A community agency or a State-Operated facility has repeatedly failed to respond to recommendations made by the Inspector General;
3.) A community agency or a State-Operated facility has failed to cooperate with an investigation; or
4.) Other instances deemed necessary by the Inspector General.

State-Operated Facilities

During FY07, two State-operated facilities failed to comply with requirements to remain certified as eligible Medicare or Medicaid service providers. As a result, Tinley Park Mental Health Center's (Tinley) Medicare provider agreement was terminated effective February 23, 2007 and Howe Developmental Center (Howe) was terminated from the program effective March 8, 2007. Failure to maintain eligible Medicare and Medicaid status not only results in lost revenue to the State, but is indicative of a diminished level of care for residents of these facilities.

We reviewed the recent surveys conducted of Tinley and Howe. The termination letter for Tinley revealed that in August of 2006 a survey conducted by federal surveyors *"identified an immediate jeopardy to the health and safety of the patients."* In addition, the hospital did not meet the Special Medical Record Requirements for Psychiatric Hospitals. Although Tinley took steps to remove the immediate jeopardy, it remained out of compliance with the medical records requirements during two subsequent reviews in October 2006 and January 2007. In the January 2007 survey, Tinley was cited specifically for failure to have an interpreter during the psychiatric evaluation process which resulted in insufficient information to justify the conclusion that patients were not at risk of harm to themselves or others. Consequently, Tinley was terminated from participation in the Medicare program.

For Howe Developmental Center, the Illinois Department of Public Health notified the Center on March 15, 2007 of the Center's immediate termination as a Medicaid provider. We reviewed the March 14, 2007 survey conducted at Howe and found that it was out of compliance with two conditions of participation, including client protection. The condition of client protection is not met when:

- Individuals have been abused, neglected, or otherwise mistreated and the facility has not taken steps to protect individuals and prevent reoccurrence;
- Individuals are subject to the use of drugs or restraints without justification; or
- Individual freedoms are denied or restricted without justification.

Even though these two State-operated facilities were terminated from participation in federal programs for non-compliance with issues related to patient safety and client protection, the OIG did not recommend a sanction against either facility. Over the past 15 years (1994 – 2008), the Inspector General has not recommended sanctions against a State-operated facility.

According to OIG officials no sanctions were recommended because the reviewers use federal regulations, but OIG must follow State law. According to OIG officials, none of the issues cited by the reviewers at Tinley Park MHC were reportable to OIG under current State law. Some issues cited by the reviewers at Howe DC did meet the State law's definitions, but

OIG identified no trends or patterns in those beyond what has been typical of other facility or agency programs. According to OIG officials, the OIG cannot recommend sanctions without identifying a pattern of uncorrected problems with abuse/neglect as defined in current law.

Community Agencies

On June 9, 2008, the OIG did utilize its authority under 20 ILCS 1305/1-17(d) to recommend sanctions and sent letters to the DHS Division of Mental Health and to the DHS Division of Developmental Disabilities related to community agencies that had not updated their abuse/neglect reporting policies. The OIG recommended a total of nine service providers for non-renewal of their DHS service provider agreement until the policies are approved by OIG.

Chapter Five

OTHER ISSUES

CHAPTER CONCLUSIONS

The Quality Care Board held all required quarterly meetings during FY07-08. This is a significant improvement from the previous audit. The Board continues to have difficulty maintaining seven members as required by statute. During part of FY07 (September 2006-April 2007), the Board had seven members as required; however, in April 2007, one of the Board members resigned. This left the Board with six members near the end of FY07 and all of FY08. As of June 2008, a successor had still not been appointed to fill the vacancy.

During FY07 and FY08, the Office of the Inspector General (OIG) conducted annual unannounced site visits at all of the mental health and developmental centers as required by statute (20 ILCS 1305/1-17(f)). Also, during FY07 and FY08, the OIG met its established timeline for submitting site visit reports to facility directors or hospital administrators. This is an improvement since the last audit.

DHS could not document that all staff at State-operated facilities received the required Rule 50 training. In addition, the OIG identified two facilities that were deficient in training staff during its FY08 site visits. The OIG site visit for Howe Developmental Center reported that only 504 of the facility's 835 (60%) employees had been trained in OIG Rule 50 during the last year, and the OIG site visit for Tinley Park Mental Health Center reported that only 172 of the facility's 207 (83%) employees had been trained in OIG Rule 50. The OIG recommended to Howe and Tinley Park that the facility should ensure that all staff, contractual workers, and volunteers received OIG Rule 50 training at least biennially. For Tinley Park, it was the third year that the recommendation for training staff had been repeated.

