STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PROGRAM AUDIT

OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HUMAN SERVICES

DECEMBER 2010

WILLIAM G. HOLLAND

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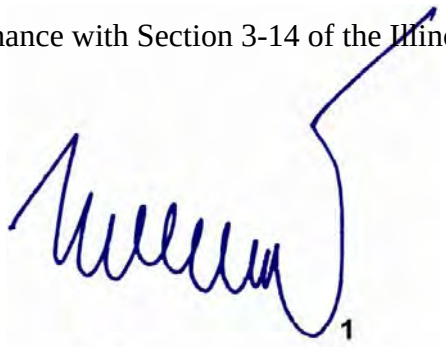
To the Legislative Audit Commission, the Speaker and Minority Leader of the House of Representatives, the President and Minority Leader of the Senate, the members of the General Assembly, and the Governor:

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(w) 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 2010

STATE OF ILLINOIS
OFFICE OF THE
AUDITOR GENERAL
William G. Holland, Auditor General

SUMMARY REPORT DIGEST

DEPARTMENT OF HUMAN SERVICES
OFFICE OF THE INSPECTOR GENERAL

PROGRAM AUDIT
For the Two Years Ended: June 30, 2010

Release Date: December 2010

Summary of Findings:

Total this audit:	**9**
Total last audit:	**10**
Repeated from last audit:	**5**

SYNOPSIS

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.

In this audit we reported that:

- Total allegations of abuse and neglect reported to the OIG increased 22 percent over the last two years. In FY10, 2,468 allegations were reported. This compares to 2,026 in FY08.

- The timeliness of OIG investigations continued to improve since our last audit. In FY10, 69 percent of investigations were completed within 60 calendar days. Using the more lenient working days standard, the OIG's timeliness of case completion reached its highest percent ever at 85 percent for FY10.

- Although there has been continued improvement in the overall timeliness of investigations, the timeliness of cases assigned to clinical coordinators (involving death or other medical issues) continues to be a problem. Of the 327 cases closed in FY10 that took more than 60 working days to complete, 98 were clinical.

- The timeliness of reporting allegations of abuse and neglect by community agencies improved substantially. For FY10, 13 percent of allegations were not reported within the required four hours, as compared to 25 percent in FY08. In FY10, 10 percent of State-operated facility incidents were not reported within the four-hour time requirement.

- In 18 percent (5 of 28) 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.

- Two facilities remained decertified from participation in Medicare and Medicaid (Howe Developmental Center and Tinley Park Mental Health Center). The U.S. Department of Justice released reports in 2009 with serious concerns about two facilities (Howe Developmental Center and Choate Developmental Center). Howe Developmental Center closed effective June 21, 2010.

- The Quality Care Board did not maintain the seven members that are required by statute. From November 2009, to May 2010, all of the members of the Board were serving under terms that had expired.

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FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

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 authorizes the OIG to conduct investigations in community agencies licensed, certified, or funded by DHS to provide mental health and developmental disability services. The Act also directs the Auditor General to conduct a program audit of the Department of Human Services, Office of the Inspector General on an as needed basis. This is the eleventh audit we have conducted of the OIG since 1990.

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 and since February 2010 has been serving on an expired term.

In FY10, DHS operated 18 State facilities. There were also 376 community agencies operating 3,473 programs providing services to individuals with developmental disabilities or mental illness in community settings within Illinois that were under OIG's jurisdiction.

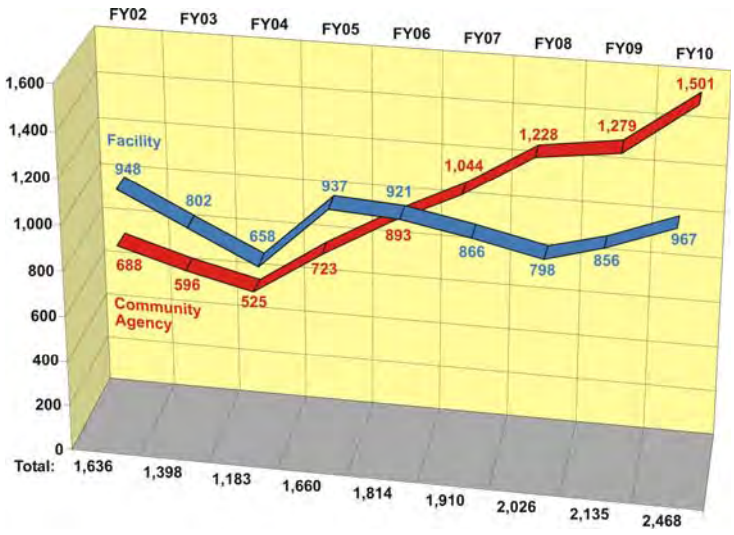
In FY08, 2,026 allegations were reported (1,631 abuse and 395 neglect) to the OIG. This compares to 2,468 in FY10 (1,877 abuse and 591 neglect) or a 22 percent increase over the last two years.

Total allegations of abuse and neglect reported to the OIG have continued to increase since our 2008 audit. In FY08, 2,026 allegations were reported (1,631 abuse and 395 neglect) to the OIG. This compares to 2,468 in FY10 (1,877 abuse and 591 neglect) or a 22 percent increase over the last two years (see Digest Exhibit 1). (pages 1-13)

SERIOUS INJURIES

In previous audits we determined that the OIG does not capture data regarding serious injuries unless they were related to an allegation of abuse or neglect. We recommended the OIG consider adding serious injuries to its investigative database. According to OIG officials, the OIG considered adding serious injuries to its database but chose instead to revise the law to clarify that serious injuries are reportable to OIG only if abuse and neglect by staff is alleged or suspected including injuries caused by an employee directing an individual to injure another. As in previous audits, we still conclude that the OIG should consider adding serious injuries to its investigative database that would allow it to look for and identify patterns and trends in serious injuries, which may be an indicator of staff neglect or other problems which need to be addressed. (pages 16-17)

Digest Exhibit 1
TOTAL ABUSE OR NEGLECT ALLEGATIONS REPORTED TO OIG
Fiscal Years 2002 to 2010



Note: State facilities served 2,485 individuals with developmental disabilities and 10,237 individuals with mental illness in FY10. Community agencies served approximately 37,500 individuals with developmental disabilities and approximately 163,147 individuals with mental illness in FY10.

Source: OIG data summarized by OAG.

INTERAGENCY AGREEMENTS

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. Although the Inspector General has clarified the investigatory role of each agency through signed interagency agreements, several of the agreements now contain outdated statutory cites and definitions that need updated. (pages 17-20)

The timeliness of OIG investigations continued to improve in FY09 and FY10.

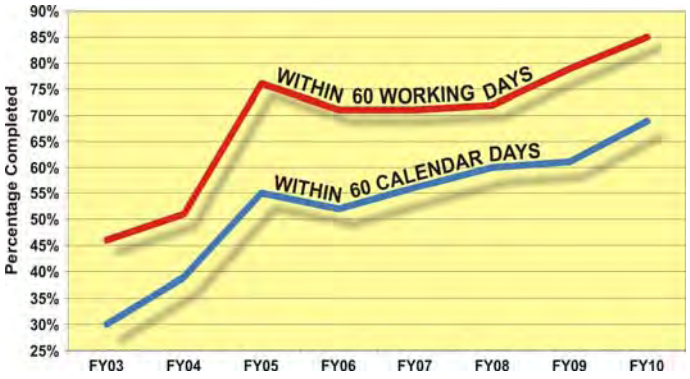
INVESTIGATION TIMELINESS

The timeliness of OIG investigations continued to improve in FY09 and FY10. In FY08, 60 percent of OIG investigations were completed in 60 calendar days. Timeliness improved in FY09 with 61 percent and in FY10 with 69 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, the OIG's timeliness of case completion reached its highest percent ever at 85 percent for FY10 (see Digest Exhibit 2).

Although there has been continued improvement over the past three audits in the overall timeliness of investigations of abuse

and neglect, the timeliness of cases assigned to clinical coordinators continues to be a problem. Cases assigned to clinical coordinators involve a death or other medical issues. Of the 327 cases closed in FY10 that took more than 60 working days to complete, 98 were clinical.

Digest Exhibit 2
ABUSE AND NEGLECT INVESTIGATION TIMELINESS TRENDS
Fiscal Years 2003 to 2010



Source: OAG analysis of OIG data.

Our FY08 audit contained a recommendation to the OIG to maintain the necessary documentation to monitor whether referrals to State Police or local law enforcement are timely. In our testing of FY10 cases, five cases were referred to State Police or local law enforcement. We obtained copies of all five checklists from the investigative files. For all five cases, the proper form was used and we determined that the incident was reported to the State Police or local law enforcement within the required 24 hours.

We reviewed investigator caseloads for the different investigative bureaus at the OIG. Caseloads have doubled for three of the four investigative bureaus since our last audit. Caseloads as of August 2010 ranged from 23 in the Metro Bureau to 12 in the South Bureau. Caseloads as of August 2008 ranged from 11 in the Metro and South Bureaus to 7 in the North Bureau.

Even though the OIG no longer requires critical interviews, we continue to look at the amount of time it takes to collect statements and interview the alleged victim and the alleged perpetrator in abuse and neglect cases. Our FY08 audit found that it took an average of 8 days to complete statements or interviews with the alleged victim, which was 4 fewer days than the 12 days it took in FY06. For FY10 cases we sampled where there was a victim identified and the victim was verbal, it took an average of 9 days to complete statements or interviews for the alleged victim.

Our FY08 audit found that it took an average of 20 days to complete statements or interviews with the alleged perpetrator,

which is 5 days fewer than the 25 days it took in FY06. For FY10 cases we sampled where there was a perpetrator identified, it took an average of 17 days to complete statements or interviews for the alleged perpetrator.

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. For 24 of the 123 (20%) 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 or is a death investigation. For 9 of the 128 (7%) cases we sampled, we could not determine whether the plan was completed in a timely manner because there was no investigative plan in the file, there was no date on the investigative plan, or we could not determine the date assigned. For 10 cases, a plan was not required. Of the remaining 109 cases, 6 (6%) were not completed and approved within the required three working days.

While alleged incidents of abuse and neglect are not consistently being reported to the OIG by facilities and community agencies in the time frames required by the statutes and OIG's administrative rules, reporting by community agencies has improved since our last audit. For FY10, the percent of allegations not reported within the required four hours for community agencies was 13 percent or nearly half of what it was two years ago. In FY10, 10 percent of facility incidents were not reported within the four-hour time requirement (see Digest Exhibit 3). (pages 25-38)

Digest Exhibit 3

ALLEGATIONS OF ABUSE AND NEGLECT NOT REPORTED WITHIN FOUR HOURS OF DISCOVERY

Fiscal Year	Facility	Community Agency
FY07	5%	21%
FY08	7%	25%
FY09	9%	19%
FY10	10%	13%

Source: OAG analysis of OIG data.

INVESTIGATION THOUROUGHNESS

OIG case reports generally were thorough, comprehensive, and addressed the allegation. However, we found that photographs

were missing in 4 of 21 (19%) cases sampled where there was an allegation of an injury sustained. Injury reports were missing in 1 of 21 (5%) cases where there was an allegation of an injury sustained. All of the sampled cases contained pertinent medical records, treatment plans, or progress notes. Only one case sampled in which restraints were involved did not contain the restraint seclusion monitoring documentation. However, in this case, the OIG cited the agency for improper use of restraints. Although all of the 128 sample cases tested contained a Case Routing/Approval Form, three were not reviewed and signed off on by a bureau chief. These three cases were all in the South Bureau.

In the previous audit we found that, for community agency conducted investigations in our sample, it was sometimes difficult to determine which bureau and investigator was responsible for reviewing the case. We also reported that the Inspector General or his designee is not required to review substantiated cases of mental injury or neglect unless it is deemed "egregious" neglect. As a result of the finding in our previous audit, the OIG created a database report to assist bureau chiefs in monitoring case reviews. The Deputy Inspector General also continues to conduct quarterly reviews of unsubstantiated cases. In July 2009, the OIG considered but decided against requiring the Inspector General or his designee to review all substantiated cases.

The OIG has continued to take steps to improve investigative consistency. In the previous two audits, we identified issues related to investigative consistency. These issues included consistency in what constitutes a reportable allegation, and the classification of the outcome of cases as substantiated, unsubstantiated, and unfounded. Effective August 13, 2009, Public Act 96-407 amended the Department of Human Services Act (20 ILCS 1305) relating to the DHS Office of Inspector General. The Public Act changed and/or clarified several of the definitions related to abuse and neglect. The OIG has also updated its administrative rules. Effective September 10, 2009, the OIG established an emergency rule to implement the changes made by Public Act 96-407. These rules were adopted effective March 25, 2010. Many of the changes made to the statutes and OIG's rules should help ensure the consistency of the OIG investigations. (pages 39-44)

ACTIONS, RECOMMENDATIONS, AND SANCTIONS

We found that DHS, in some cases, still takes an excessive amount of time to approve the actions taken by the agency or facility.

Although the annual number of substantiated abuse and neglect cases has varied over the past four years, the substantiation rate has remained fairly consistent. From FY07 to FY10 the overall substantiation rate has ranged from 11 percent to 12 percent. The substantiation rate at community agencies has been approximately 16 percent each year for the past four years.

State facilities and 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. We found that

DHS, in some cases, still takes an excessive amount of time to approve the actions taken by the agency or facility. Overall, 28 of 128 cases we sampled required a written response. Of the 28 cases, 5 (18%) took more than six months from the date the case was completed until the written response was approved by DHS. Our previous audit contained a recommendation to DHS to ensure that written responses are approved in a timely manner. In that audit there were cases that took more than a year for approval of the written response. During the later part of FY08, the Division increased its efforts to approve written responses in a timely manner. Although timeliness has improved, there are still cases that are not approved in a timely manner.

According to 59 Ill. Adm. Code 50.90, an employee may request a hearing with DHS 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 found in favor of the petitioner, and therefore the employee was not referred to the Health Care Worker Registry, increased in FY10. The ALJ decision resulted in the employee not being referred to the registry in 23 percent of the appeal decisions in FY09 (7 of 30). For FY10 appeal decisions, this increased to 51 percent (18 of 35).

During FY09 and FY10, 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(i)). Also, during FY09 and FY10, the OIG met its established timeline for submitting site visit reports to facility directors or hospital administrators. The goal of these visits is to review systemic issues that may be related to the prevention of abuse or neglect of individuals receiving services in the facilities.

During FY09, the OIG recommended that DHS' Division of Developmental Disabilities take immediate action against one community agency, up to and including sanctions. This was due to the OIG's concern that a culture of abuse and neglect at the particular agency put the individuals receiving services at a great risk of harm.

Even though two facilities remained decertified from participation in Medicare and Medicaid, and the U.S. Department of Justice released reports with serious concerns about two facilities, the OIG did not recommend any sanctions to the Secretary of DHS for any State operated facility.

Even though two facilities remained decertified from participation in Medicare and Medicaid, and the U.S. Department of Justice released reports with serious concerns about two facilities, the OIG did not recommend any sanctions to the Secretary of DHS for any State-operated facility. During FY09 and FY10 two State-operated facilities (Howe DC and Tinley Park MHC) remained terminated from participation in federal programs for non-compliance with various issues, including patient safety and client protection. In addition, in November 2009 the U.S. Department of Justice released investigations of two facilities (Howe DC and Choate DC) that raised serious concerns regarding the health and safety of residents in those facilities. Howe Developmental Center closed effective June 21, 2010. OIG has not recommended a sanction related to a State-operated facility for at least the past 17 years (1994-2010). (pages

45-62)

OTHER ISSUES

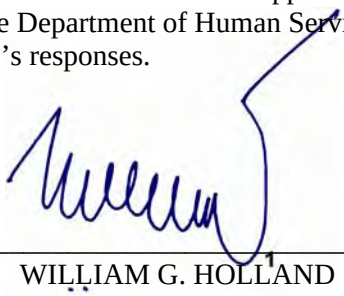
The Quality Care Board (Board) held all required quarterly meetings during FY09 and FY10. However, the Board did not maintain the seven members that are required by statute. During FY09, the Board had six members. However, from November 3, 2009, to May 2010, all of the members of the Board were serving under terms that had expired. In May 2010, the Governor made two temporary reappointments to the Board. OIG provided additional information to show that effective August 19, 2010, another Board member still serving on an expired term and a new applicant received temporary appointments to serve on the Board.

The Quality Care Board held all required quarterly meetings during FY09-10. However, the Board did not maintain the seven members that are required by statute.

In our previous audit (2008), DHS could not document that all staff at State-operated facilities received the required Rule 50 training. The DHS Division of Mental Health and the Division of Developmental Disabilities provided FY10 data that showed that Rule 50 training is now being tracked at State-operated facilities. (pages 63-66)

RECOMMENDATIONS

The audit report contains nine recommendations; seven to the Office of the Inspector General, one to DHS, and one to both OIG and DHS. The Inspector General and DHS generally agreed with all nine of the 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

AUDITORS ASSIGNED: This Program Audit was performed by the Office of the Auditor General's staff.

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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 FY10, DHS operated 18 State facilities. There were also 376 community agencies operating 3,473 programs providing services to individuals with developmental disabilities or mental illness in community settings within Illinois that were under OIG's jurisdiction. The Act authorizes the Office of the Auditor General to conduct a program audit of the Inspector General's effectiveness of investigations of abuse and neglect and compliance with the Act on an as needed basis. This is the eleventh audit we have conducted of the OIG since 1990.

Effective August 13, 2009, Public Act 96-407 amended the Department of Human Services Act (20 ILCS 1305) relating to the DHS Office of Inspector General. OIG, in a memo to the State facilities and community agencies, stated that the legislation was initiated by OIG. Some of the most significant changes made by Public Act 96-407 were to the definitions related to abuse and neglect and adding a new category for "financial exploitation." Several of the changes made to the statute addressed recommendations that have been made in our audits.

Total allegations of abuse and neglect reported to the OIG have continued to increase since our 2008 audit. In FY08, 2,026 allegations were reported (1,631 abuse and 395 neglect). This compares to 2,468 in FY10 (1,877 abuse and 591 neglect) or a 22 percent increase over the last two years. Allegations have increased at both State facilities and community agencies since the previous audit. Of the 2,026 allegations reported in FY08, 798 allegations were reported at State facilities and 1,228 allegations were reported at community agencies. For FY10, of the total of 2,468 allegations of abuse or neglect, 967 were from State facilities and 1,501 from community agencies.

In previous audits we determined that the OIG does not capture data regarding serious injuries and recommended the OIG consider adding serious injuries to its investigative database. According to OIG officials, the OIG considered adding serious injuries to its database but chose instead to revise the law to clarify that serious injuries are reportable to OIG only if abuse and neglect by staff is alleged or suspected including injuries caused by an employee directing an individual to injure another. As in previous audits, we still conclude that the OIG should continue to consider adding serious injuries to its investigative database that would allow it to

look for and identify patterns and trends in serious injuries, which may be an indicator of staff neglect or other problems which need to be addressed.

While the Department of Human Services Act (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. Although the Inspector General has clarified the investigatory role of each agency through signed interagency agreements, several of the agreements now contain outdated statutory cites and definitions that need updated.

The timeliness of OIG investigations continued to improve in FY09 and FY10. In FY08, 60 percent of OIG investigations were completed in 60 calendar days. Timeliness improved in FY09 with 61 percent and in FY10 with 69 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 working days standard, the OIG's timeliness of case completion reached its highest percent ever at 85 percent for FY10.

Although there has been continued improvement over the past three audits in the overall timeliness of investigations of abuse and neglect, the timeliness of cases assigned to clinical coordinators continues to be a problem. Cases assigned to clinical coordinators involve a death or other medical issues. Of the 327 cases closed in FY10 that took more than 60 working days to complete, 98 were clinical.

The OIG continues to utilize other OIG bureaus outside of its investigative bureaus to help complete cases. This includes assigning cases to the Bureau of Domestic Abuse (DAP), Bureau of Hotline and Intake, and the Bureau of Compliance and Evaluation (BCE). These bureaus were responsible for approximately 11 percent of investigations completed in FY10 (242 of 2,150). This is similar to the previous audit.

Our FY08 audit contained a recommendation to the OIG to maintain the necessary documentation to monitor whether referrals to State Police or local law enforcement are timely. In our testing of FY10 cases, five cases were referred to State Police or local law enforcement. We obtained copies of all five checklists from the investigative files. For all five cases, the proper form was used and we determined that the incident was reported to the State Police or local law enforcement within the required 24 hours.

We reviewed investigator caseloads for the different investigative bureaus at the OIG. Caseloads have doubled for three of the four investigative bureaus since our last audit. Caseloads as of August 2010 ranged from 23 in the Metro Bureau to 12 in the South Bureau. Caseloads as of August 2008 ranged from 11 in the Metro and South Bureaus to 7 in the North Bureau.

Even though the OIG no longer requires critical interviews, we continue to look at the amount of time it takes to collect statements and interview the alleged victim and the alleged perpetrator in abuse and neglect cases. Our FY08 audit found that it took an average of 8 days to complete statements or interviews with the alleged victim, which was 4 fewer days than the 12

days it took in FY06. For FY10 cases we sampled where there was a victim identified and the victim was verbal, it took an average of 9 days to complete statements or interviews for the alleged victim.

Our FY08 audit found that it took an average of 20 days to complete statements or interviews with the alleged perpetrator, which is 5 days fewer than the 25 days it took in FY06. For FY10 cases we sampled where there was a perpetrator identified, it took an average of 17 days to complete statements or interviews for 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 24 of the 123 (20%) 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 or is a death investigation. For 9 of the 128 (7%) cases we sampled, we could not determine whether the plan was completed in a timely manner because there was either no investigative plan in the file, there was no date on the investigative plan, or we could not determine the date assigned. For 10 of the 128 (8%) cases we sampled, an investigative plan was not required because the case involved a recanted allegation, a death, or was a State Police investigation. For the remaining cases sampled, 109 required an investigative plan. Of those 109, 6 (6%) were not completed and approved within the required three working days.

The timeliness of reporting allegations of abuse and neglect by community agencies improved substantially during FY09 and FY10. For FY10, the percent of allegations not reported within the required four hours was 13 percent or nearly half of what it was two years ago. However, alleged incidents of abuse and neglect are not consistently being reported to the OIG by facilities and community agencies in the time frames required by the statutes and OIG's administrative rules. In FY10, 10 percent of facility incidents were not reported within the four-hour time requirement.

OIG case reports generally were thorough, comprehensive, and addressed the allegation. However, we found that photographs were missing in 4 of 21 (19%) cases where there was an allegation of an injury sustained from our FY10 sample. Injury reports were missing in 1 of 21 (5%) cases where there was an allegation of an injury sustained. All of the sampled cases contained pertinent medical records, treatment plans, or progress notes. Only one case sampled in which restraints were involved did not contain the restraint seclusion monitoring documentation. However, in this case, the OIG cited the agency for improper use of restraints. All of the cases also contained a Case Tracking form. Although all of the 128 sample cases tested contained a Case Routing/Approval Form, three were not reviewed and signed off on by a Bureau Chief. These three cases were all in the South Bureau.

In the previous audit we found that, for community agency conducted investigations in our sample, it was sometimes difficult to determine which bureau and investigator was responsible for reviewing the case. We also reported that the Inspector General or his designee is not required to review substantiated cases of mental injury or neglect unless it is deemed

"egregious" neglect. As a result of the finding in our previous audit, the OIG created a database report to assist bureau chiefs in monitoring case reviews. The Deputy Inspector General also continues to conduct quarterly reviews of unsubstantiated cases. In July 2009, the OIG considered but decided against requiring the Inspector General or his designee to review all substantiated cases.

The OIG has continued to take steps to improve investigative consistency. In the previous two audits, we identified issues related to investigative consistency. These issues included consistency in what constitutes a reportable allegation, and the classification of the outcome of cases as substantiated, unsubstantiated, and unfounded. Effective August 13, 2009, Public Act 96-407 amended the Department of Human Services Act (20 ILCS 1305) relating to the DHS Office of Inspector General. The Public Act changed and/or clarified several of the definitions related to abuse and neglect. The OIG has also updated its administrative rules. Effective September 10, 2009, the OIG established an emergency rule to implement the changes made by Public Act 96-407. These rules were adopted effective March 25, 2010. Many of the changes made to the statutes and OIG's rules should help ensure the consistency of the OIG investigations.

Although the annual number of substantiated abuse and neglect cases has varied over the past four years, the substantiation rate has remained fairly consistent. From FY07 to FY10 the overall substantiation rate has ranged from 11 percent to 12 percent. The substantiation rate at community agencies has been approximately 16 percent each year for the past four years.

State facilities and 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, in some cases, still takes an excessive amount of time to approve the actions taken by the agency or facility. Overall, 28 of 128 cases we sampled required a written response. Of the 28 cases, 5 (18%) took more than six months from the date the case was completed until the written response was approved by DHS. Our previous audit contained a recommendation to DHS to ensure that written responses are approved in a timely manner. In that audit there were cases that took more than a year for approval of the written response. During the later part of FY08, the Division increased its efforts to approve written responses in a timely manner. Although timeliness has improved, there are still cases that are not approved in a timely manner.

According to 59 Ill. Adm. Code 50.90, an employee may request a hearing with DHS 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 found in favor of the petitioner, and therefore the employee was not referred to the Health Care Worker Registry, increased in FY10. The ALJ decision resulted in the employee not being referred to the registry in 23 percent of the appeal decisions in FY09 (7 of 30). For FY10 appeal decisions, this increased to 51 percent (18 of 35).

Stipulation and consent orders were used more frequently during FY09 and FY10. 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 chose not to refer a case to the Registry based on a stipulation order in 12 cases for FY09 and FY10.

During FY09, the OIG recommended that DHS' Division of Developmental Disabilities take immediate action against one community agency, up to and including sanctions. This was due to the OIG's concern that a culture of abuse and neglect at the particular agency put the individuals receiving services at a great risk of harm.

Even though two facilities remained decertified from participation in Medicare and Medicaid, and the U.S. Department of Justice released reports with serious concerns about two facilities, the OIG did not recommend any sanctions to the Secretary of DHS for any State-operated facility. During FY09 and FY10 two State-operated facilities (Howe DC and Tinley Park MHC) remained terminated from participation in federal programs for non-compliance with various issues, including patient safety and client protection. In addition, in November 2009 the U.S. Department of Justice released investigations of two facilities (Howe DC and Choate DC) that raised serious concerns regarding the health and safety of residents in those facilities. OIG has not recommended a sanction related to a State-operated facility for at least the past 17 years (1994-2010).

During FY09 and FY10, 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(i)). Also, during FY09 and FY10, the OIG met its established timeline for submitting site visit reports to facility directors or hospital administrators. During FY09 and FY10, the OIG met its established timeline for submitting site visit reports to facility directors or hospital administrators. The goal of these visits is to review systemic issues that may be related to the prevention of abuse or neglect of individuals receiving services in the facilities.

The Quality Care Board (Board) held all required quarterly meetings during FY09 and FY10. However, the Board did not maintain the seven members that are required by statute. During FY09, the Board had six members. However, from November 2009, to May 2010, all of the members of the Board were serving under terms that had expired. In May 2010, the Governor made two temporary reappointments to the Board. OIG provided additional information to show that effective August 19, 2010, another Board member still serving on an expired term and a new applicant received temporary appointments to serve on the Board.

In our previous audit (2008), DHS could not document that all staff at State-operated facilities received the required Rule 50 training. The DHS Division of Mental Health and the Division of Developmental Disabilities provided FY10 data that showed that Rule 50 training is now being tracked at State-operated facilities.

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 rules were further amended on an emergency basis effective January 1, 2002, following enactment of Public Act 92-473. The final administrative rules were 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.

Effective August 13, 2009, Public Act 96-407 amended the Department of Human Services Act (20 ILCS 1305) relating to the DHS Office of Inspector General. OIG, in a memo to the State facilities and community agencies, stated that the legislation was initiated by OIG.

Some of the most significant changes made by Public Act 96-407 were to the definitions related to abuse and neglect and adding a new category for "financial exploitation." Several of the changes made to the statutes addressed recommendations that have been made in prior OAG audits. The most significant changes were made to the following terms:

New Category - Financial Exploitation

Taking unjust advantage of an individual's assets, property, or financial resources through deception, intimidation, or conversion for the employee's, facility's, or agency's own advantage or benefit.

Source: Public Act 96-407.

- *Abuse* now only refers to each type of abuse – mental abuse, physical abuse, sexual abuse, and financial exploitation. Previously, abuse was defined as any physical injury, sexual abuse, or mental injury inflicted on an individual other than by accidental means.

- *Neglect* now contains a provision so it includes circumstances where an act or omission by an employee placed the health or safety of an individual at substantial risk, even if no actual harm was done. This issue and its impact on the inconsistency of investigations have been raised in our last two audits of the OIG.
- *Financial Exploitation* has now been defined as a category of abuse that should be investigated. OIG's rules define Financial Exploitation as, *"Taking unjust advantage of an individual's assets, property or financial resources through deception, intimidation or conversion for the employee's, facility's or agency's own advantage or benefit.*
- *Mental abuse* was changed from "mental injury" and the reference to actual harm was removed from the definition.
- *Physical abuse* was changed from "physical injury" so it doesn't require a documented physical injury and a provision was added to include indirect actions where an employee directs or encourages another person to physically abuse an individual. This change directly addresses recommendations in our previous audits in 2006 and 2008.
- *Individual* now refers to persons "on or off site" to ensure OIG's jurisdiction for an off-site incident.

One of the changes to the statutes involves how OIG interacts with the other licensing, certification, and funding units within DHS. One provision requires rules clarifying the circumstances where OIG will interact with those units to prevent further instances of abuse, neglect, or financial exploitation. OIG is also now required to "review" all reportable deaths with no allegation of abuse or neglect under another change.

Several other provisions relate to the OIG access to information and facilities. OIG now has the authority to compel production of physical evidence relating to an investigation, in addition to books and papers that were subject previously. Similarly, in addition to having access to investigate allegations and conduct unannounced site visits, OIG is to be granted access to a facility or agency to monitor compliance with a written response to a completed investigative report.

Employee conduct and treatment are also covered by new provisions. Employees are required to cooperate with OIG during an investigation, an unannounced site visit, or a written response compliance check. Retaliatory actions against any employee who acts in good faith as a required reporter are also a violation of the Act. Further, employees now have the explicit right to appeal administrative decisions in Circuit Court under the Administrative Review Law.

Requirements for reporting and responding to substantiated allegations also changed. Prior to Public Act 96-407, a complete report, including the written response, was to be sent to the Secretary (and the agency or facility) within 10 **calendar days** after a completed investigation was transmitted. Public Act 96-407 changed this requirement so that OIG now must provide the investigative report on the case to the Secretary and agency or facility within 10 **business days**. The agency or facility also now has 30 days to file the written response.

Changes were also made concerning reporting to the Health Care Worker Registry. Employees must now request a hearing within 30 days of notice or the name will be submitted to the Registry; the person reporting the allegation and the investigator must testify at the hearing.

Additionally, no employee name will be reported to the Registry until any administrative hearings and appeals are resolved and an employee may petition only once every 12 months to have his or her name removed from the registry.

Another change to the statutes involves the wording related to recommending sanctions. Prior to August 2009, the Department of Human Services Act specifically allowed the Inspector General the authority to recommend sanctions. However, the statute was changed in August 2009 by Public Act 96-407. The wording specifically allowing the Inspector General to make recommendations for sanctions to DHS or the Department of Public Health was deleted. The only remaining wording in the statute related to making recommendations to the Secretary of DHS is related to investigations of abuse and neglect (section (p)). However, the original wording is still in the OIG's administrative rules (59 Ill. Adm. Code Part 50 – Also referred to as "Rule 50"). This issue is discussed further in Chapter four.

OIG Organization

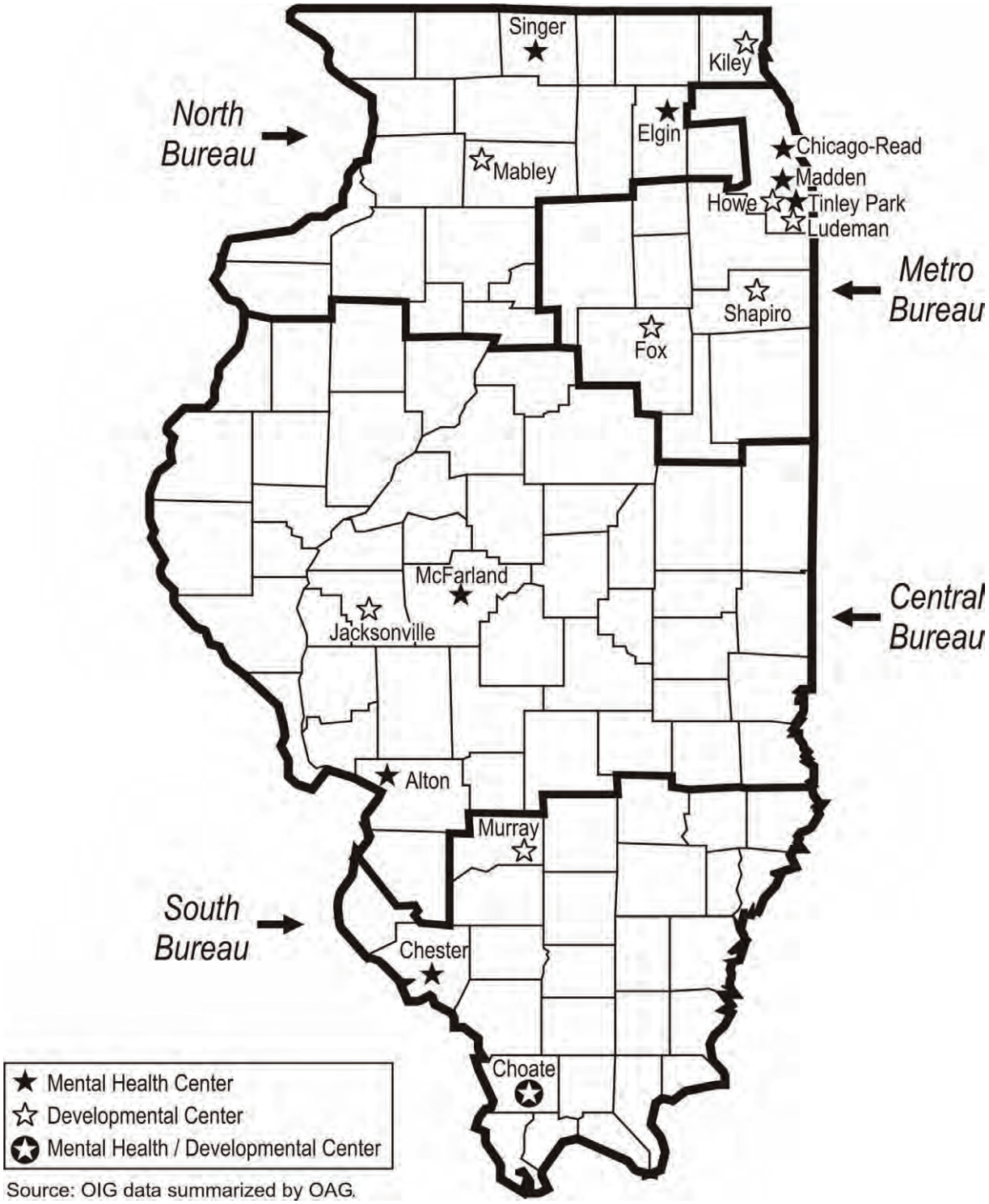
The Office of the Inspector General is located within the Department of Human Services and is appointed by the Governor and confirmed by the Senate for a four-year term. The current Inspector General was appointed in February 2006. Since February 2010, the Inspector General has been serving on an expired term.

The Department of Human Services Act directs the Auditor General to conduct a program audit of the Department of Human Services, Office of the Inspector General on an as needed basis. The Act specifically requires the audit to include the Inspector General's compliance with the Act and effectiveness in investigating reports of allegations occurring in any facility or agency. The Act also requires that the audit be released no later than January 1 following the audit period.

During FY10, the Department of Human Services operated 18 facilities statewide that served 12,722 individuals. Nine facilities served the developmentally disabled while and nine facilities served the mentally ill. 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. Howe Developmental Center closed effective June 21, 2010.