QUALITY CARE BOARD

During FY07 and FY08, the Quality Care Board (Board) met statutory requirements for meeting quarterly. During part of FY07 (September 2006-April 2007), the Board had seven members as required by statute. However, in April 2007, one of the Board members resigned leaving the Board with six members near the end of FY07 and all of FY08. As of June 2008, a successor had still not been appointed to fill the vacancy.

The Board's effort to meet quarterly is an improvement since the last audit. During the last audit, the Board did not meet at all during FY05, and it did not meet in the first quarter of FY06. The Board did meet twice in the second quarter, and had meetings in each of the other quarters, but the last meeting failed to have a quorum. The Board continues to have difficulty maintaining seven members as required by statute. During the last audit, the Board had five

members and two vacancies, and it did not fulfill membership requirements until after the audit period in September 2006.

Fulfillment of Statutory Requirements

Public Act 95-545 amended the Department of Human Services Act (20 ILCS 1305) and the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30) transferring all provisions concerning the OIG from the Abused and Neglected Long Term Care Facility Residents Reporting Act to the Department of Human Services Act. This became effective on August 28, 2007. Section 1-17(h) of the Department of Human Services Act establishes a Quality Care Board within the Department of Human Services' Office of the Inspector General. One of the requirements of the Board is to meet quarterly. Another requirement is for the Board to be comprised of seven members who are appointed by the Governor with the advice and consent of the Senate. Four Board members constitute a quorum. Although provisions concerning the OIG were transferred from one Act to another, all requirements pertaining to the Board remained the same.

During FY07 and FY08, the Board met quarterly as required by statute. In FY07, Board meetings were held in August 2006, October 2006, January 2007, and April 2007. In FY08, meetings were held in August 2007, October 2007, January 2008, and April 2008. Also, in each fiscal year all of the meetings had at least four or more Board members in attendance. This is an improvement since the last audit. During the last audit, the Board did not meet at all during FY05, and it did not meet in the first quarter of FY06. However, the Board did meet twice in the second quarter, and had meetings in each of the other quarters of the fiscal year, but the last meeting failed to have a quorum.

The Board continues to have difficulty maintaining seven members as required by statute. During part of FY07 (September 2006-April 2007), the Board had seven members as required; however, in April 2007, one of the Board members resigned. This left the Board with six members near the end of FY07 and all of FY08. Statutory requirements regarding Board membership mention that in the case of a vacancy of any member, the Governor shall appoint a successor for the remainder of the unexpired term. At the end of the audit period, June 30, 2008, a successor had still not been appointed to fill the vacancy.

SITE VISITS

During FY07 and FY08, the OIG conducted annual unannounced site visits at all of the mental health and developmental centers as required by statute (20 ILCS 1305/1-17(f)). Also, during FY07 and FY08, the OIG met its established timeline for submitting site visit reports to facility directors or hospital administrators. This is an improvement since the last audit. During the last audit, the OIG did not always comply with its established timeline for submitting site visit reports. In FY06, 6 of the 18 (33%) mental health and developmental centers received a site visit report after the 60-working day timeline. In FY05, 10 of the 18 (56%) centers received a site visit report after the timeline. According to the OIG directives, site visit reports should be submitted to facility directors or hospital administrators within 60 days of the completion of the site visit.

The OIG provided us with documentation regarding FY07 and FY08 site visits. This included site visit reports, site visit status reports, and site visit guidelines. As part of the site visit guidelines, the OIG has a directive for unannounced site visits that became effective in May 2002, which was revised in April and November 2003 and August 2005. In addition, the OIG developed a site visit plan for FY07 site visits in spring 2006 that was finalized in June 2006. OIG also developed a plan for FY08 site visits in spring 2007 that was finalized in June of the same year. The directive and site visit plans provide procedures for site visitors to follow while conducting site visits.

The OIG staff from the Bureau of Compliance and Evaluation (compliance reviewer) and from Clinical Coordination (registered nurse) were responsible for conducting site visits. Also, the OIG hired a registered nurse to work on contract to assist in conducting site visits during FY08. Site visits generally lasted 2-3 days. Based on a review of the site visit reports, the site visitors appeared to have effectively applied procedures as outlined in the plans and directive. The site visit reports appeared to focus on relevant issues and provided useful information to the mental health and developmental centers.

The OIG unannounced site visit process for FY07 and FY08 included focused reviews of particular issues. All of the site visit reports noted each of the issues, what the site visitors reviewed to address the issues, and the site visitors' findings and recommendations related to the issues. During FY07, site visitors reviewed a sample of the facility's progress notes to evaluate legibility, frequency, thoroughness, and appropriateness. They reviewed nursing assessments and external consultations to determine if issues and recommendations were reflected in treatment/habilitation plans. They also reviewed policies and procedures on ensuring continuity of care, and on training relative to security and medical emergencies. In addition, site visitors reviewed the facility's reportable and non-reportable incident response, such as its handling of complaints called into the OIG's Hotline, and its curriculum for proper reporting and handling of evidence, including verifying that facility staff who do respond are adequately trained. Further, site visitors reviewed the facility's patient safety initiative. Site visitors also reviewed recommendations from the previous site visit to check for compliance.

During FY08, site visitors followed up on recommendations and issues that were reviewed in FY07, and they conducted focused reviews of new issues. As part of any needed follow-up, site visitors continued to review progress notes, clinical assessments, continuity of care, and patient safety initiatives, as well as the facility's responses to emergencies and reportable and non-reportable incidents and injuries. In addition, site visitors reviewed five new issues at facilities: suicide risk assessments, special needs, medication administration, weight monitoring, and the sex offender directive. For example, they reviewed the facility's policies on suicide risk assessment and its follow-up documentation of those individuals at high risk. Site visitors reviewed how facility staff met certain individuals' special needs, and they observed medication passes to ensure medication was administered properly. Site visitors also reviewed the facility's policies and procedures on weight monitoring; and they determined whether mental health centers had policies and procedures related to sex offenders, and whether the new sex offender directive had been implemented at developmental centers.

TRAINING

DHS could not document that all staff at State-operated facilities received the required Rule 50 training. The Department of Human Services Act (20 ILCS 1305/1-17 (e)) states that "the Inspector General shall establish and conduct periodic training programs for Department of Human Services employees and community agency employees concerning the prevention and reporting of neglect and abuse." The OIG provides State-operated facilities and community agencies with Rule 50 training materials such as a self running module or training CD and the agency or facility provides the training for its employees. Employees at community agencies and State facilities are required to have Rule 50 training biennially.

We requested information from DHS regarding whether all staff at State-operated facilities had received Rule 50 Training. On July 28, 2008, we received information from DHS that showed that only management staff was being trained at three facilities (Jacksonville Developmental Center, Murray Developmental Center, and Shapiro Developmental Center). During the audit exit process, DHS provided additional information for these three facilities regarding abuse and neglect training that had been conducted. While the information provided showed that additional staff was trained, we were unable to determine whether all staff were being trained in abuse and neglect. For instance, information provided for the Murray Developmental Center showed that 122 staff received training in reporting abuse and neglect between February 7, 2007 and May 14, 2008. However, information previously provided by DHS showed that during FY08 there was a total average headcount at Murray Developmental Center of 550 employees. Therefore, the training information provided only accounted for approximately 22 percent of staff. In addition, some lists of employees that were trained included duplicates or were outside the audit period.

In addition, the OIG identified two other facilities that were deficient in training staff during its FY08 site visits. The OIG site visit for Howe Developmental Center reported that only 504 of the facility's 835 (60%) employees had been trained in OIG Rule 50 during the last year, and the OIG site visit for Tinley Park Mental Health Center reported that only 172 of the facility's 207 (83%) employees had been trained in OIG Rule 50. The OIG recommended to Howe and Tinley Park that the facility should ensure that all staff, contractual workers, and volunteers received OIG Rule 50 training at least biennially. For Tinley Park, it was the third year that the recommendation for training staff had been repeated.

The statute does not require the OIG to monitor compliance with training; it only requires that they establish and conduct training concerning prevention and reporting of abuse and neglect. According to OIG officials, the amount of resources that it would take to monitor compliance with Rule 50 training at the more than 350 community agencies would be prohibitive. However, beginning in FY09, training is now mandated through agency contractual agreements with DHS; the DHS divisions of Mental Health and Developmental Disabilities along with the Bureau of Accreditation, Licensure, and Certification are responsible for ensuring compliance with contractual agreements. For the State-operated facilities, the DHS DD division and the DHS MH division monitor training.

Not ensuring that employees at community agencies and state-operated facilities are trained in the prevention and reporting of abuse and neglect endangers the safety of individuals served. If employees do not receive the required training, they may not be able to properly identify what constitutes abuse and neglect or how to report it. As a result, abuse and neglect may go unreported.

RULE 50 TRAINING	
RECOMMENDATION 10	***The Department of Human Service should ensure that all staff are consistently trained in abuse and neglect and at least once biennially and should maintain adequate documentation to show that the training has been conducted.***
DEPARTMENT OF HUMAN SERVICES RESPONSE	Agree. Developmental Disabilities staff are trained in abuse and neglect at least once biennially; however, at the time of this audit there was no system in place to track compliance from a central location. A new tracking system will be established by State Operated Developmental Center (SODC) Operations to ensure compliance with the OAG recommendation. The Bureau of Quality Management will also issue a notice to all community developmental disabilities providers reminding them of their responsibility to conduct training at least biennially. The Bureau of Quality Management will sample providers, in person and via paper audits, to verify that training in the reporting of abuse and neglect has been completed.