In addition, DHS licenses, certifies, or provides funding for 376 community agencies operating 3,473 programs providing services to individuals with developmental disabilities or mental illness in community settings within Illinois. In FY10, approximately 37,500 individuals with developmental disabilities and approximately 163,147 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

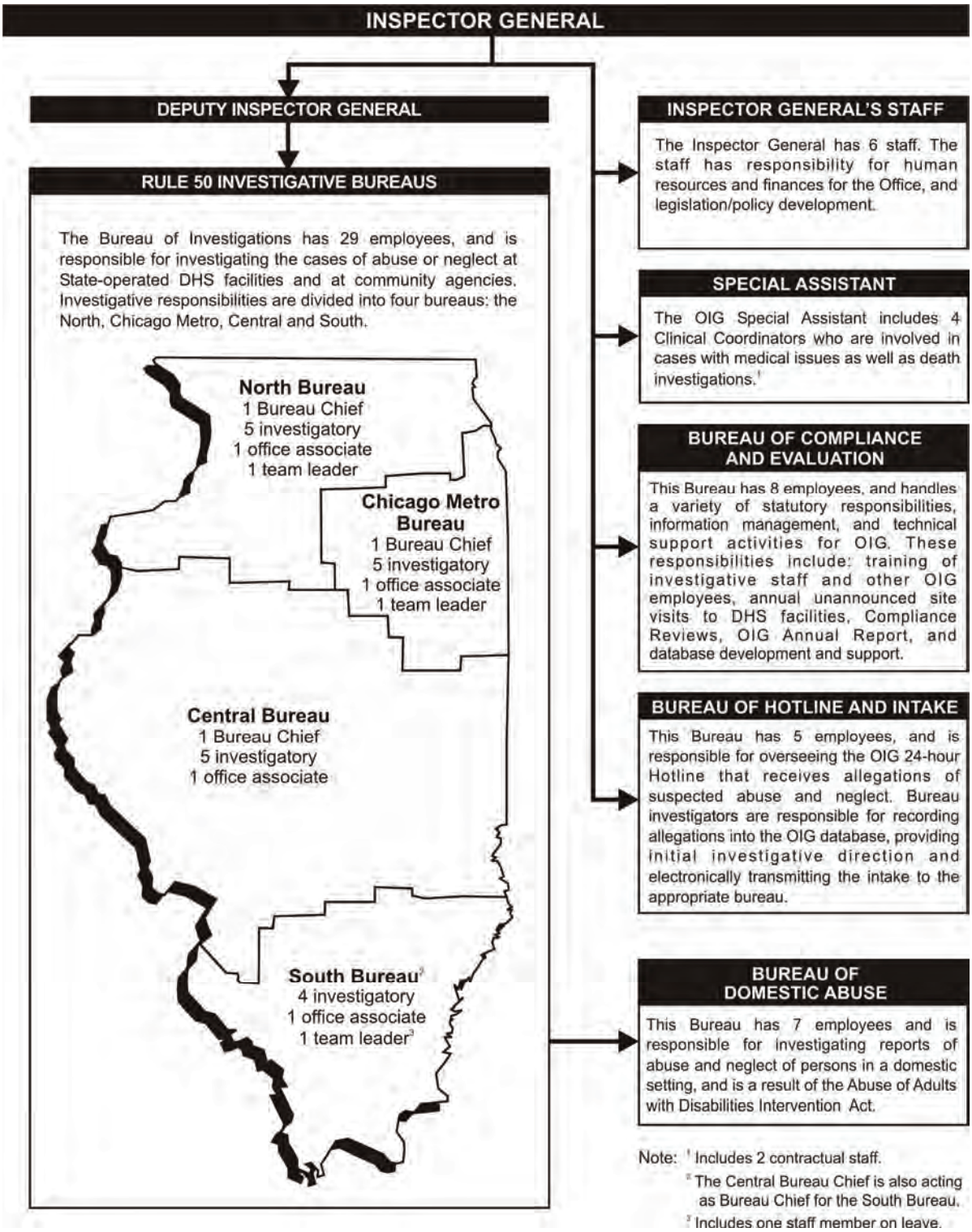


Note: Howe Developmental Center closed effective June 21, 2010.

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, 2010, the OIG had 57 employees, including one on leave. In addition the OIG hired two contractual employees as clinical coordinators to bring the total employees to 59. This represents a decrease of four positions from staffing levels reported in our 2008 OIG audit. The number of investigative staff for abuse and neglect investigations is similar to the number of staff during the previous audit (20 in FY08; 19 in FY10). The OIG had an appropriation of $4.7 million for FY08. In FY09, the OIG's appropriation was $5.1 million and for FY10 the appropriation was $4.6 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. In addition, as of July 1, 2010, the Bureau Chief of the Central Bureau was also acting as the Bureau Chief of the South Bureau.

Exhibit 1-2
OIG ORGANIZATIONAL CHART
As of July 1, 2010



Source: OIG data summarized by OAG.

Trends in Allegations of Abuse or Neglect

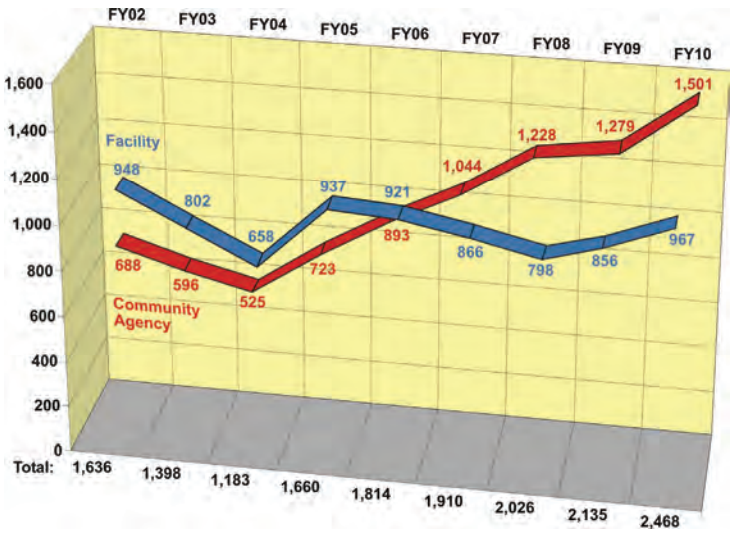
Overall, allegations of abuse and neglect reported to the OIG have been increasing since FY04. In FY08, 2,026 allegations were reported (1,631 abuse and 395 neglect). This compares to 2,468 in FY10 (1,877 abuse and 591 neglect) or a 22 percent increase over the last two years.

After decreasing for several years, the number of allegations reported at State facilities has also increased since our 2008 audit. Of the 2,026 allegations reported in FY08, 798 allegations were reported at State facilities and 1,228 allegations were reported at community agencies. For FY10, of the total of 2,468 allegations of abuse or neglect, 967 were from State facilities and 1,501 from community agencies.

Exhibit 1-3 summarizes abuse or neglect allegations reported to the OIG from the two sources for Fiscal Years 2002 to 2010. State facilities served 2,485 individuals with developmental disabilities and 10,237 individuals with mental illness in FY10. Community agencies served approximately 37,500 individuals with developmental disabilities and 163,147 individuals with mental illness in FY10.

Allegations of abuse reported to the OIG have continued to increase since our last audit. In FY08, there were 1,631 abuse allegations reported to the OIG.

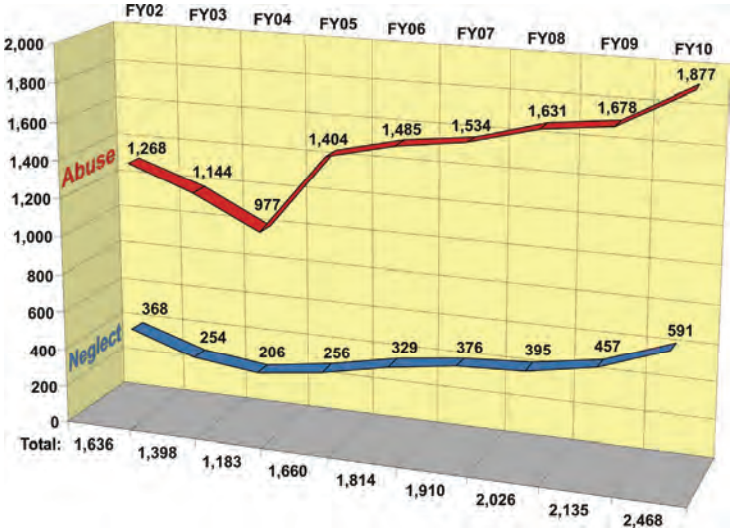
Exhibit 1-3
TOTAL ABUSE OR NEGLECT ALLEGATIONS REPORTED TO OIG
Fiscal Years 2002 to 2010



Note: State facilities served 2,485 individuals with developmental disabilities and 10,237 individuals with mental illness in FY10. Community agencies served approximately 37,500 individuals with developmental disabilities and approximately 163,147 individuals with mental illness in FY10.

Source: OIG data summarized by OAG.

Exhibit 1-4
TRENDS IN REPORTING ABUSE & NEGLECT
Fiscal Years 2002 to 2010



Source: OIG data summarized by OAG.

This compares to 1,877 in FY10 or a 15 percent increase since FY08. Allegations of neglect have increased 50 percent since FY08. In FY08, there were 395 neglect allegations reported to the OIG. This compares to 591 in FY10. 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 new and broader statutory definitions of abuse and neglect are largely responsible for the significant increase in allegations.

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.

Physical Abuse

An employee's non-accidental and inappropriate contact with an individual that causes bodily harm. "Physical Abuse" also includes actions that cause bodily harm as a result of an employee directing an individual or person to physically abuse another individual.

Sexual Abuse

Any sexual behavior, sexual contact, or intimate physical contact between an employee and an individual, including an employee's coercion or encouragement of an individual to engage in sexual activity that results in sexual contact, intimate physical contact, sexual behavior or intimate physical behavior.

Neglect

An employee's, agency's or facility's failure to provide adequate medical care, personal care or maintenance, and that, as a consequence, causes an individual pain, injury or emotional distress, results in either an individual's maladaptive behavior or the deterioration of an individual's physical condition or mental condition, or places an individual's health or safety at substantial risk of possible injury, harm or death.

Source: 59 Ill. Adm. Code Part 50.

OIG directives require the Bureau Chief to assign the case to an investigator within **one working day** and the investigators to complete an investigative plan within **three working days** of the assignment. When the investigator completes an investigation, an investigative report is developed in accordance with OIG directives and is forwarded 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.

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 review. 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 Bureau Chief or ITL to contact the Clinical Coordinator for a consultation. The OIG investigator must also contact the Clinical Coordinator prior to rendering a conclusion in a case involving a medical issue.

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. Any of these parties may submit in writing a request for reconsideration or clarification of the finding. 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.

If the case is substantiated or contains recommendations, the OIG sends the community agency or facility a copy of the investigative report that includes the OIG's finding in the case. If the case is unfounded or unsubstantiated without a recommendation, the facility or agency only receives the finding. 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 to the respective DHS program division office. If reconsideration is requested and denied or after clarification has been provided, the community agency or facility shall submit a written response within 15 calendar days after the receipt of the clarification or denial of reconsideration. The Inspector General shall provide a complete investigative report within 10 days to the Secretary of Human Services when abuse or neglect is substantiated or administrative action is recommended.

Community Agencies and Approved Protocol for Conducting Investigations

The community agencies that OIG has jurisdiction over can apply for an approved protocol, which authorizes the agency to conduct certain investigations, by submitting an annual application to the OIG Protocol Coordinator. The OIG still assumes primary responsibility for investigating allegations of physical abuse or sexual abuse by an employee or allegations of financial exploitation over $300 by an employee, facility or agency. In addition, OIG assumes primary responsibility for investigating allegations of neglect by an employee that result in an individual's death or other serious deterioration of an individual's physical or mental condition. For any other allegation, OIG may designate primary responsibility for the investigation to the community agency with an approved protocol on a case-by-case basis. Cases that may be

assigned to a community agency to investigate include allegations of mental abuse by an employee, allegations of financial exploitation under $300 by an employee, and allegations of neglect that did not result in an individual's death, or other serious deterioration of an individual's physical or mental condition.

In order to be considered the agency must:

- Adopt the OIG's Investigative Protocol for investigations under Rule 50;
- Appoint a liaison; and
- Appoint at least one investigator who has successfully completed OIG-conducted investigator training.

As of July 2010, 117 of the 376 community agencies (31 percent) under the OIG's jurisdiction had an approved protocol for conducting investigations. No community agency may conduct any abuse or neglect investigation without first obtaining authorization from OIG and then receiving specific approval on a case-by-case basis. If at any time during the course of the investigation the community agency requests that OIG assume primary responsibility for the investigation, OIG is required to do so.

When OIG designates primary responsibility for the investigation to the community agency, OIG provides investigative guidance and retains the right to assume primary responsibility for the investigation at any time. The OIG prepares the investigative plan for the agency, and also assigns an OIG investigator to oversee the investigation. At the conclusion of an investigation completed by a community agency, the case is submitted to the OIG for review and approval.

The agency investigator is required to follow the approved protocols and the same standards when conducting an investigation. To maintain eligibility for investigative authorization, a community agency investigator must attend OIG-conducted Rule 50 training and Basic Investigative Skills, or OIG's Investigative Skills Refresher Course within the two years prior to the start of the calendar year.

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). For FY10, 2,468 allegations were reported (1,877 abuse and 591 neglect). According to OIG officials, the new and broader statutory definitions of abuse and neglect are largely responsible for the significant increase in allegations.

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

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 or other appropriate law enforcement authority within 24 hours after determining that there is credible evidence indicating that a criminal act may have been committed. The State Police are required to investigate any report from a State-operated facility indicating a possible murder, sexual assault, or other felony by an employee (20 ILCS 1305/1-17(l)).

Reporting Serious Injuries

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 continued 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 specific 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). In the 2008 audit, we

determined that the OIG does not capture this data and again we recommended the Office of the Inspector General should continue to consider adding serious injuries to its investigative database. The OIG responded in our 2008 audit that requiring agencies and facilities to report even accidental serious injuries to OIG would require a change in the statute.

According to OIG officials, the OIG considered adding serious injuries to its database but chose instead to revise the law to clarify that serious injuries are reportable to OIG only if abuse and neglect by staff is alleged or suspected, including injuries caused by an employee directing an individual to injure another. In August 2009, Public Act 96-407 became effective. In September 2009, OIG revised Rule 50 on an emergency basis. In October 2009, the OIG distributed by e-mail to all community agencies and State facilities a letter that detailed the changes in statute and highlighted the expanded definitions.

As in previous audits, we still conclude 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 specific 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 may be identifiable if an examination of patterns and trends of serious injuries is conducted.

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 that would allow it to look for and identify patterns and trends in serious injuries, which may be an indicator of staff neglect or other problems which need to be addressed.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Partially agree. OIG cannot effectively review every injury report from the thousands of community agency sites and facilities. Rather, since licensing requirements already mandate careful review of all injuries by agency/facility administrations, State law (20 ILCS 1305/1-17) requires reporting to OIG those injuries alleged – including those only suspected – to involve abuse or neglect, even non-serious injuries. OIG will continue to add those injuries to OIG's investigative database.

OTHER STATE AGENCIES

While the Department of Human Services Act (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.

The OIG's administrative rules stipulate 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 (Section 1-17(a) of the Act) unless another State agency has requested that OIG participate in the investigation (such as the Departments of State Police, Children and Family Services, or Public Health)."* Although the Inspector General has clarified the investigatory role of each agency through signed interagency agreements, several of the agreements now contain outdated statutory cites and definitions that need updated.

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, the OIG is required to 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 is required to investigate any report from a State-operated facility indicating a possible murder, sexual assault, or other felony by an employee (20 ILCS 1305/1-17(l)).

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.

The most recent agreement between the OIG and the Illinois State Police was signed in July 2005 prior to the OIG's investigative authority being moved to the Department of Human Services Act. Consequently, the statutory references are outdated in the agreement. More importantly, the definition for reporting to the State Police contained in the interagency agreement no longer matches the definition contained in the statutes. The interagency agreement still requires that the OIG shall within 24 hours after receiving a report of suspected abuse or neglect determine whether the evidence indicates that any possible criminal act has been committed and report it immediately. The statutes now requires that within 24 hours after determining that there is credible evidence indicating that a criminal act may have been committed or that special expertise may be required in an investigation, the Inspector General shall notify the Department of State Police or other appropriate law enforcement authority, or ensure that such notification is made.

Department of Public Health

The Department of Public Health (DPH) 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 current interagency agreement between the OIG and Public Health was signed in January 2001 and contains outdated statutory references and language. As an example, the agreement still makes reference to the Nurse Aide Registry which is now known as the Health Care Worker Registry.

According to Public Health officials that we met with during the audit, there has been some confusion regarding the investigative processes related to allegations of abuse and neglect. When DPH receives a complaint against a long-term care facility, an unannounced site visit is planned. DPH sends a copy of the complaint to the OIG because of the interagency agreement. DPH officials provided auditors with an example of a case in which OIG notified the facility that there would be a visit, which defeats the purpose of a surprise investigation. According to DPH officials, OIG should not call or notify facilities and agencies about the complaint received by DPH before DPH is able to start its investigation. OIG should hold the complaint as confidential until the DPH investigation is completed.

When the OIG receives an allegation, its administrative rules require that officials contact the facility or agency to notify them of the allegation within three days unless the notification compromises the integrity of the investigation (50 Ill. Adm. Code 50.20). DPH and OIG should clarify issues like notification in their interagency agreement.

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. Like the agreements with ISP and DPH, the agreement with DCFS also contains outdated statutory cites.

INTERAGENCY AGREEMENTS	
RECOMMENDATION 2	***The Office of the Inspector General should update its interagency agreements with other State agencies that have investigatory powers.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree. OIG has begun the process of updating interagency agreements with the Illinois State Police, Illinois Department of Public Health, and Department of Children and Family Services.

PRIOR AUDIT FINDINGS

The audit of the OIG released in December 2008 contained seven recommendations to the OIG and three to DHS. The Inspector General fully or partially implemented six of the seven recommendations from the 2008 audit that were made to the OIG. DHS implemented or partially implemented all three of the recommendations that were made to DHS. The following summarizes what the OIG or DHS has done to implement the previous audit recommendations.

- **OIG Investigative Database (Partially Implemented) –** According to OIG officials, the OIG considered adding serious injuries to its database but chose instead to revise the law to clarify that serious injuries are reportable to OIG only if abuse and neglect by staff is alleged or suspected including injuries caused by an employee directing an individual to injure another. In August 2009, Public Act 96-407 became effective. In September 2009, OIG revised Rule 50 on an emergency basis. In October 2009, the OIG distributed by e-mail to all community agencies and State facilities a letter that detailed the changes in statute and highlighted the expanded definitions. According to data provided by the OIG, since November 2009, allegations of abuse and neglect have increased significantly. In March 2010, the final rules were adopted for Rule 50.

- **Timeliness of Case Completion (Partially Implemented) –** Timeliness of abuse and neglect investigations has improved in each of the past three audits. According to OIG officials, despite fiscal constraints, the time to complete investigations has continued to drop. The OIG has hired two nurses under contract to assist with abuse and neglect investigations and more specifically death investigations. According to the OIG, this has had a positive impact on these cases. Overall case completion for abuse and neglect investigations for FY09 and FY10 continued to improve (see Chapter Two).

- **Reporting to State Police (Implemented) –** According to OIG officials, all investigative bureau chiefs were e-mailed in December 2008, and reminded to document notification of ISP with the new form. An electronic database version of the form was also implemented. According to data provided by the OIG, during the first half of FY10, 17 cases were reported to ISP with an average of less than three hours after credible evidence was determined and all of the cases were reported

within 24 hours. During our case file testing we found that all cases were reported in a timely manner and documented using the proper OIG form.