APPENDICES

APPENDIX A
(20 ILCS 1305/1-17)

Appendix A

ILLINOIS COMPILED STATUTES
20 ILCS 1305
DEPARTMENT OF HUMAN SERVICES ACT

Sec. 1-17(m) Program audit . The Auditor General shall conduct a biennial program audit of the Office of the Inspector General in relation to the Inspector General's compliance with this Act. The audit shall specifically include the Inspector General's effectiveness in investigating reports of alleged neglect or abuse of residents in any facility operated by the Department of Human Services and in making recommendations for sanctions to the Departments of Human Services and Public Health. The Auditor General shall conduct the program audit according to the provisions of the Illinois State Auditing Act and shall report its findings to the General Assembly no later than January 1 of each odd-numbered year.

(Source: P.A. 95-545, eff. 8-28-07.)

APPENDIX B

Sampling & Analytical Methodology

Appendix B

SAMPLING & ANALYTICAL METHODOLOGY

The Department of Human Services Act (Act) directs the Auditor General to conduct a biennial program audit of the Department of Human Services, Office of the Inspector General (OIG). The Act specifically requires the audit to include the Inspector General's effectiveness in investigating reports of alleged neglect or abuse of residents in any facility operated, licensed, certified, or funded by the Department of Human Services (DHS) and in making any recommendations for sanctions to DHS and to the Department of Public Health. Detailed audit objectives include:

- Following up on previous recommendations;
- Reviewing the OIG's organizational structure including its mission, strategic plans, vision, and goals;
- Analyzing investigative data to determine the number of allegations reported, timeliness of investigations, and substantiation rates for allegations;
- Testing investigative files to determine the adequacy of investigations; and
- Reviewing several compliance issues including investigator training, conducting site visits and Quality Care Board meetings.

We interviewed representatives and obtained information and documentation from the Inspector General's Office, the Department of Human Services, the Department of Public Health, Department of State Police, and the Department of Children and Family Services. We analyzed OIG's electronic database from fiscal years 2007 and 2008. We examined the current OIG organizational structure, policies and procedures, investigations process, case review process, documentation requirements and changes to directives. We reviewed backgrounds of investigators hired since our last OIG audit and reviewed investigators' training records.

We assessed risk by reviewing recommendations from previous OIG audits, OIG internal documents, policies and procedures, management controls, and the OIG's administrative rules. We reviewed management controls relating to the audit objectives that are identified in section 1-17(m) of the Department of Human Services Act (20 ILCS 1305)(see Appendix A). This audit identified some weaknesses in those controls, which are included as recommendations in this report.

In conducting the audit, we reviewed applicable State statutes, administrative rules, and OIG policies. We reviewed compliance with these laws, rules, and policies to the extent necessary to meet the audit's objectives. Any instances of non-compliance we identified are noted as recommendations in this report.

Testing and Analytical Procedures

Initial work began on this audit in February 2008 and fieldwork was concluded in September 2008. In order to test case files for thoroughness of investigation methods, we selected a sample of cases closed in FY08. Using a data collection instrument, we gathered certain information from case files and developed a database of sample information to analyze. That information included verification of data from the OIG electronic system. Our sample was chosen from the universe of cases closed in FY08. We took a systematic random sample of 127 cases with a confidence level of at least 90 percent and an acceptable error rate of 10 percent. Our random sample was stratified into the two following case classifications:

- Cases investigated by OIG at State-operated facilities (including death cases),
- Cases investigated by OIG or the community agency occurring at the community agencies.

We also performed analyses of timeliness and thoroughness based on an electronic database of OIG reported cases from fiscal years 2007 and 2008 and did comparisons of similar data from prior OIG audits. The validity of electronic data was verified as part of our case file testing described above.

APPENDIX C

Rate of Substantiated Abuse or Neglect Cases by Facility

FY06 through FY08

Appendix C
RATE OF SUBSTANTIATED ABUSE OR NEGLECT CASES BY FACILITY
(Includes Allegations Categorized as Abuse, Neglect or Death at Intake)
FY06, FY07, and FY08

	Fiscal Year 2006			Fiscal Year 2007			Fiscal Year 2008		
Facility	Number Closed	Number Substantiated by OIG	Substantiation Rate	Number Closed	Number Substantiated by OIG	Substantiation Rate	Number Closed	Number Substantiated by OIG	Substantiation Rate
Alton	103	4	4%	73	1	1%	97	5	5%
Chester	107	1	1%	134	4	3%	147	2	1%
Chicago-Read	28	0	0%	28	0	0%	18	2	11%
Choate	201	6	3%	132	4	3%	112	3	3%
Elgin	27	1	4%	66	4	6%	55	3	5%
Fox	7	1	14%	8	2	25%	7	3	43%
Howe	79	4	5%	149	6	4%	73	6	8%
Jacksonville	104	6	6%	120	3	3%	102	8	8%
Kiley	47	11	23%	48	7	15%	35	2	6%
Ludeman	22	1	5%	28	2	7%	30	4	13%
Mabley	12	1	8%	24	3	13%	12	0	0%
Madden	15	0	0%	23	2	9%	34	0	0%
McFarland	33	2	6%	21	2	10%	27	3	11%
Murray	27	7	26%	26	6	23%	19	3	16%
Shapiro	58	10	17%	43	6	14%	39	4	10%
Singer	45	3	7%	42	5	12%	12	2	17%
Tinley Park	6	0	0%	18	1	6%	6	0	0%
Community Agencies [1]	878	154	18%	1,102	178	16%	1,282	212	17%
Totals	**1,799**	**212**	**12%**	**2,085**	**236**	**11%**	**2,107**	**262**	**12%**

[1] Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

APPENDIX D

Allegations by Facility
FY06 through FY08

CATEGORIES FOR ALLEGATIONS AND OTHER INCIDENTS

Allegations of **Abuse**

A1 -- Physical abuse with imminent danger alleged

A2 -- Physical abuse with serious harm alleged

A3 -- Physical abuse without serious harm alleged

A4 -- Sexual abuse alleged

A5 -- Mental injury (verbal) alleged

A6 -- Mental injury (psychological) alleged

Allegations of **Neglect**

N1 -- Neglect with imminent danger alleged

N2 -- Neglect in any serious injury

N3 -- Neglect in any non-serious injury

N4 -- Neglect in an individual's absence

N5 -- Neglect in sexual activity between recipients

N7 -- Neglect with risk of harm or injury

Recipient **Deaths**

D1 -- Suicide in residential program (or after transfer)

D2 -- Suicide within 14 days after discharge

D4 -- Death in residential program (not suicide or natural)

D5 -- Death not in residential program (not suicide or natural)

D6 -- Death by natural causes in a program (or after transfer)

D7 -- Death - any other reportable death

Appendix D
ALLEGATIONS BY FACILITY
FY06 through FY08

Location	Abuse Allegations								
	A1 physical abuse - imminent danger			A2 physical abuse - serious injury			A3 other physical abuse		
	FY06	FY07	FY08	FY06	FY07	FY08	FY06	FY07	FY08
DD Facilities									
Fox	0	0	0	0	0	0	2	1	2
Howe	0	0	0	1	3	2	57	52	43
Jacksonville	0	0	0	2	2	0	92	79	61
Kiley	0	0	0	1	0	0	20	34	20
Ludeman	0	0	0	0	0	0	16	22	12
Mabley	0	0	1	0	0	0	6	10	13
Murray	0	0	0	0	0	0	24	12	13
Shapiro	0	0	0	1	1	0	37	27	28
MH Facilities									
Alton	0	0	1	0	1	0	39	41	51
Chester	0	0	0	1	2	4	92	98	104
Chicago-Read	0	0	0	1	0	0	12	14	6
Elgin	0	0	0	0	1	0	15	14	13
Madden	0	0	0	0	0	0	8	8	18
McFarland	0	0	0	0	0	0	21	10	19
Singer	0	0	0	1	0	0	18	14	7
Tinley Park	0	0	0	0	0	0	8	2	7
Dual Facility									
Choate	0	0	0	1	2	0	130	91	68
Community Agencies [1]	0	1	3	6	4	9	418	488	593
Totals	**0**	**1**	**5**	**15**	**16**	**15**	**1,015**	**1,017**	**1,078**

[1] Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

Appendix D
ALLEGATIONS BY FACILITY
FY06 through FY08

Abuse Allegations								
A4 sexual abuse			**A5 verbal abuse**			**A6 psychological abuse**		
FY06	**FY07**	**FY08**	**FY06**	**FY07**	**FY08**	**FY06**	**FY07**	**FY08**
0	0	0	0	0	0	0	0	0
0	0	4	16	14	10	15	12	2
4	2	4	7	8	7	4	5	11
2	1	0	0	3	1	2	1	1
0	3	0	1	2	1	1	0	1
0	1	0	0	0	1	1	1	0
0	0	0	0	2	0	0	1	2
0	0	0	2	2	2	6	0	4
9	6	6	27	8	12	16	5	26
1	5	7	6	15	16	10	11	14
4	2	1	2	3	2	2	4	2
5	24	4	6	7	3	7	4	7
0	3	2	4	6	5	2	4	4
3	0	5	3	5	6	1	1	6
4	3	1	7	2	0	7	3	3
0	0	0	2	2	3	1	2	2
6	5	2	5	13	7	12	20	10
59	74	79	83	111	131	100	94	116
97	**129**	**115**	**171**	**203**	**207**	**187**	**168**	**211**