- **Emergency Hires (Implemented) –** Our personnel review of new DHS OIG employees since the previous audit found that emergency hires were not used by the OIG.

- **Investigator Assignment and Investigative Plans (Not Implemented) –** 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 24 of the 123 (20%) 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 9 of the 128 (7%) 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 cases sampled, 109 required an investigative plan. Of those 109, 6 (6%) were not completed and approved within the required three working days.

- **Allegation Reporting (Partially Implemented) –** According to OIG officials, the OIG conducted 27 trainings in Rule 50 reporting with a total of 583 participants during FY09 and 31 trainings with a total of 752 participants during FY10. The OIG also sends monthly reports to the DHS Divisions of Mental Health and Developmental Disabilities regarding the timeliness of reporting. Reporting allegations of abuse and neglect by community agencies improved over the past two years. For FY10, the percent of allegations not reported within the required four hours was 13 percent or nearly half of what it was two years ago. State facilities, however, continue to struggle with meeting the four hour reporting requirement with 10 percent not reported within four hours.

- **Case File Reviews (Implemented) –** OIG created a database report to assist bureau chiefs in monitoring case review time, which had accounted for a substantial portion of OIG's total time to completion. The Deputy IG continues to conduct Quarterly Reviews of unfounded and unsubstantiated cases that are not required to have his routine review by the OIG directives. According to OIG officials, these reviews have not identified any substantial issues. Thus, the OIG considered but decided against requiring the Inspector General or his designee to review all substantiated cases.

- **Investigative Consistency (Implemented) –** Changes made by Public Act 96-407 in August 2009 include "substantial risk" in the definition of neglect. OIG administrative rules also now define "bodily harm" and no longer require proving that a "physical injury" occurred. OIG also conducted internal training with investigative staff to ensure consistent understanding and application of these definitions. During our file review we found that overall the investigations were consistently conducted.

- **DHS Approval of Written Responses (Partially Implemented) –** During our case file testing we found that DHS, in some cases, still takes an excessive amount of time to receive and approve the actions taken by the agency or facility. Overall there were 28 cases in our sample that required a written response. Of the 28 cases in our sample, 5 of 28 (18%) took more than six months from the date the case was completed until the written response was approved by DHS (see Chapter Four).

- **Rule 50 Training (Implemented) –** DHS is now tracking and monitoring facility staff training in Rule 50. In our previous audit in 2008, DHS could not document that all staff at State-operated facilities received the required Rule 50 training (see Chapter Five).

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. 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 compliance with the Act and effectiveness in investigating reports of allegations occurring in any facility or agency. Detailed audit objectives are outlined in Appendix B of this report.

Initial work began on this audit in March 2010 and fieldwork was concluded in September 2010. We interviewed or contacted representatives from the DHS 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 FY10 and analyzed electronic data for Fiscal Years 2009 and 2010. 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(w) of the Department of Human Services Act (20 ILCS 1305) (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 10 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, 2006, and 2008.

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, site visits, and sanctions.
- **Chapter Five** discusses the Quality Care Board and training.

Chapter Two

TIMELINESS OF ABUSE OR NEGLECT INVESTIGATIONS

CHAPTER CONCLUSIONS

The timeliness of OIG investigations continued to improve in FY09 and FY10. In FY08, 60 percent of OIG investigations were completed in 60 calendar days. Timeliness improved in FY09 with 61 percent and in FY10 with 69 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 working days standard, the OIG's timeliness of case completion reached its highest percent ever at 85 percent for FY10.

Although there has been continued improvement over the past three audits in the overall timeliness of investigations of abuse and neglect, the timeliness of cases assigned to Clinical Coordinators continues to be a problem. Cases assigned to Clinical Coordinators involve a death or other medical issues. Of the 327 cases closed in FY10 that took more than 60 working days to complete, 98 were clinical.

The OIG continues to utilize other OIG bureaus outside of its investigative bureaus to help complete cases. This includes assigning cases to the Bureau of Domestic Abuse (DAP), Bureau of Hotline and Intake, and the Bureau of Compliance and Evaluation (BCE). These bureaus were responsible for approximately 11 percent of investigations completed in FY10 (242 of 2,150). This is similar to the previous audit.

Our FY08 audit contained a recommendation to the OIG to maintain the necessary documentation to monitor whether referrals to State Police or local law enforcement are timely. In our testing of FY10 cases, five cases were referred to State Police or local law enforcement. We obtained copies of all five checklists from the investigative files. For all five cases, the proper form was used and we determined that the incident was reported to the State Police or local law enforcement within the required 24 hours.

We reviewed investigator caseloads for the different investigative bureaus at the OIG. Caseloads have doubled for three of the four investigative bureaus since our last audit. Caseloads as of August 2010 ranged from 23 in the Metro Bureau to 12 in the South Bureau. Caseloads as of August 2008 ranged from 11 in the Metro and South Bureaus to 7 in the North Bureau.

Even though the OIG no longer requires critical interviews, we continue to look at the amount of time it takes to collect statements and interview the alleged victim and the alleged perpetrator in abuse and neglect cases. Our FY08 audit found that it took an average of 8 days to complete statements or interviews with the alleged victim, which was 4 fewer days than the 12

days it took in FY06. For FY10 cases we sampled where there was a victim identified and the victim was verbal, it took an average of 9 days to complete statements or interviews for the alleged victim.

Our FY08 audit found that it took an average of 20 days to complete statements or interviews with the alleged perpetrator, which is 5 days fewer than the 25 days it took in FY06. For FY10 cases we sampled where there was a perpetrator identified, it took an average of 17 days to complete statements or interviews for 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 24 of the 123 (20%) 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 or is a death investigation. For 9 of the 128 (7%) cases we sampled, we could not determine whether the plan was completed in a timely manner because there was either no investigative plan in the file, there was no date on the investigative plan, or we could not determine the date assigned. For 10 of the 128 (8%) cases we sampled, an investigative plan was not required because the case involved a recanted allegation, a death, or was a State Police investigation. For the remaining cases sampled, 109 required an investigative plan. Of those 109, 6 (6%) were not completed and approved within the required three working days.

The timeliness of reporting allegations of abuse and neglect by community agencies improved substantially during FY09 and FY10. For FY10, the percent of allegations not reported within the required four hours was 13 percent or nearly half of what it was two years ago. However, alleged incidents of abuse and neglect are not consistently being reported to the OIG by facilities and community agencies in the time frames required by the statutes and OIG's administrative rules. In FY10, 10 percent of facility incidents were not reported within the four-hour time requirement.

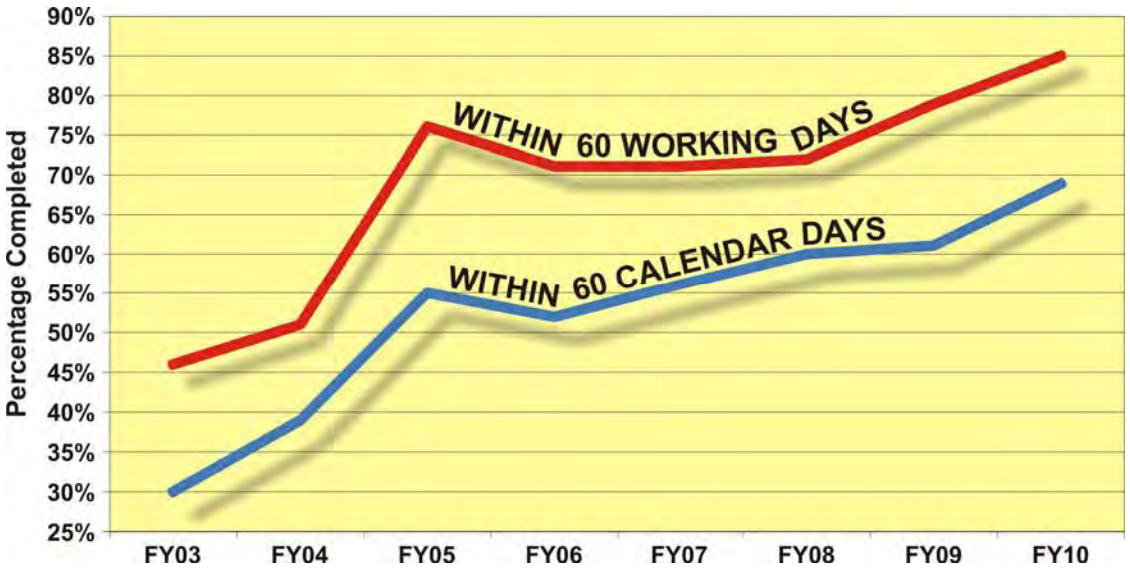
INVESTIGATION TIMELINESS

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 ten previous OIG audits. Exhibit 2-1 shows that since FY03 the OIG has made significant improvements to the timeliness of investigations. During this audit period, the OIG again made improvements in its timeliness for completing investigations. In FY08, 60 percent of OIG investigations were completed in 60 calendar days. For FY10, 69 percent of cases were completed within 60 calendar days.

Exhibit 2-1
ABUSE AND NEGLECT INVESTIGATION TIMELINESS TRENDS
Fiscal Years 2003 to 2010



Source: OAG analysis of OIG data.

In FY06, the average was 69 calendar days and the median was 57 calendar days. In FY08, the average was 63 calendar days and the median was 43 calendar days. For FY10, the average calendar days to complete an investigation was 57 days and the median was 42 days.

Exhibit 2-2 shows the percentage of cases completed in terms of ranges of the number of days to completion for Fiscal Years 2005 to 2010. 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.

Exhibit 2-2
CALENDAR DAYS TO COMPLETE ABUSE OR NEGLECT INVESTIGATIONS
Fiscal Years 2005 to 2010

Days to Complete Cases	FY05 % of Cases	FY06 % of Cases	FY07 % of Cases	FY08 % of Cases	FY09 % of Cases	FY10 % of Cases
0-60	**55%**	**52%**	**56%**	**60%**	**61%**	**69%**
61-90	22%	19%	15%	13%	19%	17%
91-120	11%	14%	13%	13%	10%	8%
121-180	6%	11%	11%	11%	6%	4%
181-200	1%	2%	1%	0%	1%	0%
>200	5%	2%	3%	2%	4%	2%
Total > 60 days	**45%**	**48%**	**44%**	**40%**	**39%**	**31%**
Total Cases	1,659	1,597	1,936	1,929	2,147	2,150

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.

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 71 percent of its FY07 cases and 72 percent of its FY08 cases within 60 working days. For FY09 and FY10, this improved to 79 percent and 85 percent of cases, respectively, when using the 60 working day standard.

Exhibit 2-3 shows that the Central and North Bureaus had the smallest percentages of cases taking longer than 60 working days, with 8 percent and 4 percent respectively. For the South Bureau, cases taking longer than 60 working days were 11 percent of total cases. The Metro Bureau cases taking longer than 60 working days were 24 percent of total cases. Even through the Metro Bureau had the highest percentage of cases taking more than 60 working days, the 24 percent for FY10 is a substantial improvement over the 64 percent that were not completed within 60 working days for FY08.

Exhibit 2-3
CASES WITH INVESTIGATIONS GREATER THAN 60 WORKING DAYS
Cases Closed During Fiscal Year 2010

OIG Bureaus	Number of Cases Greater Than 60 Working Days	Total Cases Closed	Percent Greater Than 60 Working Days
North	20	510	4%
Metro	115	471	24%
Central	48	565	8%
South	39	362	11%
Other [1]	105	242	43%
Total	**327**	**2,150**	**15%**

Note:

[1] Other includes cases assigned to the Bureau of Compliance and Evaluation, Bureau of Domestic Abuse, Bureau of Hotline and Intake, or Clinical Coordinators. Of the 105 cases completed by other bureaus, 98 were clinical.

Source: OIG data summarized by OAG.

The OIG has taken steps to address these timeliness problems by utilizing other bureaus to help complete cases. This includes assigning cases to be completed by the Bureau of Domestic Abuse (DAP), Bureau of Hotline and Intake, and the Bureau of Compliance and Evaluation (BCE). For the 2,150 cases closed in FY10, 242 cases were completed by other bureaus. For FY08, 219 cases were completed by other bureaus. The 242 cases completed by other bureaus during FY10 included 149 assigned to Clinical Coordinators which include death cases and cases that involve a medical issue. About two-thirds (98 of 149) of the cases assigned to Clinical Coordinators took longer than 60 working days to complete. Of the remaining cases, 68 were assigned to intake investigators, 10 were assigned to DAP, and 15 were assigned to BCE.

Cases Over 200 Days

Exhibit 2-4 shows the types of allegations taking more than 200 calendar days to complete from FY06 through FY10. The number of OIG investigations taking more than 200 calendar days to complete increased from 38 in FY06 to 40 in FY08 to 51 in FY10. The primary reason is because of the number of allegations over 200 days involving deaths investigations increased considerably in FY09 and FY10.

Exhibit 2-4
TYPES OF ALLEGATIONS IN CLOSED CASES OVER 200 CALENDAR DAYS TO COMPLETE
Fiscal Years 2006, 2008, & 2010

Type of Allegation	FY06	FY08	FY10
Physical Abuse	16	9	1
Neglect	16	20	11
Verbal Abuse	2	5	1
Death	0	3	38
Sexual Abuse	3	3	0
Mental Injury/Psychological Abuse	1	0	0
Total	**38**	**40**	**51**

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

Source: OAG analysis of OIG data.

For FY09, there were 82 investigations that took more than 200 days to complete. Of these 82 investigations, 50 involved a death. As shown in Exhibit 2-4, for FY10 there were 51 cases that took more than 200 days to complete. Of these 51, 38 involved a death. These cases are not assigned to a specific bureau but instead are assigned to a Clinical Coordinator. According to OIG officials, death cases take longer to complete because it is a serious event: records from hospitals and medical examiners often take a long time to obtain, and additional consults may be needed.

Of the 51 cases that took more than 200 days to complete for FY10, 17 of 51 (33%) were State-operated facilities, while 34 (67%) were investigations of allegations at community agencies.

Clinical Coordinators

The 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. As of June 30, 2010, the OIG had four Clinical Coordinators (two full-time staff and two contract staff). One of these coordinators also conducts annual site visits to State-operated facilities.

The time to conduct investigations assigned to a Clinical Coordinator increased significantly from FY06 to FY10. 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. For FY10 the average completion time for cases assigned to Clinical Coordinators was 166 days. According to OIG officials, Clinical Coordinators have been involved in more cases. During FY07-08, Clinical Coordinators

completed 231 cases and were secondary investigators in 51 other cases. During FY09-10, Clinical Coordinators completed 302 cases and were secondary investigators in 145 other cases, nearly three times as many. The OIG hired another registered nurse on contract in FY09 to help reduce the time required for completing death cases, as well as conducting investigations involving clinical issues.

TIMELINESS OF CASE COMPLETION	
RECOMMENDATION 3	***The Office of the Inspector General should continue to work to improve the timeliness of investigations of abuse and neglect. The OIG should also work to improve the timeliness of investigations conducted by Clinical Coordinators, especially death investigations.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree. Exhibit 2-1 shows that OIG has greatly improved the timeliness of its investigations, including those into deaths; investigations in FY10 took 10% less time than in FY08. OIG now involves a Clinical Coordinator in more of these investigations, to ensure clinical issues are covered. As a result, reviews of deaths with no abuse/neglect have been given lower priority. The Bureau Chiefs and Clinical Coordinators will be reminded not to delay these reviews unnecessarily.

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(l)) requires that:

Within 24 hours after determining that there is credible evidence indicating that a criminal act may have been committed or that special expertise may be required in an investigation, the Inspector General shall notify the Department of State Police or other appropriate law enforcement authority, or ensure that such notification is made. The Department of State Police shall investigate any report from a State-operated facility indicating a possible murder, sexual assault, or other felony by an employee. All investigations conducted by the Inspector General shall be conducted in a manner designed to ensure the preservation of evidence for possible use in a criminal prosecution.

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 2-5 shows the number of cases referred to the State Police and the disposition of those cases.

Exhibit 2-5
DISPOSITION OF CASES REFERRED TO STATE POLICE
Fiscal Years 2007 to 2010

Disposition	Number of Cases			
	FY07	FY08	FY09	FY10
Referred back to OIG without investigation	43	44	38	34
Declined by Prosecutor	10	2	9	3
Not Sustained	13	8	0	1
Conviction	6	0	0	0
Unfounded	1	0	2	0
Dismissed	1	1	1	0
Admin. Closed	0	0	8	5
Total	**74**	**55**	**58**	**43**

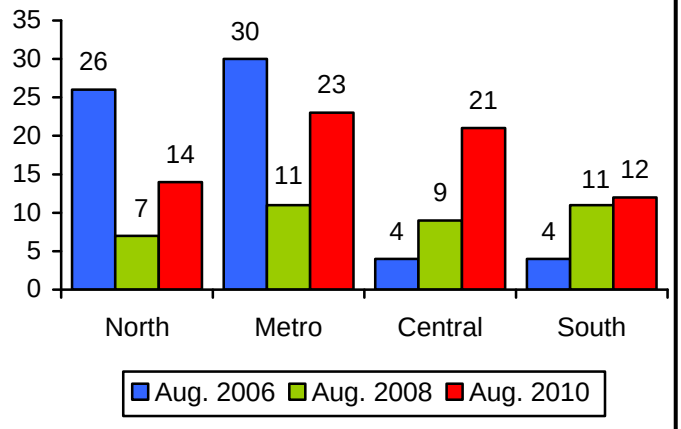
Source: OAG analysis of Illinois State Police data.

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. Our FY08 audit contained a recommendation to the OIG to maintain the necessary documentation to monitor whether referrals are timely. In our testing of FY10 cases, 5 of 128 cases sampled were referred to State Police or local law enforcement. We obtained copies of all five checklists from the investigative files. For all five cases, the proper form was used and we determined that the incident was reported to the State Police or local law enforcement within the required 24 hours.

Investigator Caseloads

Caseloads have doubled for three of the four investigative bureaus since our last audit. Exhibit 2-6 shows the trend in caseloads by bureau from 2006 through 2010. Caseloads as of August 2010 ranged from 23 in the Metro Bureau to 12 in the South Bureau.

Exhibit 2-6
INVESTIGATOR CASELOADS
By Bureau as of August 14, 2006, 2008, and 2010



Source: OIG data summarized by OAG.

Exhibit 2-7 shows that in FY10, the highest average cases completed per month by investigator and bureau was 9.9 in the South Bureau. This is double the number reported in the previous audit for the South Bureau. The lowest monthly average cases completed per investigator was 7.8 in the Metro Bureau. The average days to complete a case in FY10 ranged from 44 in the Central Bureau to 79 days in the Metro Bureau. The 79 average days is a significant improvement over the 103 average days in the previous audit in FY08 and the 124 days in the FY06 audit. The North Bureau average also dropped significantly from an average of 114 days in FY06 to 67 days in FY08 to 45 days for FY10. The Central and South Bureaus saw increases to 44 days and 53 days respectively.