Appendix D
ALLEGATIONS BY FACILITY
FY06 through FY08

Location	Neglect Allegations								
	N1 neglect- imminent danger			N2 neglect- serious injury			N3 neglect- non-serious injury		
	FY06	FY07	FY08	FY06	FY07	FY08	FY06	FY07	FY08
DD Facilities									
Fox	0	0	0	0	1	0	4	1	1
Howe	0	0	0	3	6	5	7	10	2
Jacksonville	0	0	0	1	0	1	10	5	4
Kiley	0	0	0	6	0	1	4	5	0
Ludeman	0	0	0	2	1	0	2	1	1
Mabley	0	0	0	0	1	0	5	1	0
Murray	0	0	0	1	0	1	2	1	1
Shapiro	0	0	0	2	2	0	0	0	0
MH Facilities									
Alton	0	0	0	1	0	3	0	5	5
Chester	0	0	0	2	2	6	0	2	5
Chicago-Read	0	0	0	2	2	0	3	0	2
Elgin	0	1	0	0	4	2	1	8	2
Madden	0	0	0	0	1	0	0	1	1
McFarland	0	0	0	0	0	0	1	2	0
Singer	0	0	0	0	0	0	4	2	1
Tinley Park	0	0	0	0	0	0	3	4	0
Dual Facility									
Choate	0	0	0	1	3	0	6	6	2
Community Agencies [1]	3	1	2	44	34	41	123	171	119
Totals	**3**	**2**	**2**	**65**	**57**	**60**	**175**	**225**	**146**

[1] Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

Appendix D
ALLEGATIONS BY FACILITY
FY06 through FY08

Neglect Allegations

N4 neglect in individual absence			**N5 neglect in recipient sexual activity**			**N7 neglect with risk of harm or injury**		
FY06	**FY07**	**FY08**	**FY06**	**FY07**	**FY08**	**FY06**	**FY07**	**FY08**
0	0	0	0	0	0	0	1	2
0	0	1	0	0	1	5	2	10
1	1	1	0	0	0	2	1	3
0	1	0	0	0	0	5	0	1
0	0	0	0	0	0	0	2	2
0	0	0	0	0	0	2	0	0
0	0	0	0	0	0	0	1	0
0	0	0	0	0	0	1	1	0
0	0	0	0	0	1	1	1	1
0	0	0	0	0	1	1	1	4
1	0	1	0	0	1	1	2	1
0	0	1	0	0	0	1	5	7
0	0	0	1	1	1	2	3	1
0	0	0	0	0	2	0	0	0
0	0	0	2	0	1	0	1	0
0	0	0	0	0	0	1	0	2
1	0	0	0	0	1	1	2	5
2	1	5	4	9	11	51	56	118
5	**3**	**9**	**7**	**10**	**20**	**74**	**79**	**157**

Appendix D
ALLEGATIONS BY FACILITY
FY06 through FY08

Location	Death Allegations								
	D1 suicide in program			**D2 suicide within 14 days after discharge**			**D4 death in residential program**		
	FY06	**FY07**	**FY08**	**FY06**	**FY07**	**FY08**	**FY06**	**FY07**	**FY08**
DD Facilities									
Fox	0	0	0	0	0	0	2	1	1
Howe	0	0	0	0	0	0	2	2	2
Jacksonville	0	0	0	0	0	0	0	0	3
Kiley	0	0	0	0	0	0	0	0	1
Ludeman	0	0	0	0	0	0	1	0	0
Mabley	0	0	0	0	0	0	1	0	0
Murray	0	0	0	0	0	0	2	0	1
Shapiro	0	0	0	0	0	0	3	1	2
MH Facilities									
Alton	0	0	0	0	0	0	0	0	0
Chester	0	0	0	0	0	0	0	0	0
Chicago-Read	0	1	1	1	0	0	0	0	0
Elgin	0	1	0	0	0	0	1	0	2
Madden	1	0	0	0	0	0	0	0	0
McFarland	0	0	0	0	0	0	0	0	0
Singer	0	0	0	0	0	0	0	0	0
Tinley Park	0	0	0	0	1	1	0	0	0
Dual Facility									
Choate	0	0	0	0	0	0	0	1	0
Community Agencies [1]	1	2	0	0	0	0	35	33	45
Totals	**2**	**4**	**1**	**1**	**1**	**1**	**47**	**38**	**57**

[1] Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

Appendix D
ALLEGATIONS BY FACILITY
FY06 through FY08

Death Allegations

D5 death not in residential program			**D6 death due to natural causes in a program**			**D7 any other reportable deaths**		
FY06	**FY07**	**FY08**	**FY06**	**FY07**	**FY08**	**FY06**	**FY07**	**FY08**
0	1	0	0	1	1	0	0	0
2	1	1	4	1	3	1	0	2
0	0	1	1	5	1	0	0	0
0	2	0	1	0	0	0	0	0
3	0	0	1	2	0	0	0	0
0	0	0	0	0	0	0	1	0
1	1	1	2	0	0	0	2	1
2	2	1	6	3	1	0	2	1
0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	2	1	0
0	0	1	0	0	0	0	1	1
0	0	0	1	1	2	1	0	1
0	0	0	0	0	0	1	0	0
0	0	0	1	0	0	1	2	0
2	2	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	2
1	0	0	2	1	0	0	0	0
20	18	15	42	25	38	7	19	11
31	**27**	**20**	**61**	**39**	**46**	**13**	**28**	**19**

APPENDIX E

Agency Responses

Rod R. Blagojevich, *Governor*

Illinois Department of Human Services

Carol L. Adams, Ph.D., *Secretary*

Office of the Inspector General
100 West Randolph Street, Suite 4-750
Chicago, Illinois 60601

November 25, 2008

William G. Holland
Illinois Auditor General
Iles Park Plaza
740 East Ash St.
Springfield, Il 62703-3154

Dear Auditor General Holland:

Thank you for the opportunity to respond to the recommendations in your draft report of your program audit report of this office in our ongoing efforts to investigate and prevent the abuse and neglect of individuals in Illinois receiving mental health and developmental disability services.

We are pleased that the report recognizes the substantial steps that this office has taken to address the recommendations from the previous audit and to deal with the continuing increase in allegations in the face of the serious fiscal constraints facing the State and this office. We also appreciate the work of Audit Manager Michael Paoni and his staff in understanding and presenting the information.

Responses to your recommendations addressing the Office of the Inspector General are attached. I will also forward a copy of the letter and responses via email in MS Word format. If you have any questions about the responses, please feel free to contact me at (312) 814-2718.

Sincerely,

William M. Davis
Inspector General

cc: Carol L. Adams, PhD, DHS Secretary
Solomon Oriaikhi, Director, DHS Fiscal Services

Responses to the Program Audit Recommendations Addressing OIG

Recommendation 1
The Office of the Inspector General should continue to consider adding serious injuries to its investigative database.

OIG's Response
OIG agrees in part. Rule 50 requires reporting of serious injuries when they are alleged or suspected to have resulted from abuse or neglect by staff. These serious injuries are already being added to our investigative database. Requiring agencies and facilities to report even accidental serious injuries to OIG would require a change in the statute.

Recommendation 2
The Office of the Inspector General should continue to work to improve the timeliness of investigations of abuse and neglect.

OIG's Response
OIG agrees and will work to continue to improve. However, OIG is gratified that, as the audit report recognizes, we have significantly reduced our time for completing abuse/neglect investigations, from an average of 53 days/case in FY06 to an average of 44 days/case in FY08, despite the ongoing increase in allegations and decrease in investigators.

Recommendation 3
The Office of the Inspector General should maintain the necessary documentation to monitor referrals to the Illinois State Police. Monitoring should be in place to ensure that the referrals are timely as required by State law.

OIG's Response
OIG agrees. The investigative bureaus have been reminded to use the current version of the form. The bureau chiefs will continue to be responsible to monitor this form.

Recommendation 5
The Office of the Inspector General should assign all allegations to an investigator within one working day and complete all investigative plans within three working days as is required by OIG directives.

OIG's Response
OIG agrees. The investigative bureaus have been reminded to assign investigations and complete investigative plans timely.

Recommendation 6

The Office of the Inspector General should continue to work with State facilities and community agencies to ensure that allegations of abuse or neglect are reported within the time frames specified in Department of Human Services Act and OIG's administrative rule.