As seen in Exhibit 2-7, there continue to be increases in the number of allegations of abuse or neglect reported since FY08. From FY08 to FY10, allegations increased by 412 (22%), not including death investigations or State Police investigations. The number of allegations reported increased for every bureau. The Metro Bureau had a 21 percent increase in allegations and the South Bureau had a 29 percent increase.

Exhibit 2-7
INVESTIGATIONS COMPLETED AND INVESTIGATION TIMELINESS BY BUREAU
Fiscal Years 2008 and 2010

	Cases Reported		**Investigations Completed**		**Investigations Open at End of Fiscal Year**		**Monthly Cases Completed Per Investigator**		**Avg. Calendar Days to Complete**	
	FY08	FY10	FY08	FY10	FY08	FY10	FY08	FY10	FY08	FY10
North	308	426	393	506	64	58	9.2	8.4	67	45
Metro	625	755	559	496	118	152	7.5	7.8	103	79
Central	588	651	522	570	73	93	10.2	9.2	36	44
South	354	455	312	363	52	72	4.6	9.9	43	53
Totals	**1,875**	**2,287**	**1,786**	**1,935**	**307**	**375**	**7.1**	**8.7**	**65**	**55**

Source: OIG data summarized by OAG.

The OIG has been proactive in trying to improve the timeliness of investigations. The OIG began redistributing caseloads among different bureaus during the previous audit. For instance, the North Bureau completed 138 investigations for the Metro Bureau. The redistribution of cases also includes using some traditionally non-investigative bureaus including the Bureau of Hotline and Intake, the Bureau of Domestic Abuse, and the Bureau of Compliance and Evaluation (see Exhibit 2-8).

Exhibit 2-8
BUREAU OF INCIDENT VS. INVESTIGATIVE BUREAU
Abuse or Neglect Cases Closed in Fiscal Year 2010

Investigating Bureau	Bureau of Incident			
	North	Metro	Central	South
North	373	138	0	0
Metro	0	488	1	0
Central	1	2	562	2
South	0	0	4	359
Intake	8	9	9	42
Clinical	11	2	2	0
DAP	0	0	10	4
BCE-Comp	0	0	15	0
Totals	393	639	603	407

Note: This exhibit presents cases closed for FY10, not including death investigations. Numbers presented in Exhibit 2-7 represent investigations completed which may include cases not yet closed.

Source: OAG analysis of OIG data.

During our previous audit in FY08, the Bureau of Hotline and Intake conducted investigations of allegations that were recanted at intake and also investigated some allegations of mental injury. In FY10, Intake conducted 10 percent (42 of 407) of investigations for the South Bureau. We reviewed these 42 cases and found that they included 26 allegations made and later recanted by the same individual.

Timeliness of Investigative Interviews

Even though the OIG no longer requires critical interviews, we continue to look at the amount of time it takes to collect statements and interview the alleged victim and the alleged perpetrator in abuse and neglect cases. 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.

Our FY08 audit found that it took an average of 8 days to complete statements or interviews with the alleged victim, which was 4 fewer days than the 12 days it took in FY06. For FY10 cases we sampled where there was a victim identified and the victim was verbal, it took an average of 9 days to complete statements or interviews for the alleged victim.

Our FY08 audit found that it took an average of 20 days to complete statements or interviews with the alleged perpetrator, which is 5 days fewer than the 25 days it took in FY06. For FY10 cases we sampled where there was a perpetrator identified, it took an average of 17 days to complete statements or interviews for 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. For cases in which we could determine an assignment date, 80 percent (99 of 123) we reviewed were assigned within one working day. However, for 24 of the 123 (20%) 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 2 days to 23 days. For five 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 or is a death investigation. For 10 of the 128 (8%) cases we sampled, an investigative plan was not required because the case involved a recanted allegation, a death, or was a State Police investigation. For 9 additional cases we could not determine whether the plan was completed in a timely manner because there was either no investigative plan in the file (2 cases), there was no date on the investigative plan (4 cases), or we could not determine the date assigned (3 cases). For the remaining 109 cases sampled for which an investigative plan was required and we could calculate the days from assignment to approval, 6 (6%) were not completed and approved within the required three working days.

INVESTIGATOR ASSIGNMENT AND INVESTIGATIVE PLANS	
RECOMMENDATION 4	***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	Agree. OIG will remind the investigative bureaus to assign all investigations and to complete all investigative plans within the required time frames.

Timeliness of Case File Reviews

Timeliness of case file review has improved since our last audit for cases that were not substantiated, while timeliness of case file review for substantiated cases remained about the same (see Exhibit 2-9). 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) or 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.

Exhibit 2-9
AVERAGE CALENDAR DAYS FROM DATE SUBMITTED FOR REVIEW UNTIL FINAL REVIEW BY BUREAU CHIEF
Fiscal Years 2008 to 2010

	Cases Substantiated [1]			Cases Not Substantiated [1]		
	FY08	**FY09**	**FY10**	**FY08**	**FY09**	**FY10**
North	17	23	20	7	9	6
Metro	44	39	37	14	14	13
Central	19	26	30	13	15	16
South	29	21	21	8	8	4
Total Avg.	**26**	**27**	**27**	**11**	**12**	**10**

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 the longest (37 days on average) to review substantiated cases when compared to the other three bureaus. This is a substantial improvement over FY06 when it took 68 days on average for case review in the Metro Bureau. 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.

Reporting allegations of abuse and neglect by community agencies improved over the past two years. For FY10, the percent of allegations not reported within the required four hours was 13 percent or nearly half of what it was two years ago. State facilities, however, saw an increase in the percent of cases that were not reported within the required four hours. Exhibit 2-10 shows allegations of abuse and neglect not reported within four hours of discovery for State facilities and community agencies from FY07 through FY10.

- **Facility** - 10 percent of facility incidents were not reported within the four-hour time requirement in FY10 compared to 7 percent in FY08.

- **Community Agency** - 13 percent of community agency incidents were not reported within the four-hour time requirement in FY10 compared to 25 percent in FY08.

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

Fiscal Year	Facility	Community Agency
FY07	5%	21%
FY08	7%	25%
FY09	9%	19%
FY10	10%	13%

Source: OAG analysis of OIG data.

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. The OIG continues to cite late reporting in its investigations when it occurs. OIG officials cited late reporting in 34 cases in FY06, 68 cases in FY07, and 175 cases in FY08. The FY09 OIG annual report shows that the OIG cited late reporting in 305 cases in FY09. For FY10, the OIG cited late reporting in 190 cases.

ALLEGATION REPORTING	
RECOMMENDATION 5	***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 the Department of Human Services Act and OIG's administrative rules.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree. OIG has proposed a revision to the DHS program directive on reporting of abuse or neglect, clarifying and strengthening the requirements for reporting. OIG continues to flag late reporting on initial intakes, to identify late reporting to the divisions every month, to cite late reporting in investigative case reports, and to provide an electronic Rule 50 training for the facilities and agencies to use for internal training on reporting.
DEPARTMENT OF HUMAN SERVICES RESPONSE **DHS Response Continued on Next Page**	The Department accepts the recommendation. The Division of Mental Health will enhance their procedures to ensure that the Office of the Inspector General's (OIG) Late Reporting Data will be added to each hospital's FY'11 Performance Indicators (measures) to ensure that allegations of abuse or neglect are reported within the time frame specified in the Department of Human Services Act and OIG's Administrative Rules. The Division of Developmental Disabilities, Bureau of Quality Management will communicate with community agencies on an on-going basis regarding community agency responsibility to ensure that

DHS Response (Continued)	allegations of abuse or neglect are reported to the Office of the Inspector General within the required time frame.

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 4 of 21 (19%) cases where there was an allegation of an injury sustained from our FY10 sample. Injury reports were missing in 1 of 21 (5%) cases where there was an allegation of an injury sustained. All of the sampled cases contained pertinent medical records, treatment plans, or progress notes. Only one case sampled in which restraints were involved did not contain the restraint seclusion monitoring documentation. However, in this case, the OIG cited the agency for improper use of restraints. All of the cases also contained a Case Tracking form. Although all of the 128 sample cases tested contained a Case Routing/Approval Form, three were not reviewed and signed off on by a Bureau Chief. These three cases were all in the South Bureau.

In the previous audit we found that, for community agency conducted investigations in our sample, it was sometimes difficult to determine which bureau and investigator was responsible for reviewing the case. We also reported that the Inspector General or his designee is not required to review substantiated cases of mental injury or neglect unless it is deemed "egregious" neglect. As a result of the finding in our previous audit, the OIG created a database report to assist Bureau Chiefs in monitoring case reviews. The Deputy Inspector General also continues to conduct quarterly reviews of unsubstantiated cases. In July 2009, the OIG considered but decided against requiring the Inspector General or his designee to review all substantiated cases.

The OIG has continued to take steps to improve investigative consistency. In the previous two audits, we identified issues related to investigative consistency. These issues included consistency in what constitutes a reportable allegation, and the classification of the outcome of cases as substantiated, unsubstantiated, and unfounded. Effective August 13, 2009, Public Act 96-407 amended the Department of Human Services Act (20 ILCS 1305) relating to the DHS Office of Inspector General. The Public Act changed and/or clarified several of the definitions related to abuse and neglect. The OIG has also updated its administrative rules. Effective September 10, 2009, the OIG established an emergency rule to implement the changes made by Public Act 96-407. These rules were adopted effective March 25, 2010. Many of the changes made to the statutes and OIG's rules should help ensure the consistency of the OIG investigations.

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 working days of assignment and send the plan to the Bureau Chief.

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 FY10 were generally thorough and contained the appropriate documentation. However, some files were missing documentation that should have been gathered during the investigation.

OIG administrative rules require that the case files contain all investigatory materials, including physical and documentary evidence, such as photographs, interview statements and records (59 Ill. Adm. Code 50.60 (c)). 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 4 of 21 (19%) cases from our sample where there was an allegation of an injury sustained. In one case, the case file stated that photos were taken; however, no photos were in the file. In another case, the injury was a hip fracture found a few days after it occurred. According to OIG officials, the client had no external evidence of an injury, so photos were not taken.
- **Injury Report:** Injury reports were missing in 1 of 21 (5%) cases where there was an allegation of an injury sustained. This was a community agency case. According to OIG officials, community agencies do not use the DHS injury report forms.
- **Medical Records/Treatment Plans/Progress Notes:** All 128 sample cases, contained pertinent medical records, treatment plans, or progress notes.
- **Restraint/Seclusion Records:** Of the 128 cases sampled, 13 involved the use of restraints. Only one case sampled in which restraints were involved did not contain the restraint seclusion monitoring documentation. However, in this case, the OIG cited the agency for improper use of restraints.

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 FY10 cases to see if they included a statement or interview with the alleged victim and the alleged perpetrator. Of the 128 cases we reviewed, two cases involved a victim that was verbal and the case file did not contain a written statement or interview with the victim. One case did not contain documentation of an interview with the alleged perpetrator. These cases were investigations that were conducted by a community agency. The OIG provided copies of the final case reports for these investigations that referenced interviews conducted with the alleged victims and the alleged perpetrator.

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. Although the tracking form was in the file, there were instances in which the information on the tracking sheet did not match the information in OIG's database. 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. We followed up on critical differences and found that although there were some typos, in most cases the database we use for calculations in the audit was correct.

- **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. All of the 128 cases tested contained a Case Routing/Approval Form. However, for three cases there was no review or approval by the Bureau Chief or anyone else for that matter on the case routing and approval form. The OIG's directives require that the Bureau Chief sign off on the Case Routing/Approval Form (INV 02-020). All three of these cases were in the South Bureau. In FY10, the OIG's Bureau Chief for the South Bureau retired effective November 30, 2009. As of June 30, 2010, the Bureau Chief for the OIG's Central Bureau was also filling in as the acting Bureau Chief for the South Bureau.

CASE FILE REVIEWS	
RECOMMENDATION 6	***The Office of the Inspector General should ensure that all routing and approval forms are completed and signed off on by the Bureau Chief.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree. The audit report indicates that 125 of 128 (98%) of the routing and approval forms tested were complete and signed; the only three not signed were from a bureau where the bureau chief position was in transition. OIG will remind the bureau chiefs to sign these forms.

Investigative Reports

The OIG investigative reports that we tested 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.

In the previous audit we found that, 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. We also discussed the fact that the Inspector General or his designee is not required to review substantiated cases of mental injury or neglect unless it is deemed "egregious" neglect.

We recommended that the Office of the Inspector General:

- 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.

As a result of the finding in our previous audit, the OIG created a database report to assist Bureau Chiefs in monitoring case reviews. The Deputy Inspector General also continues to conduct quarterly reviews of unsubstantiated cases. In July 2009, the OIG considered but decided against requiring the Inspector General or his designee to review all substantiated cases.

CONSISTENCY AMONG INVESTIGATIVE BUREAUS

The OIG has continued to take steps to try to improve investigative consistency. In the previous two audits, we identified issues related to investigative consistency. These issues included consistency in what constitutes a reportable allegation, and the classification of the outcome of cases as substantiated, unsubstantiated, and unfounded.

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.

In response to our FY06 audit, 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 FY10 quarterly reviews conducted by the Deputy Inspector General of unsubstantiated cases. The reviews contained a summary of each case and a short review of any issues or problems found during the review for the unsubstantiated or unfounded cases sampled. These reviews identified problems such as minor issues with case files and cases that should have been unsubstantiated rather than unfounded. The reviews did not identify any cases that the Deputy Inspector General thought should have been substantiated rather than unfounded or unsubstantiated.

Effective August 13, 2009, Public Act 96-407 amended the Department of Human Services Act (20 ILCS 1305) relating to the DHS Office of Inspector General. The OIG, in a memo to the State facilities and community agencies, stated that the legislation was initiated by

OIG. The Public Act changed and/or clarified several of the definitions related to abuse and neglect (see Chapter One). The OIG has also updated its administrative rules. Effective September 10, 2009, the OIG established an emergency rule to implement the changes made by Public Act 96-407. These new rules were adopted effective March 25, 2010.

Many of the changes made to the statutes and OIG's rules should help the consistency of the OIG investigations. For instance, in our previous audit, we identified neglect cases that involved clients that were left unsupervised that had different outcomes. The definition for neglect now contains a provision so that it includes circumstances where an act or omission by an employee placed the health or safety of an individual at substantial risk, even if no actual harm was done. The statutes now define "neglect" as an employee's, agency's or facility's failure to provide adequate medical care, personal care or maintenance, and that, as a consequence, causes an individual pain, injury or emotional distress, results in either an individual's maladaptive behavior or the deterioration of an individual's physical condition or mental condition, or places an individual's health or safety at substantial risk. This issue and its impact on the inconsistency of investigations has been raised in the last two audits.

Another consistency issue raised in previous audits is related to the definition of ***physical harm***. In our 2006 audit, we found that there may have been different interpretations for the definition of physical harm. The OIG's definition, at that time, of abuse and neglect in its administrative rules included the term "physical injury." OIG's administrative rules at the time defined physical injury as physical harm. However, physical harm was not defined in the Department of Human Services Act (20 ILCS 1305/1-17) or in Rule 50. We recommended that the Inspector General should clearly define what constitutes physical injury and physical harm.

Public Act 96-407 changed the definition for physical abuse so that it no longer requires a documented physical injury and a provision was added to include indirect actions where an employee directs or encourages another person to physically abuse an individual. "Physical abuse" is now defined as an employee's non-accidental and inappropriate contact with an individual that causes bodily harm. "Physical abuse" includes actions that cause bodily harm as a result of an employee directing an individual or person to physically abuse another individual." The OIG also promulgated rules that define "bodily harm" as any injury, damage or impairment to an individual's physical condition, or making physical contact of an insulting or provoking nature with an individual (59 Ill. Adm. Code 50.10). Prior to the newly promulgated rules, neither the statutes nor administrative rules defined "bodily harm." These changes directly address recommendations in our previous audits in 2006 and 2008.

Chapter Four

ACTIONS, SANCTIONS, AND RECOMMENDATIONS

CHAPTER CONCLUSIONS

Although the annual number of substantiated abuse and neglect cases has varied over the past four years, the substantiation rate has remained fairly consistent. From FY07 to FY10 the overall substantiation rate has ranged from 11 percent to 12 percent. The substantiation rate at community agencies has been approximately 16 percent each year for the past four years.

State facilities and 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, in some cases, still takes an excessive amount of time to approve the actions taken by the agency or facility. Overall, 28 of 128 cases we sampled required a written response. Of the 28 cases, 5 (18%) took more than six months from the date the case was completed until the written response was approved by DHS. Our previous audit contained a recommendation to DHS to ensure that written responses are approved in a timely manner. In that audit there were cases that took more than a year for approval of the written response. During the later part of FY08, the Division increased its efforts to approve written responses in a timely manner. Although timeliness has improved, there are still cases that are not approved in a timely manner.

According to 59 Ill. Adm. Code 50.90, an employee may request a hearing with DHS 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 found in favor of the petitioner, and therefore the employee was not referred to the Health Care Worker Registry, increased in FY10. The ALJ decision resulted in the employee not being referred to the registry in 23 percent of the appeal decisions in FY09 (7 of 30). For FY10 appeal decisions, this increased to 51 percent (18 of 35).

Stipulation and consent orders were used more frequently during FY09 and FY10. 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 chose not to refer a case to the Registry based on a stipulation order in 12 cases for FY09 and FY10.

During FY09, the OIG recommended that DHS' Division of Developmental Disabilities take immediate action against one community agency, up to and including sanctions. This was due to the OIG's concern that a culture of abuse and neglect at the particular agency put the individuals receiving services at a great risk of harm.

Even though two facilities remained decertified from participation in Medicare and Medicaid, and the U.S. Department of Justice released reports with serious concerns about two facilities, the OIG did not recommend any sanctions to the Secretary of DHS for any State operated-facility. During FY09 and FY10 two State-operated facilities (Howe DC and Tinley Park MHC) remained terminated from participation in federal programs for non-compliance with various issues, including patient safety and client protection. In addition, in November 2009 the U.S. Department of Justice released investigations of two facilities (Howe DC and Choate DC) that raised serious concerns regarding the health and safety of residents in those facilities. OIG has not recommended a sanction related to a State-operated facility for at least the past 17 years (1994-2010).

During FY09 and FY10, 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(i)). Also, during FY09 and FY10, the OIG met its established timeline for submitting site visit reports to facility directors or hospital administrators. The goal of these visits is to review systemic issues that may be related to the prevention of abuse or neglect of individuals receiving services in the facilities.