OIG's Response

OIG agrees. OIG has taken the following steps to reinforce timeliness of reporting:

- Notified the facilities and community agencies of the new law (P.A. 94-853) making intentional late reporting or failure to report a Class A misdemeanor;

- Re-issued to all facilities and community agencies a handbook, "Reporting and Investigating Abuse and Neglect of Adults with Disabilities," which emphasizes timely reporting;

- Ensured the DHS contracts with community providers includes the requirement for reporting and a mandate for at least biennial training of all staff in Rule 50;

- Reviewed all community agency internal policies on reporting to ensure that every one includes the time requirements in Rule 50;

- Maintained the database-generated "flags" on all new intakes, so investigators are notified of identified or potential late reporting when it occurs;

- Routinely cites late reporting in investigative reports, which requires the facility or community agency to submit a Written Response listing actions that will be taken to prevent recurrence and address problems identified;

- On a monthly basis, notifies the DHS divisions of facilities and community agencies that reported late; and

- Continues to conduct trainings of community agency staff, conducting 26 trainings with a total of 681 participants in Rule 50 during FY 2008 alone.

Recommendation 7

The Office of the Inspector General should: ensure that review responsibility for all cases is clearly assigned and that all forms are completed and contained in the case file; and consider requiring that the Inspector General or his designee review all substantiated cases of abuse or neglect.

OIG's Response

OIG agrees. OIG has required all reviewing staff to ensure that the database reflects all receipt and completion dates for reviews. OIG is also developing new and more detailed database reports to monitor and evaluate review time. In addition, OIG will consider requiring that the Inspector General or his/her designee review all substantiated cases of abuse or neglect.

Recommendation 8

The Office of the Inspector General should: continue to work to ensure consistency of investigations and recommendations; and consider clearly defining what constitutes physical injury and physical harm.

OIG's Response

OIG agrees in part. OIG will continue efforts to ensure consistency of investigative findings. OIG has defined physical injury in Rule 50 but maintains that the issue of defining physical harm would be resolved by revisions to the statute. Until the statute is revised, however, any change to Rule 50 would be premature. In the meantime, OIG will continue to reinforce that physical "harm" is a physical "wrong or injustice."

Rod R. Blagojevich, *Governor*

Illinois Department of Human Services

Carol L. Adams, Ph.D., *Secretary*

100 South Grand Avenue, East • Springfield, Illinois 62762
401 South Clinton Street • Chicago, Illinois 60607

November 25, 2008

William G. Holland
Office of the Auditor General
Iles Park Plaza
740 East Ash Street
Springfield, IL 62703-3154

Dear Auditor General Holland:

Following is the response for the findings reported in the draft report for the biennial audit of the DHS Office of the Inspector General performed by the Office of the Auditor General. Please note the Office of the Inspector General has already provided responses for their office under a separate cover. This letter only addresses the three DHS findings contained in the draft report.

Recommendation #4: The Department of Human Services should comply with CMS rules and DHS policy by not renewing emergency appointments

Department Response: Agree. The agency has now ceased all consecutive emergency appointments.

Recommendation #9: The Department of Human Services should ensure that written responses from facilities and community agencies are received and approved in a timely manner.

Department Response: Agree. Beginning July 2008, an improved process was established which has significantly reduced the number of past due written responses and will continue to result in more timely receipt and review of written responses from community agencies. The receipt of written responses is being tracked and monitored, weekly review meetings are held and bi-monthly reports are used to ensure prompt review of all responses received. Reminder notices are being sent to developmental disabilities service providers to remind them of the written response development and submission expectations.

Recommendation #10: The Department of Human Services should ensure that all staff are consistently trained in abuse and neglect at least once biennially and should maintain adequate documentation to show that the training has been conducted.

Auditor General Holland
Page 2
November 25, 2008

Department Response: Agree. Developmental Disabilities staff are trained in abuse and neglect at least once biennially; however, at the time of this audit there was no system in place to track compliance from a central location. A new tracking system will be established by State Operated Developmental Center (SODC) Operations to ensure compliance with the OAG recommendation. The Bureau of Quality Management will also issue a notice to all community developmental disabilities providers reminding them of their responsibility to conduct training at least biennially. The Bureau of Quality Management will sample providers, in person and via paper audits, to verify that training in the reporting of abuse and neglect has been completed.

If you have any questions, please feel free to contact Albert Okwuegbunam, Chief, Audit Liaison Bureau, Office of Fiscal Services at 217/785-7797.

Sincerely,

Carol L. Adams, Ph.D.
Secretary

cc: Jerome Butler, Assistant Secretary
Grace Hou, Assistant Secretary
Robert Stanek, Chief Financial Officer
Solomon Oriaikhi, Director, Office of Fiscal Services
William M. Davis, Inspector General
Lilia Teninty, Director, Developmental Disabilities
Elizabeth Sarmiento, Human Resources Manager
Albert Okwuegbunam, Chief, Audit Liaison Bureau