Exhibit 4-1
ABUSE AND NEGLECT CASES CLOSED AND SUBSTANTIATED
(Allegations Categorized as Abuse or Neglect at Intake)
Fiscal Years 2002 to 2010

	Individuals Served[1]	Closed Cases	Substantiated Cases	Substantiated %
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%**
FY09 Facility	12,583	891	37	4%
FY09 Community[2]	206,013	1,334	216	16%
FY 2009 Total	**218,596**	**2,225**	**253**	**11%**
FY10 Facility	12,722	870	45	5%
FY10 Community[2]	200,647	1,292	213	16%
FY 2010 Total	**213,369**	**2,162**	**258**	**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–FY10 DD individuals served data 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.

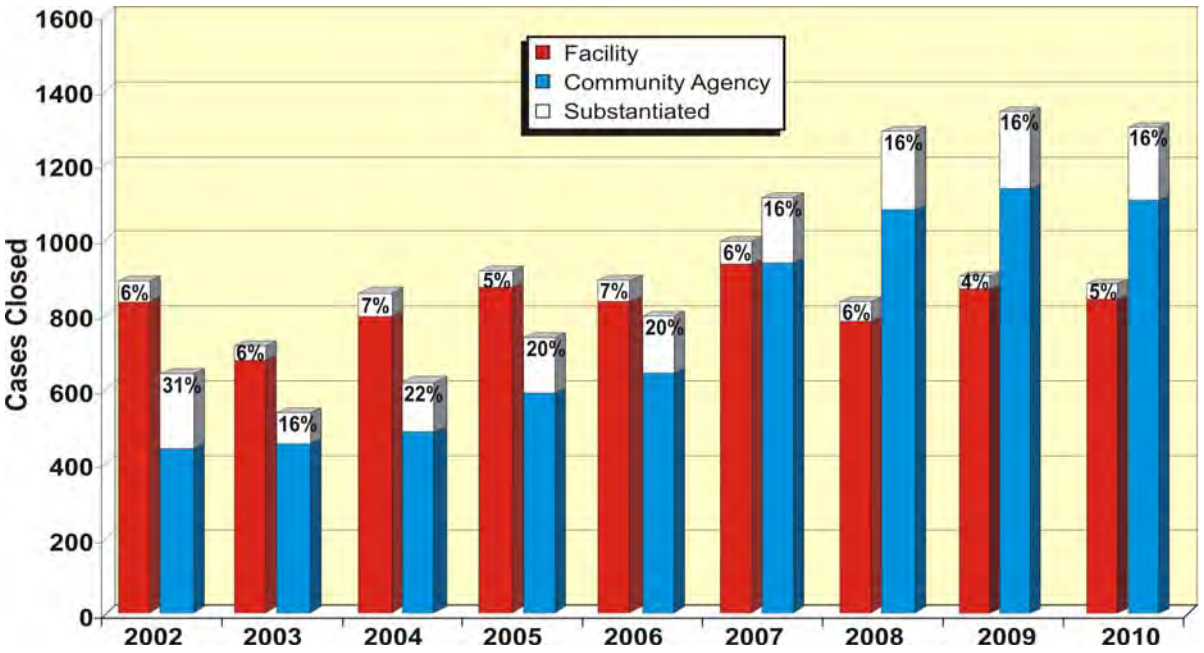
Source: OIG information summarized by OAG.

SUBSTANTIATED ABUSE AND NEGLECT CASES

In FY10, the OIG closed a total of 2,162 investigations of allegations of abuse or neglect. The OIG substantiated 258 cases 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 varied over the past four years, the substantiation rate has remained fairly consistent. From FY07 to FY10 the overall substantiation rate has ranged from 11 percent to 12 percent. The substantiation rate at community agencies has been approximately 16 percent each year for the past four years.

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 2002 to 2010



Note: State facilities served 2,485 individuals with developmental disabilities and 10,237individuals with mental illness in FY10. Community agencies served approximately 37,500 individuals with developmental disabilities and approximately 163,147 individuals with mental illness in FY10.

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 issues the OIG thinks should be addressed. Some examples of recommendations for actions in substantiated cases include retraining, or policy creation or revision. The OIG may also report the individual 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 FY10 by the type of recommended action and by the investigating agency. The number of recommended actions is similar to our previous audit. For FY10, there were 261 substantiated cases while FY08 had 262.

Exhibit 4-3
RECOMMENDED ACTIONS FOR SUBSTANTIATED CASES
(All Allegations Regardless of Category at Intake)[1]
Fiscal Year 2010

RECOMMENDED ACTION	INVESTIGATED BY			TOTAL
	OIG	Community Agency	State Police	
No Action	49	4	0	53
Retraining	37	5	0	42
Policy Creation or Revision	16	0	0	16
Other Administrative Action	64	20	3	87
Referral to Other Agency	1	0	0	1
Health Care Worker Registry	57	0	5	62
Total Substantiated	**224**	**29**	**8**	**261**

Notes:
[1] Data in Exhibit 4-3 includes 3 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.

For FY10, as in previous years, other administrative action was the most recommended action in substantiated cases. Other administrative actions were recommended in 87 cases or 33 percent of the cases. It was the most frequently used action in both the OIG and community agency investigations. Other administrative actions include, but are not limited to, suspension, termination, and reprimand. In FY10, recommended actions of "no action" and "retraining" were similar to those in the previous audit. The number of cases in which the recommended action was referral to the Health Care Worker Registry decreased slightly from 65 in FY08 to 62 in FY10.

Exhibit 4-4
SUBSTANTIATED CASES BY TYPE OF ALLEGATION AND ACTIONS TAKEN
(All Allegations and Deaths Regardless of Category at Intake)
Fiscal Year 2010

TYPE OF ALLEGATION	INVESTIGATED BY				ACTIONS TAKEN AGAINST EMPLOYEE(S)[2]
	OIG	Agency	DII/ LLE [1]	Total	
A-1 -Physical abuse with imminent danger	0	0	1	1	Counseling, Discharge, Re-Training, Suspension
A-2 -Physical abuse with serious harm alleged	1	0	0	1	Discharge
A-3 -Physical abuse without serious harm alleged	70	0	2	72	Administrative change, Counseling, Discharge, Fired (other cause), Group training, Hab./Treatment change, Oral Reprimand, Policy change, Procedural change, Reassignment, Resignation, Re-Training, Reviewed, Supervision, Suspension, Transferred, Written Reprimand
A-4 -Sexual abuse alleged	4	0	3	7	Discharge, Procedural change, Resignation
A-5 -Mental abuse (verbal) alleged	35	9	0	44	Administrative change, Counseling, Discharge, Group training, Hab./Treatment change, Performance Evaluation, Job Reassignment, Resignation, Re-Training, Supervision, Suspension, Written Reprimand
A-6 -Mental abuse (psychological) alleged	20	1	0	21	Counseling, Discharge, Group training, Hab./Treatment change, Procedural change, Resignation, Re-Training, Reviewed, Supervision, Suspension, Written Reprimand
A-7 -Financial exploitation alleged	6	2	0	8	Counseling, Discharge, Procedural change, Resignation
Total Abuse Cases	**136**	**12**	**6**	**154**	
N-1 -Neglect with imminent danger	0	1	0	1	Action pending
N-2 -Neglect in any serious injury	20	3	1	24	Administrative change, Discharge, Fired (other cause), Group training, Hab./Treatment change, Policy change, Procedural change, Reassignment, Resignation, Re-Training, Structural upgrade, Suspension, Written Reprimand
N-3 -Neglect in any non-serious injury	29	6	0	35	Administrative change, Counseling, Discharge, Group training, Hab./Treatment change, Nothing, Policy change, Procedural change, Reassignment, Resignation, Re-Training, Reviewed, Structural repair, Structural upgrade, Suspension, Written Reprimand
N-4 -Neglect in an individual's absence	5	1	0	6	Administrative change, Discharge, Group training, Hab./Treatment change, Procedural change, Reassignment, Re-Training, Written Reprimand
N-5 -Neglect in sexual activity between individuals	1	2	0	3	Counseling, Re-Training, Reviewed, Suspension, Written Reprimand
N-7 -Neglect with risk of harm or injury	30	4	1	35	Administrative change, Counseling, Discharge, Fired (other cause), Group training, Hab./Treatment change, Performance evaluation, Policy change, Procedural change, Reassignment, Resignation, Re-Training, Reviewed, Structural upgrade, Supervision, Suspension, Written Reprimand
Total Neglect Cases	**85**	**17**	**2**	**104**	
D-5 -Death not in a residential program (not suicide or natural)	1	0	0	1	Group training, Procedural change
D-6 -Death by natural cause in residential program (or after transfer)	1	0	0	1	Administrative change, Discharge, Group training, Procedural change, Re-Training
D-7 -Any other reportable death	1	0	0	1	Group training, Policy change
Total Death Cases	**3**	**0**	**0**	**3**	
Total Substantiated	**224**	**29**	**8**	**261**	

[1] DII is the Division of Internal Investigation at the Illinois State Police. LLE is Local Law Enforcement.; only one case was an LLE for FY10.
[2] Each case may involve multiple employees or multiple actions against a single employee.

Exhibit 4-4 shows the type of allegation and the actions taken in the 261 substantiated cases closed in FY10. 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 FY08 through FY10.

OIG SUBSTANTIATED CASES AND WRITTEN RESPONSES

The Department of Human Services Act requires that:

> *Upon completion of an investigation, the Office of Inspector General shall issue an investigative report identifying whether the allegations are substantiated, unsubstantiated, or unfounded. Within 10 business days after the transmittal of a completed investigative report substantiating an allegation, or if a recommendation is made, the Inspector General shall provide the investigative report on the case to the Secretary and to the director of the facility or agency… (20 ILCS 1305/1-17(m)).*

The Act further states that:

> *Within 30 calendar days from receipt of a substantiated investigative report or an investigative report which contains recommendations, absent a reconsideration request, the facility or agency shall file a written response that addresses, in a concise and reasoned manner, the actions taken to: (i) protect the individual; (ii) prevent recurrences; and (iii) eliminate the problems identified. The response shall include the implementation and completion dates of such actions. If the written response is not filed within the allotted 30 calendar day period, the Secretary shall determine the appropriate corrective action to be taken (20 ILCS 1305/1-17(n)).*

According to Rule 50.80(a), 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 implemented the action in the written response.

The OIG is required by the Department of Human Services Act to monitor compliance through a random review of completed written responses. 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

Exhibit 4-5
WRITTEN RESPONSE COMPLIANCE REVIEWS CONDUCTED
Fiscal Years 2008-2010

	FY08	FY09	FY10
Agency	96	166	136
Facility	34	28	43
Total	**130**	**194**	**179**

Source: OIG compliance review data.

time period May 2008 through April 2009, OIG received a total of 982 written responses approved by DHS. For the period May 2008 through April 2009, the OIG conducted reviews of 194 written responses (166 from community agencies and 28 from State facilities). The OIG conducted on-site reviews for 33 written responses and phone interviews for an additional 31 written responses.

For the time period May 2009 through April 2010, OIG received a total of 770 written responses approved by DHS. For the period May 2009 through April 2010, the OIG conducted reviews of 179 written responses (136 from community agencies and 43 from State facilities). The OIG conducted two on-site reviews, 39 phone interviews, and 138 document reviews. Exhibit 4-5 shows the number of reviews of written responses by OIG. In FY08, the OIG reviewed 130 written responses. For FY09 and FY10, the OIG reviewed 194 and 179 respectively.

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 128 case files, we identified 11 files that did not contain the required written response. Even though the written responses were not contained in the case file, we were able to obtain copies of the written response from the OIG for 10 of the 11 files.

In our review of written responses, we found that DHS, in some cases, still takes an excessive amount of time to receive and approve the actions taken by the agency or facility. Overall there were 28 cases in our sample that required a written response. Of the 28 cases in our sample, 5 of 28 (18%) took more than six months from the date the case was completed until the written response was approved by DHS. As an example, for one case in our sample, the written response from the agency was dated October 30, 2009, but was not approved by DHS for over five months on April 1, 2010. In another case, it took 330 days from the date the investigation was completed until the written response was received by OIG. For the one case that we could not obtain a DHS approved written response, the investigation was completed March 1, 2010, but as of September 23, 2010, a written responses had not been received by OIG.

Our previous audit contained a recommendation to DHS to ensure that written responses are approved in a timely manner. In that audit there were cases that took more than a year for approval of the written response. During the later part of FY08 the Division increased its efforts to approve written responses in a timely manner. Although timeliness has improved, there are

still cases that are not approved in a 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 7	***The Department of Human Services should continue its efforts to ensure that written responses from facilities and community agencies are received and approved in a timely manner.***
DEPARTMENT OF HUMAN SERVICES RESPONSE	The Department accepts the recommendation. The Division of Developmental Disabilities, Bureau of Quality Management will develop and present training to community agencies to ensure that written responses from facilities and community agencies are received and approved in a timely manner. The Division of Mental Health will enhance their procedures to ensure that written responses from facilities and community agencies are received and approved in a timely manner.

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 or clarifications or 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 reconsideration or clarification process that allows the notified parties 15 days to submit a reconsideration request after receipt of a report or notification of a finding. 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 87 cases for FY09 and 124 cases in FY10. In FY09, 26 of 87 (30%) and in FY10, 40 of 124 (32%) requests for reconsideration or clarification were granted by the OIG. In FY09 and FY10, OIG revised the investigative report in 22 cases each year as a result of a reconsideration or clarification request. Of the 44 investigative reports that were revised, 7 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.

Prior to September 2009, 59 Ill. Adm. Code 50.80 allowed for a person or community agency to appeal an administrative action taken against them, based on the finding of an OIG investigation. The purpose of the appeal was to review the type or severity of discipline or the administrative action taken against an employee. As part of the changes to the administrative rules, the OIG deleted this section. According to OIG officials this section allowing an appeal of the action taken was deleted because the new law (PA 96-407) deleted the appeal of any action that an agency or facility took in response to the OIG finding and thus there was no longer any statutory authority to keep it. In general, according to the OIG, the appeal process had no legal enforcement authority (e.g. it could not return a fired employee back to work) and therefore no practical effect.

According to DHS officials, 37 appeals were filed during FY09 and FY10. Of the 37 appeals filed, 15 were dismissed due to the filing of the appeal before the OIG investigation was closed or other reasons, 4 were dismissed based on petitioner's failure to appear at the hearing, 9 were withdrawn by the petitioner, 6 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 so that background checks can be 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. The Illinois Department of Public Health (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 64 referrals for substantiated cases to the Health Care Worker Registry in FY09 and 67 referrals in FY10. Of these 131 referrals, 5 (4%) were sent for substantiated egregious neglect while the other 126 were for substantiated physical or sexual abuse.

In our review of Health Care Worker Registry appeals activities provided by OIG, a total of 42 cases were appealed in FY09 and 32 cases were appealed in FY10. Exhibit 4-6 shows the number of appeals won and lost by petitioners for FY09 and FY10 decisions.

Exhibit 4-6
HEALTH CARE WORKER REGISTRY APPEALS
Fiscal Years 2009 and 2010

	FY09	FY10
Petitioner **Lost** Appeal (Referred to Registry)[1]	15	13
Petitioner **Won** Appeal (Not Referred)	7	18
Stipulation Order (Not Referred)	8	4
Total Decisions	**30**	**35**

Note:
[1] Also includes appeals that were dismissed or withdrawn.

[2] OIG made 64 referrals to the HCWR in FY09 and 67 referrals to the HCWR in FY10.

Source: OIG data summarized by OAG.

The percentage of cases appealed in which the Administrative Law Judge's (ALJ) decision found in favor of the petitioner, and therefore the employee was not referred to the Health Care Worker Registry, increased in FY10. The ALJ decision resulted in the employee not being referred to the registry in 23 percent of the appeal decisions in FY09 (7 of 30). For FY10 appeal decisions, this increased to 51 percent (18 of 35).

Stipulated Motions to Dismiss Process

Stipulation and consent orders were used more during FY09 and FY10. 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 in 12 cases for FY09 and FY10.

SITE VISITS

During FY09 and FY10, the OIG conducted annual unannounced site visits at each of the mental health and developmental facilities as required by statute (20 ILCS 1305/1-17(i)). In addition, during both fiscal years, the OIG met its established timeline for submitting site visit reports to facility directors or hospital administrators within 60 days after completion of the site visit. In the last audit, the OIG also met its statutory requirement for conducting site visits at each of the facilities, and met its established timeline for submitting site visit reports. The goal of these visits is to review systemic issues that may be related to the prevention of abuse or neglect of individuals receiving services in the facilities. OIG staff from the Bureau of Compliance and Evaluation (Compliance Reviewer) and a Clinical Coordinator (Registered Nurse) were responsible for conducting site visits.

The OIG provided us with documentation regarding FY09 and FY10 site visits including site visit guidelines and site visit reports. All of the site visit reports noted each issue; what the site visitors reviewed to address the issues; and the site visitors' findings and recommendations related to the issues. In addition, the OIG developed new site visit plans for FY09 and FY10. The OIG directives and plans provide procedures for site visitors to follow while conducting unannounced site visits. Site visits generally lasted two days. After completion of the site visit, each facility was requested to send the OIG copies of any action plans it developed to address the recommendations in the site visit report.

During FY09, site visitors followed up on prior recommendations and reviewed the actions taken by the facility to address the recommendations. They also looked at issues concerning the patient's habilitation/treatment planning, quality assurance reviews, facility investigative protocol, and employee return from administrative leave.

As part of the site visit procedures for FY10 for DHS facilities, site visitors reviewed the facility's process for preventing and responding to outbreaks of common or serious infectious disease and several medication related issues. They reviewed how each facility scheduled staffing levels and the facility's practices regarding reassignment. Site visitors also reviewed the facility's incidents related to peer to peer aggression and/or aggressive individuals for possible staff involvement. Recommendations made as part of the FY10 site visits included: adopting policies regarding medication errors, better documenting administrative reassignments, reviewing peer to peer aggression for possible staff involvement, and documenting follow up for OIG non-reportable complaints.

During FY10, site visitors continued to follow up on prior recommendations to check for compliance. Site visitors also conducted focused reviews of new issues. These issues pertained to infectious disease, medication errors, outdated medications, staffing levels, administrative reassignment, and peer aggression.

SANCTIONS

During FY09, the OIG recommended that DHS's Division of Developmental Disabilities take immediate action against one community agency, up to and including sanctions. This was due to the OIG's concern that a culture of abuse and neglect at the particular agency put the individuals receiving services at a great risk of harm. However, for the two year period July 1, 2008 through June 30, 2010, OIG did not recommend sanctions to either DHS or the Department of Public Health related to a State-operated facility. OIG has not recommended a sanction related to a State-operated facility for at least the past 17 years (1994-2010).

Although no sanctions were recommended by the Inspector General for State-operated facilities during the audit period:

- Two State-operated facilities that were decertified in February and March of 2007 remained decertified. These included Howe Developmental Center (Howe DC) which was decertified in March 2007 and Tinley Park Mental Health Center (Tinley Park MHC) which was decertified in February 2007. Howe DC was closed effective June 21, 2010;

- The U.S. Department of Justice (DOJ) released two investigations that were critical of Howe DC and Choate DC in November 2009; and

- OIG site visits of State-operated facilities contain recommendations that have been repeated three and four times in some cases.

Statutory Changes

Prior to August 13, 2009, the Department of Human Services Act specifically allowed the Inspector General the authority to recommend sanctions. However, the statute was changed in August 2009 by Public Act 96-407. As shown in Exhibit 4-7 below, the wording specifically allowing the Inspector General to make recommendations for sanctions to DHS or the Department of Public Health was deleted. The only remaining wording in the statute related to making recommendations to the Secretary of DHS is related specifically to investigations of abuse and neglect (section (p) – Secretary Review of investigative reports). The original wording is still in Rule 50 (see Exhibit 4-8).

Exhibit 4-7
STATUTORY CHANGES TO SANCTIONS

Prior to Public Act 96-407	Public Act 96-407 (Eff. Aug. 13, 2009)
(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)).(emphasis added)*	*(r) Sanctions. Sanctions, if imposed by the Secretary under Subdivision (p)(iv) of this Section, shall be designed to prevent further acts of mental abuse, physical abuse, sexual abuse, neglect, egregious neglect, or financial exploitation or some combination of one or more of those acts at a facility or agency, and may include any one or more of the following:* *(1) Appointment of on-site monitors.* *(2) Transfer or relocation of an individual or individuals.* *(3) Closure of units.* *(4) Termination of any one or more of the following: (i) Department licensing, (ii) funding, or (iii) certification.* The Inspector General may seek the assistance of the Illinois Attorney General or the office of any State's Attorney in implementing sanctions. *(20 ILCS 1305/1-17(r)).*

Source: 20 ILCS 1305/1-17 and Public Act 96-407.

Administrative Rules

Effective March 25, 2010, the OIG updated its administrative rules. The updated rules include a section related to recommendations for sanctions. This section includes the types of sanctions that might be recommended by the OIG including: termination of licensing, funding, or certification of a facility (see Exhibit 4-8).

Exhibit 4-8
OIG ADMINISTRATIVE RULES FOR RECOMMENDING SANCTIONS

Recommendations for sanctions

1) *The Inspector General may recommend to the Illinois Department of Public Health and the Department of Human Services that sanctions be imposed against facilities or community agencies to protect residents, including:*

   A) *appointment of on-site monitors or receivers;*
   B) *transfer or relocation of an individual or individuals;*
   C) *closure of units; and*
   D) *termination of any one or more of the following:*
      i) *Department licensing;*
      ii) *Department funding; or*
      iii) *Department certification.*

2) *The Inspector General may seek the assistance of the Attorney General of Illinois or the State's attorney for imposing sanctions listed in subsection (g)(1).*

Source: 59 Ill. Adm. Code 50.70(g).

Directives

Since December 2002, the Inspector General has had a directive that specifies criteria regarding when to recommend sanctions against mental health and developmental disability facilities. Most recently updated in April 2008, the directive includes procedures the OIG is to follow when recommending 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;*
4. *Other instances deemed necessary by the Inspector General.* ***(OIG Directive INV 02-033)***

State-Operated Facility Decertifications

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 Park) 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. As of June 2010, one State-operated facility remained decertified (Tinley Park) while the other (Howe) closed effective June 21, 2010.

In December 2007, Tinley Park submitted an application for recertification to the Centers for Medicare and Medicaid Services (CMS) stating that all previous noncompliance issues had been corrected. CMS conducted a resurvey in September 2009. However, on October 21, 2009, Tinley Park was informed by CMS that the hospital still did not meet the requirements for participation in the Medicare program. The resurvey concluded that Tinley Park did not meet the following two special Conditions of Participation for psychiatric hospitals: Special Medical Record Requirements for Psychiatric Hospitals (42 CFR 482.61) and Special Staff Requirements for Psychiatric Hospitals (42 CFR 482.62). Tinley Park's management stated that the failure to comply with requirements were primarily the result of staff reduction, job assignment transfers, and inadequate training of personnel.

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 were reportable to OIG under current State law. Some issues cited by the reviewers at Howe 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.

US Department of Justice Investigations

In November 2009, the United States Department of Justice (DOJ) released reports of investigations conducted at two State-operated facilities (Howe DC and Choate DC). The on-site visits for these investigations were conducted in July, September, and December of 2007. These investigations covered many areas including: transition and discharge planning, protection from harm, general medical care, psychiatric care, behavioral treatment and habilitation, and integrated treatment planning. Regarding protection from harm, the DOJ investigative report for Howe stated that:

- "Howe residents continue to be at significant risk of harm and injury due to the facility's absent or ineffective responses to ongoing harm."
- "Based on extensive record and mortality reviews, we find that abuse and neglect of residents is pervasive at Howe."
- "Restraint practices at Howe deviate substantially from generally accepted professional standards....Residents at Howe are subject to such restraints too frequently and for too long."

The DOJ investigative report for Choate Developmental Center stated that:

- "Individuals residing at Choate are subject to repeated injuries of similar nature, unchecked self-injurious behavior, abuse, and neglect. The harm Choate residents experience as a result of these deficiencies is multi-faceted and includes physical injury; psychological harm; excessive and inappropriate use of restraints; and inadequate, ineffective, and counterproductive treatment."

- "Choate does not adequately protect its residents from harm and risk of harm and does not provide its residents with a reasonably safe living environment."

- "Our review of Choate's incident reporting process found significant deficiencies resulting in substantial underreporting of incidents, events, and risks that affect the health and safety of residents at Choate."

- "Moreover, Choate's actual investigations substantially depart from generally accepted professional standards in violation of the Constitution. Our review of Choate's investigations from November 2006 to July 2007 revealed that, out of 81 investigations conducted, not a single one of the allegations of abuse or neglect was substantiated."

We asked OIG officials if they ever considered recommending sanctions against these facilities. According to OIG officials, the OIG considered recommending sanctions but noted that most of DOJ's issues (e.g., questionable restraint use, accidental injuries, and inadequate paperwork on events) met neither the statutory definition of abuse or neglect nor the established criteria for recommending sanctions. Therefore, OIG did not recommend sanctions. According to OIG officials, they conducted follow up on issues identified by the DOJ reports if it involved a specific allegation of abuse or neglect. The OIG noted it was conducting investigations at these facilities. OIG officials indicated that there was nothing that they would have changed in the findings of the cases that they were able to identify from the Choate DOJ report.

When asked about what actions DHS has taken in response to the DOJ investigations, officials from the DHS Division of Developmental Disabilities responded that they were compiling a list of remedial measures implemented, planned, and proposed in response to the DOJ "Letter of Findings" for the Choate Developmental Center. Generally, the Division has been modifying and standardizing the individual habiliative planning processes to comply. However, a meeting between DHS Legal and USDOJ lawyers to discuss how DHS intends to respond to the "Letter of Findings" had not been held.

Repeated Site Visit Recommendations

In our review of OIG conducted site visits, we noted that Tinley Park Mental Health Center's FY10 site visit report contained a total of eight recommendations, three of which were repeated for the fourth year in a row without being corrected. These three recommendations were:

- The facility should maintain documentation on the outcomes and actions taken as a result of the issues identified in medical emergency drills.

- The facility should include in the file for each OIG non-reportable complaint: full investigation of the incident; a description of any follow-up through committee review(s); a detailed description of all actions taken to protect the alleged victim(s); and a statement of the outcomes.

- The facility should revise its policy entitled, "Administrative Inspections and Searches" (No. 236) to require written documentation of visitor entry and screening.

One of the criteria listed in the OIG directives regarding when to issue a recommendation for sanctions is when "*A community agency or a state-operated facility has repeatedly failed to respond to recommendations made by the Inspector General."* Although OIG site visit recommendations have not been implemented for several years at Tinley Park, no such recommendation for sanctions was issued. Madden MHC, Jacksonville DC, and Singer MHC also had FY10 site visits reports with recommendations that were repeated for three and four years in a row.

The enabling statute that created the DHS Office of the Inspector General states that:

> ***It is the express intent of the General Assembly to ensure the health, safety, and financial condition of individuals receiving services in this State due to mental illness, developmental disability, or both by protecting those persons from acts of abuse, neglect, or both by service providers. To that end, the Office of the Inspector General for the Department of Human Services is created…***

Although reviews and investigations conducted by other entities may have used different standards than the OIG, the federal reviews conducted of Howe, Tinley Park, and Choate in recent years have raised serious questions concerning the safety of residents in those facilities. The Choate DOJ investigations specifically referenced the underreporting of incidents. Prior OAG audits have also raised concerns about facility reporting of incidents including abuse and neglect. As part of its annual site visit protocol, the OIG should examine in greater detail the areas of concern raised by other agencies' investigations.

PROTECTING INDIVIDUALS RECEIVING SERVICES AT STATE FACILITIES	
RECOMMENDATION 8	***The Office of the Inspector General should use the annual site visit process to target and examine areas at individual facilities where other investigations and/or reports have identified systemic resident safety concerns, such as the underreporting of abuse and neglect. Furthermore, if State facilities repeatedly fail to take corrective action on matters raised by OIG site visits or arising out of other investigations, the Inspector General should also consider making recommendations, up to and including sanctions, to ensure the safety of State-operated facility residents.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree. OIG already uses the annual site visit process to address systemic issues related to abuse and neglect at the DHS facilities. OIG also already considers recommending sanctions when warranted. Yet, the State law authorizing OIG site visits defines abuse and neglect, and OIG cannot replace these definitions with those from other entities' regulatory authority.

Community Agency Sanctions

During FY09, the Inspector General recommended sanctions to DHS for one community agency. In an April 20, 2009 letter to DHS regarding the community agency, the Inspector General stated that, "I strongly recommend the Division of Developmental Disabilities take immediate actions, up to and including sanctions, to ensure the health and safety of the individuals receiving services from the State of Illinois…."

During an OIG investigation of the agency, serious concerns were raised about onsite dental services, the agency's medical/nursing services, and obstruction of an OIG investigation. As a result, the DHS Division of Developmental Disabilities met with representatives of the agency and took immediate action including suspending referral, enrollment, and admission activity for all residential and day programs funded by the Division. A corrective action plan and benchmarks for mandatory improvements were established by DHS in order for the Division of Developmental Disabilities to consider any contract extensions beyond September 2009 for this community agency.

Chapter Five

OTHER ISSUES

CHAPTER CONCLUSIONS

The Quality Care Board (Board) held all required quarterly meetings during FY09 and FY10. However, the Board did not maintain the seven members that are required by statute. During FY09, the Board had six members. However, from November 2009, to May 2010, all of the members of the Board were serving under terms that had expired. In May 2010, the Governor made two temporary reappointments to the Board. OIG provided additional information to show that effective August 19, 2010, another Board member still serving on an expired term and a new applicant received temporary appointments to serve on the Board.

In our previous audit (2008), DHS could not document that all staff at State-operated facilities received the required Rule 50 training. The DHS Division of Mental Health and the Division of Developmental Disabilities provided FY10 data that showed that Rule 50 training is now being tracked at State-operated facilities.

QUALITY CARE BOARD

Section 1-17(u) of the Department of Human Services Act establishes a Quality Care Board within the Department of Human Services' Office of the Inspector General. The Quality Care Board is required to monitor and oversee the operations, policies, and procedures of the Inspector General to ensure the prompt and thorough investigation of allegations of neglect and abuse. In fulfilling these responsibilities, the Board may do the following:

- Advise the Inspector General on the content of training activities;
- Provide independent, expert consultation to the Inspector General on policies and protocols for investigations of alleged abuse, neglect, or both;
- Review existing regulations relating to the operation of facilities; and
- Recommend policies concerning methods for improving intergovernmental relationships between the office of the Inspector General and other State or federal offices.

One of the requirements of the Board is to meet quarterly; and four Board members constitute a quorum, which allows the Board to conduct its business. 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. Effective August 13, 2009, Public Act 96-407 amended the Department of Human Services Act (20 ILCS 1305); however, all requirements pertaining to the Quality Care Board remained the same.

During FY09 and FY10, the Board met five times in each fiscal year. This included quarterly meetings, and an additional meeting that was held within one of the quarters. The FY09 meetings were held in July 2008, August 2008, October 2008, January 2009, and April

2009. The FY10 meetings were held in July 2009, October 2009, December 2009, January 2010, and May 2010. However, the July 2008 and October 2009 Board meetings failed to have quorums. During the last audit, the Board met quarterly as required by statute, and each meeting had a least four or more Board members in attendance.

The Board continues to have problems maintaining seven members as required by statute. During FY09, the Board had six members. In April 2009, according to documentation provided by OIG, all of the Board members e-mailed the Governor's Boards and Commissions website to request renewal of their memberships. During FY10, one Board member resigned in July 2009, and another member resigned in October 2009. This left the Board with only four members; and all of these members requested renewal of their memberships again, in January 2010, on the Governor's new website. One of the four members indicated in March 2010 that he would not seek renewal of his membership, but agreed to stay on the Board until the end of the calendar year. According to DHS officials, Board members continue to serve until the next appointment is made by the Governor.

From November 2009 to May 2010, all of the remaining member's of the Board were serving under terms that had expired. The Governor temporarily appointed two Board members in May 2010. This extended one Board members term date to November 2011, and another Board member's term date to November 2013. As of June 30, 2010, the Board only had two members serving under appointments that had not expired. After the audit period, the OIG provided additional information to show that effective August 19, 2010, another Board member was temporarily reappointed and a new applicant received a temporary appointment to serve on the Board. Exhibit 5-1 shows the Quality Care Board membership as of June 30, 2010.

Exhibit 5-1
QUALITY CARE BOARD MEMBERSHIP
As of June 30, 2010

Board Member	Appointed	Expiration Date	Current Status
Rita Ann Burke (Chair)	7/8/05	11/3/11	Reappointed
Thane Dykstra	7/8/05	11/3/09	Expired
Nathaniel Gibson	6/29/05	11/3/09	Expired
Keith Kemp	6/24/05	11/3/09	Resigned 10/11/09
Maria Lopez	9/1/06	11/3/09	Resigned 7/20/09
Brian Rubin	6/24/05	11/3/13	Reappointed
Rick Karpawicz	9/1/06	9/18/09	Resigned 4/6/07

Note: On August 19, 2010, Thane Dykstra was temporarily reappointed through November 3, 2013, and a new member, Edward Baker, was temporarily appointed through September 18, 2013.

Source: OAG analysis of OIG information.

Statutory requirements regarding Board membership state that upon the expiration of each member's term, a successor shall be appointed; and in the case of a vacancy in the office of any member, the Governor shall appoint a successor for the remainder of the unexpired term (20 ILCS 1305/1-17(u)). With only four members serving on the Board as of August 2010 and three

vacancies, it is possible that the Board may not have a quorum at quarterly meetings. Further, even if new members are appointed to the Board, the Board still may not meet the statutory requirement to have seven members. Documentation provided by OIG officials show that they have continued to urge Boards and Commissions (the Governor's Office) to appoint these individuals promptly.

The Department of Human Services Act requires that the initial appointments to the Board made by the Governor be made so that four members were appointed to a four-year term and three members were appointed to a two-year term. By doing this, members were on staggered terms in which there would always be at least three to four members whose term had not expired. When appointments are made to the Board, staggering terms should be considered as to avoid the situation that occurred between November 2009 and May 2010 in which all the members' terms had expired.

QUALITY CARE BOARD	
RECOMMENDATION 9	***The Secretary of the Department of Human Services and the Inspector General should continue to work with the Governor's Office to get members appointed to the Board as promptly as possible, in order to fulfill statutory membership requirements (20 ILCS 1305/1-17(u)). Staggering the terms of members should be used in order to ensure membership.***
DEPARTMENT OF HUMAN SERVICES AND OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree. As noted in the audit report, OIG has strongly urged the appointment/reappointment of Quality Care Board members, as provided in State statute, and will continue to do so.

RULE 50 TRAINING

In our previous audit (2008), 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 (h)) 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." In the previous audit, we recommended that the Department of Human Services 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.

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. All employees at community agencies and State facilities are required to have Rule 50 training biennially (59 Ill. Adm. Code 50.20(d)(2)).

The statute does not require the OIG to monitor compliance with training; it only requires that the OIG 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 Division of Developmental Disabilities and the DHS Division of Mental Health monitor training.

DHS is now tracking and monitoring State-facility staff training in Rule 50. In our previous audit in 2008, DHS could not document that all staff at State-operated facilities received the required Rule 50 training.

We requested information from DHS' Division of Developmental Disabilities and the Division of Mental Health related to Rule 50 training. Both divisions provided us with summaries of staff training in Rule 50 – Abuse and Neglect Training for each facility.

The Division of Mental Health provided information for the period July 1, 2008, to June 30, 2010, showing that of the nine State-operated mental health facilities, seven had 100 percent of staff trained in Rule 50, while the other two facilities had 99 percent of staff trained in Rule 50. The Division of Developmental Disabilities provided information that showed that of the eight State-operated developmental disability facilities, four had 100 percent of staff trained in Rule 50, while the other four facilities ranged from 93 percent to 99 percent of staff trained.

APPENDICES

APPENDIX A

20 ILCS 1305/1-17(w)

Appendix A

ILLINOIS COMPILED STATUTES
20 ILCS 1305
DEPARTMENT OF HUMAN SERVICES ACT

Sec. 1-17(w) Program audit . The Auditor General shall conduct a program audit of the Office of the Inspector General on an as-needed basis, as determined by the Auditor General. The audit shall specifically include the Inspector General's compliance with the Act and effectiveness in investigating reports of allegations occurring in any facility or agency. 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 following the audit period.

(Source: P.A. 96-407, eff. 8-13-09.)

APPENDIX B

Sampling & Analytical Methodology

Appendix B

SAMPLING & ANALYTICAL METHODOLOGY

The Department of Human Services Act (Act) directs the Auditor General to conduct a program audit of the Department of Human Services, Office of the Inspector General (OIG) on an as-needed basis. The Act specifically requires the audit to include the Inspector General's compliance with the act and effectiveness in investigating reports of allegations occurring in any facility or agency. Detailed audit objectives include:

- Following up on previous recommendations;
- Reviewing the OIG's organizational structure including its staffing, 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
- Testing several compliance issues including investigator training, conducting site visits, and Quality Care Board meetings.

We interviewed or contacted representatives from the DHS Inspector General's Office, the Illinois State Police, the Department of Public Health, and the Department of Children and Family Services. We analyzed OIG's electronic database from fiscal years 2009 and 2010. 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(w) 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 March 2010 and fieldwork was concluded in September 2010. In order to test case files for thoroughness of investigation methods, we selected a sample of cases closed in FY10. 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 FY10. We took a systematic random sample of 128 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); and
- 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 2009 and 2010 and did comparisons of similar data from prior OIG audits. These databases represent a snapshot at the time we received the information. 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

FY08 through FY10

Appendix C
RATE OF SUBSTANTIATED ABUSE OR NEGLECT CASES BY FACILITY
(Includes Allegations Categorized as Abuse, Neglect or Death at Intake)
FY08, FY09, and FY10

	Fiscal Year 2008			Fiscal Year 2009			Fiscal Year 2010		
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	97	5	5%	88	5	6%	79	1	1%
Chester	147	2	1%	196	4	2%	219	2	1%
Chicago-Read	18	2	11%	31	0	0%	25	0	0%
Choate	112	3	3%	82	3	4%	89	10	11%
Elgin	55	3	5%	49	0	0%	78	4	5%
Fox	7	3	43%	9	3	33%	11	1	9%
Howe	73	6	8%	64	5	8%	53	8	15%
Jacksonville	102	8	8%	112	8	7%	91	4	4%
Kiley	35	2	6%	36	2	6%	23	2	9%
Ludeman	30	4	13%	33	0	0%	40	2	5%
Mabley	12	0	0%	17	2	12%	7	3	43%
Madden	34	0	0%	37	0	0%	24	0	0%
McFarland	27	3	11%	42	1	2%	52	4	8%
Murray	19	3	16%	23	1	4%	30	1	3%
Shapiro	39	4	10%	55	2	4%	33	1	3%
Singer	12	2	17%	47	1	2%	34	1	3%
Tinley Park	6	0	0%	14	0	0%	12	1	8%
Community Agencies [1]	1,282	212	17%	1,433	218	15%	1,404	216	15%
Totals	**2,107**	**262**	**12%**	**2,368**	**255**	**11%**	**2,304**	**261**	**11%**

[1] Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

APPENDIX D

Allegations by Facility
FY08 through FY10

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 abuse (verbal) alleged

A6 -- Mental abuse (psychological) alleged

A7 -- Financial exploitation

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 individuals

N6 -- Neglect in theft of recipient property

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 a 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
FY08 through FY10

Location	Abuse Allegations								
	A1 physical abuse - imminent danger			A2 physical abuse - serious injury			A3 other physical abuse		
	FY08	FY09	FY10	FY08	FY09	FY10	FY08	FY09	FY10
DD Facilities									
Fox	0	0	0	0	0	0	2	3	1
Howe	0	2	0	2	3	1	43	23	17
Jacksonville	0	0	0	0	1	3	61	72	67
Kiley	0	0	0	0	0	0	20	17	10
Ludeman	0	0	0	0	0	2	12	28	34
Mabley	1	0	0	0	0	0	13	10	7
Murray	0	0	0	0	1	0	13	17	20
Shapiro	0	0	1	0	1	2	28	36	32
MH Facilities									
Alton	1	0	1	0	0	1	51	34	32
Chester	0	0	0	4	4	3	104	149	137
Chicago-Read	0	0	0	0	0	1	6	7	11
Elgin	0	0	0	0	0	0	13	13	21
Madden	0	0	0	0	0	0	18	11	16
McFarland	0	0	0	0	0	0	19	20	23
Singer	0	1	0	0	1	0	7	19	16
Tinley Park	0	0	0	0	0	0	7	3	2
Dual Facility									
Choate	0	0	0	0	0	1	68	49	65
Community Agencies [1]	3	1	1	9	13	11	593	606	634
Totals	**5**	**4**	**3**	**15**	**24**	**25**	**1,078**	**1,117**	**1,145**

[1] Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

Appendix D
ALLEGATIONS BY FACILITY
FY08 through FY10

Abuse Allegations											
A4 sexual abuse			**A5 verbal abuse**			**A6 psychological abuse**			**A7 financial exploitation**		
FY08	**FY09**	**FY10**	**FY08**	**FY08**	**FY08**	**FY08**	**FY09**	**FY10**	**FY08**	**FY09**	**FY10**
0	0	0	0	2	0	0	0	1	n/a	n/a	0
4	0	1	10	7	0	2	1	3	n/a	n/a	0
4	1	0	7	14	16	11	6	6	n/a	n/a	1
0	1	0	1	1	2	1	1	5	n/a	n/a	0
0	0	2	1	1	1	1	0	1	n/a	n/a	0
0	0	0	1	2	0	0	0	0	n/a	n/a	0
0	0	0	0	4	4	2	0	1	n/a	n/a	0
0	0	0	2	2	4	4	0	7	n/a	n/a	0
6	10	16	12	17	28	26	13	11	n/a	n/a	0
7	5	19	16	18	25	14	12	17	n/a	n/a	0
1	4	3	2	6	8	2	3	3	n/a	n/a	0
4	4	12	3	10	17	7	2	9	n/a	n/a	0
2	6	1	5	4	8	4	3	4	n/a	n/a	0
5	5	8	6	6	7	6	3	5	n/a	n/a	0
1	9	5	0	7	4	3	0	1	n/a	n/a	1
0	0	3	3	1	2	2	1	2	n/a	n/a	0
2	2	1	7	10	10	10	4	6	n/a	n/a	1
79	76	72	131	125	201	116	124	109	n/a	n/a	30
115	**123**	**143**	**207**	**237**	**337**	**211**	**173**	**191**	**n/a**	**n/a**	**33**

Appendix D
ALLEGATIONS BY FACILITY
FY08 through FY10

Location	Neglect Allegations								
	N1 neglect- imminent danger			N2 neglect- serious injury			N3 neglect- non-serious injury		
	FY08	FY09	FY10	FY08	FY09	FY10	FY08	FY09	FY10
DD Facilities									
Fox	0	0	0	0	1	2	1	3	1
Howe	0	0	0	5	4	6	2	6	4
Jacksonville	0	1	1	1	1	1	4	5	3
Kiley	0	0	0	1	1	1	0	1	2
Ludeman	0	0	0	0	0	0	1	4	4
Mabley	0	0	0	0	1	1	0	1	0
Murray	0	0	0	1	0	0	1	2	1
Shapiro	0	0	0	0	0	2	0	2	1
MH Facilities									
Alton	0	0	0	3	0	1	5	2	2
Chester	0	0	0	6	3	0	5	6	3
Chicago-Read	0	0	0	0	1	0	2	1	3
Elgin	0	0	0	2	2	4	2	7	10
Madden	0	0	0	0	0	1	1	3	4
McFarland	0	0	0	0	0	2	0	2	3
Singer	0	0	0	0	0	0	1	3	2
Tinley Park	0	0	0	0	1	1	0	2	1
Dual Facility									
Choate	0	0	0	0	2	1	2	2	8
Community Agencies [1]	2	4	3	41	35	64	119	140	147
Totals	**2**	**5**	**4**	**60**	**52**	**87**	**146**	**192**	**199**

[1] Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

Appendix D
ALLEGATIONS BY FACILITY
FY08 through FY10

Neglect Allegations

N4 neglect in individual absence			**N5 neglect in recipient sexual activity**			**N6 neglect in theft of recipient property**			**N7 neglect with risk of harm or injury**		
FY08	**FY09**	**FY10**	**FY08**	**FY09**	**FY10**	**FY08**	**FY09**	**FY10**	**FY08**	**FY09**	**FY10**
0	0	0	0	0	0	0	0	0	2	1	2
1	0	4	1	0	1	0	0	0	10	1	4
1	0	0	0	0	0	0	0	0	3	5	3
0	1	2	0	0	0	0	0	0	1	7	4
0	0	0	0	0	1	0	0	0	2	1	1
0	0	0	0	0	0	0	0	0	0	1	2
0	0	0	0	0	0	0	0	0	0	1	7
0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	1	0	0	0	0	0	1	2	3
0	0	0	1	2	0	0	0	1	4	2	5
1	0	0	1	1	2	0	0	0	1	1	5
1	0	0	0	0	1	0	0	0	7	5	7
0	0	0	1	3	0	0	0	0	1	1	5
0	0	0	2	0	0	0	0	0	0	3	0
0	0	0	1	0	1	0	0	0	0	10	2
0	0	0	0	0	0	0	0	0	2	1	1
0	0	1	1	1	0	0	0	0	5	3	7
5	8	11	11	13	19	0	0	3	118	134	196
9	**9**	**18**	**20**	**20**	**25**	**0**	**0**	**4**	**157**	**179**	**254**

Appendix D
ALLEGATIONS BY FACILITY
FY08 through FY10

Location	Death Allegations								
	D1 suicide in program			**D2 suicide within 14 days after discharge**			**D4 death in residential program**		
	FY08	**FY09**	**FY10**	**FY08**	**FY09**	**FY10**	**FY08**	**FY09**	**FY10**
DD Facilities									
Fox	0	0	0	0	0	0	1	0	1
Howe	0	0	0	0	0	0	2	3	2
Jacksonville	0	0	0	0	0	0	3	2	1
Kiley	0	0	0	0	0	0	1	0	0
Ludeman	0	0	0	0	0	0	0	0	0
Mabley	0	0	0	0	0	0	0	1	0
Murray	0	0	0	0	0	0	1	2	2
Shapiro	0	0	0	0	0	0	2	0	2
MH Facilities									
Alton	0	0	0	0	0	0	0	0	0
Chester	0	0	0	0	0	0	0	0	2
Chicago-Read	1	0	0	0	1	0	0	1	0
Elgin	0	0	0	0	0	0	2	0	0
Madden	0	0	0	0	1	0	0	0	0
McFarland	0	0	0	0	1	1	0	0	0
Singer	0	0	0	0	0	0	0	0	0
Tinley Park	0	0	0	1	0	1	0	0	0
Dual Facility									
Choate	0	0	0	0	0	0	0	1	3
Community Agencies [1]	0	2	0	0	0	0	45	41	58
Totals	**1**	**2**	**0**	**1**	**3**	**2**	**57**	**51**	**71**

[1] Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

Appendix D
ALLEGATIONS BY FACILITY
FY08 through FY10

Death Allegations

D5 death not in residential program			**D6 death due to natural causes in a program**			**D7 any other reportable deaths**		
FY08	**FY09**	**FY10**	**FY08**	**FY09**	**FY10**	**FY08**	**FY09**	**FY10**
0	1	2	1	0	0	0	0	2
1	1	0	3	3	1	2	0	0
1	0	1	1	3	1	0	0	0
0	0	0	0	2	0	0	0	0
0	0	0	0	0	1	0	0	0
0	0	0	0	0	0	0	0	0
1	1	0	0	1	1	1	0	0
1	1	0	1	3	2	1	0	0
0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0
1	0	0	0	1	0	1	0	0
0	1	0	2	1	0	1	0	0
0	0	0	0	0	0	0	1	0
0	0	0	0	1	0	0	0	0
0	0	0	0	1	0	0	0	0
0	0	0	0	0	1	2	0	0
0	0	0	0	2	1	0	0	0
15	20	18	38	45	26	11	4	6
20	**25**	**21**	**46**	**63**	**34**	**19**	**5**	**8**

APPENDIX E

Agency Responses

Pat Quinn, *Governor*

Illinois Department of Human Services

Grace Hong Duffin, *Acting Secretary*

Office of the Inspector General
160 North LaSalle Street, Suite S-200
Chicago, Illinois 60601

November 22, 2010

William G. Holland
Illinois Auditor General
Iles Park Plaza
740 E. Ash St.
Springfield, IL 62703

Dear Auditor General Holland:

Thank you for the opportunity to respond to the draft report of your FY09-FY10 program audit of this Office. We are pleased that the audit recognizes that we have built upon the significant progress we made during the prior audit period, improving in all areas even further, and fully accomplishing our statutory responsibilities once again.

We appreciate the efforts by Audit Manager Michael Paoni and his staff to fully understand, objectively review, and accurately present the significant statutory changes during the audit period and the complicated processes of reporting, investigating, and preventing abuse and neglect of individuals in Illinois who receive mental health or developmental disability services.

Attached are our responses to the recommendations addressing this Office. If you have questions about the responses, please feel free to contact me at (312) 814-2718.

Sincerely,

William M. Davis
Inspector General

cc: Grace Hong Duffin, Acting Secretary
Carol Kraus
Lorrie Rickman Jones, PhD
Lilia Teninty

RESPONSES TO RECOMMENDATIONS ADDRESSING OIG

Recommendation 1

The Office of the Inspector General should continue to consider adding serious injuries to its investigative database that would allow it to look for and identify patterns and trends in serious injuries, which may be an indicator of staff neglect or other problems which need to be addressed.

OIG Response

Partially agree. OIG cannot effectively review every injury report from the thousands of community agency sites and facilities. Rather, since licensing requirements already mandate careful review of all injuries by agency/facility administrations, State law (20 ILCS 1305/1-17) requires reporting to OIG those injuries alleged – including those only suspected – to involve abuse or neglect, even non-serious injuries. OIG will continue to add those injuries to OIG's investigative database.

Recommendation 2

The Office of the Inspector General should update their interagency agreements with other State agencies that have investigatory powers.

OIG Response

Agree. OIG has begun the process of updating interagency agreements with the Illinois State Police, Illinois Department of Public Health, and Department of Children and Family Services.

Recommendation 3

The Office of the Inspector General should continue to work to improve the timeliness of investigations of abuse and neglect. The OIG should also work to improve the timeliness of investigations conducted by clinical coordinators, especially death investigations.

OIG Response

Agree. Exhibit 2-1 shows that OIG has greatly improved the timeliness of its investigations, including those into deaths; investigations in FY10 took 10% less time than in FY08. OIG now involves a clinical coordinator in more of these investigations, to ensure clinical issues are covered. As a result, reviews of deaths with no abuse/neglect have been given lower priority. The bureau chiefs and clinical coordinators will be reminded not to delay these reviews unnecessarily.

Recommendation 4

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 required by OIG directives.

OIG Response

Agree. OIG will remind the investigative bureaus to assign all investigations and to complete all investigative plans within the required time frames.

Recommendation 5

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

OIG Response

Agree. OIG has proposed a revision to the DHS program directive on reporting of abuse or neglect, clarifying and strengthening the requirements for reporting. OIG continues to flag late reporting on initial intakes, to identify late reporting to the divisions every month, to cite late reporting in investigative case reports, and to provide an electronic Rule 50 training for the facilities and agencies to use for internal training on reporting.

Recommendation 6

The Office of the Inspector General should ensure that all routing and approval forms are completed and signed off on by the Bureau Chief.

OIG Response

Agree. The audit report indicates that 125 of 128 (*98%*) of the routing and approval forms tested were complete and signed; the only three not signed were from a bureau where the bureau chief position was in transition. OIG will remind the bureau chiefs to sign these forms.

Recommendation 8

The Office of the Inspector General should use the annual site visit process to target and examine areas at individual facilities where other investigations and/or reports have identified systemic resident safety concerns, such as the underreporting of abuse and neglect. Furthermore, if State facilities repeatedly fail to take corrective action on matters raised by OIG site visits or arising out of other investigations, the Inspector General should also consider exercising enforcement options, up to and including sanctions, to ensure the safety of State operated facility residents.

OIG Response

Agree. OIG already uses the annual site visit process to address systemic issues related to abuse and neglect at the DHS facilities. OIG also already considers recommending sanctions when warranted. Yet, the State law authorizing OIG site visits defines abuse and neglect, and OIG cannot replace these definitions with those from other entities' regulatory authority.

OIG Comment *(for inclusion in the text on the bottom of page 63)*

The DOJ reports on Choate DC and Howe DC were reviews based on its interpretation of federal regulations, not based on the Illinois law governing OIG. So, the reports use "abuse" and "neglect" with no reference to the definitions that OIG is mandated to follow. Rather, the reports highlight restraint use and injuries, most of which were not legally reportable to OIG. Further, those reports provide some incomplete and inaccurate information about alleged abuse/neglect incidents. DOJ may certainly use its regulatory authority to review the facilities and to comment on documentation examined, but OIG may not use those reports to override its own statutory authority.

Recommendation 9

The Secretary of the Department of Human Services and the Inspector General should continue to work with the Governor's Office to get members appointed to the Board as promptly as possible, in order to fulfill statutory membership requirements (20 ILCA 1305/1-17(u)). Staggering the terms of members should be used in order to ensure membership.

OIG Response

Agree. As noted in the audit report, OIG has strongly urged the appointment/reappointment of Quality Care Board members, as provided in State statute, and will continue to do so.

Pat Quinn, *Governor*

Illinois Department of Human Services

Grace Hong Duffin, *Acting Secretary*

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

William G. Holland
Illinois Auditor General
Iles Park Plaza
740 E. Ash St.
Springfield, IL 62703

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 Inspector General performed by the Illinois Office of the Auditor General during the FY09/10 audit period. Please note the Office of the Inspector General has already provided responses for their office under a separate cover. This letter only addresses the two DHS findings (recommendations 5 and 7) contained in the draft report.

Recommendation 5
The Office of the Inspector General should continue to work with the State facilities and community agencies to ensure that allegations of abuse or neglect are reported within the time frame specified in the Department of Human Services Act and OIG's administrative rules.

Department of Human Services Response :
The Department accepts the recommendation.
The Division of Mental Health will enhance their procedures to ensure that the Office of Inspector General's (OIG) Late Reporting Data will be added to each hospital's FY'11 Performance Indicators (measures) to ensure that allegations of abuse or neglect are reported within the time frame specified in the Department of Human Services Act and OIG's Administrative Rules.

The Division of Developmental Disabilities, Bureau of Quality Management will communicate with community agencies on an on-going basis regarding community agency responsibility to ensure that allegations of abuse or neglect are reported to the Office of Inspector General within the required time frame.

Recommendation #7

The Department of Human Services should continue its efforts to ensure that written responses from facilities and community agencies are received and approved in a timely manner.

Department of Human Services Response:

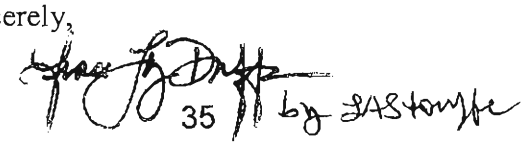
The Department accepts the recommendation.

The Division of Developmental Disabilities, Bureau of Quality Management will develop and present training to community agencies to ensure that written responses from facilities and community agencies are received and approved in a timely manner.

The Division of Mental Health will enhance their procedures to ensure that written responses from facilities and community agencies are received and approved in a timely manner.

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

Sincerely,



Grace Hong Duffin, Acting Secretary

cc: Grace Hou, Assistant Secretary
Matthew Hammoudeh, Assistant Secretary
Lorrie Rickman Jones, Director, Division of Mental Health
Lilia Teninty, Director Division of Developmental Disabilities
Greg Fenton Deputy Director, Division of Developmental Disabilities
Carol Kraus, Chief Financial Officer
Matthew Grady, Director, Office of Fiscal Services
Elaine Novak, Associate Director, Division of Mental Health
Michael Hurt, Deputy Director, Division of Developmental Disabilities
Albert Okwuegbunam, Chief, Bureau of Audit Liaison