STATE OF ILLINOIS

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PROGRAM AUDIT

OFFICE OF THE INSPECTOR GENERAL
DEPARTMENT OF HUMAN SERVICES

DECEMBER 2017

FRANK J. MAUTINO

AUDITOR GENERAL

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OFFICE OF THE AUDITOR GENERAL
FRANK J. MAUTINO

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.

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

Springfield, Illinois
December 2017

STATE OF ILLINOIS
OFFICE OF THE
AUDITOR GENERAL
Frank J. Mautino, Auditor General

REPORT DIGEST

PROGRAM AUDIT

Release Date:
December 2017

Audit performed in accordance with
20 ILCS 1305/1-17(w)

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EXECUTIVE SUMMARY

Illinois Department of Human Services Office of the Inspector General

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 requires the OIG to investigate allegations of abuse and neglect that occur in community agencies licensed, certified, or funded by DHS to provide mental health and developmental disability services.

In FY17, DHS operated 14 State facilities. For FY17, there were also a total of 421 community agencies with 4,552 program sites (i.e., CILAs, group homes, day programs, etc.) that were under the investigative jurisdiction of the OIG. This represents an increase of 1,079 program sites since our FY10 audit or 31 percent.

In this audit we reported that:

- Total allegations of abuse and neglect reported to the OIG increased from 2,468 in FY10 to 3,698 in FY17 or 50 percent.
- The timeliness of completion for OIG investigations has deteriorated significantly since our FY10 audit. For FY10, 85 percent of closed cases were completed within the 60 working day requirement. For FY17, 50 percent of closed cases were completed within 60 working days.
- OIG case reports we reviewed generally were thorough, comprehensive, and addressed the allegation.
- The number of abuse and neglect investigations closed has increased substantially since FY10 (from 2,162 in FY10 to 3,601 in FY17); however, the substantiation rate has remained consistent. The substantiation rate for abuse and neglect investigations closed for FY10 was 12 percent, while it was 13 percent for FY17.
- DHS, in some cases, still takes an extended amount of time to receive and approve the actions taken by community agencies or State-operated facilities. For 4 of 20 investigations sampled (20%), the OIG could not provide an approved written response. These four investigations had been completed for an average of 180 days as of September 1, 2017, with a range of between 106 days to 289 days since the case was completed.
- The Quality Care Board did not have seven members during FY16 and FY17 as is required by the Act. In September 2017, a board member resigned leaving the Board with only three members. Four members are needed for a quorum.
- The OIG could not provide documentation to show that investigators had received the required initial training courses delineated in OIG Directives.

The audit report contains a total of 13 recommendations to the OIG and DHS. The OIG and DHS generally agreed with the recommendations in the report.

AUDIT SUMMARY AND RESULTS

The Department of Human Services Act (Act) (20 ILCS 1305/1-17(w)) directs the Auditor General to conduct a program audit of the Department of Human Services (DHS), 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. This is the 12th audit we have conducted of the OIG since 1990.

The Act requires the OIG to investigate allegations of abuse and neglect that occur in mental health and developmental disability facilities operated by DHS. The Act also requires the OIG to investigate allegations of abuse and neglect that occur in community agencies licensed, certified, or funded by DHS to provide mental health and developmental disability services (20 ILCS 1305/1-17(a)).

In FY17, DHS operated 14 State facilities. For FY17, there were also a total of 421 community agencies with 4,552 program sites (i.e., CILA's, Group Homes, Day Programs, etc.) that were under the investigative jurisdiction of the OIG. This represents an increase of 1,079 program sites since our FY10 audit or 31 percent.

Total allegations of abuse and neglect reported to the OIG have increased since our 2010 audit. In FY10, 2,468 allegations were reported. In FY17, allegations of abuse and neglect increased to 3,698 or 50 percent. Allegations reported at community agencies increased from 1,501 in FY10 to 2,714 in FY17 or 81 percent. (pages 1-4)

TIMELINESS OF INVESTIGATIONS

The timeliness of completion for OIG investigations has deteriorated significantly since our FY10 audit.

The timeliness of completion for OIG investigations has deteriorated significantly since our FY10 audit. For FY10, 85 percent of closed cases were completed within the 60 working day requirement. For FY17, 50 percent of closed cases were completed within 60 working days. This represents a decrease of 35 percent since the previous audit. In May 2017, the OIG's administrative rules were amended to remove the requirement that investigations be completed within 60 working days. However, this requirement is still included in the OIG's Directives.

Although FY17 data provided by the OIG showed improvement in timely reporting of allegations of abuse and neglect, timeliness could not be determined for 20 percent of facility allegations and 22 percent of community agency allegations. This was because the incident discovered time/date was reported as unknown, was inaccurate, or the time/date recorded was not specific. For FY17, the percent of allegations not reported within the statutorily required four hours was 11 percent at community agencies and 5 percent at State-operated facilities. Compared to FY10, late reporting at State facilities has decreased or improved from 10 percent in FY10 to 5 percent in FY17. For community agencies, late reporting improved from 13 percent in FY10 to 11 percent in FY17.

The OIG needs to improve the timeliness of investigator assignment and supervisory approval.

- OIG directives require that investigations be assigned to an investigator within one working day of the Bureau Chief or Investigative Team Leader (ITL) receiving the intake. For investigations closed during FY17, 96 percent (3,643 of 3,797) were initially assigned within one working day of the allegations being added to the OIG database. However, when compared to the date reported, nearly 50 percent (1,891 of 3,797) of investigations took two or more working days to be assigned to an investigator.

- OIG directives require the ITL or Bureau Chief to review cases within seven working days of receipt absent extenuating circumstances. For cases closed in FY17, 55 percent (2,079 of 3,797) were approved within 7 working days of submission.

The time it takes to obtain a written statement or interview from the alleged victim and perpetrator has increased since our last audit in FY10. 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.

For FY17 cases we sampled where there was a victim identified, it took an average of 26 days from the reporting of an incident for the alleged victim to be interviewed or a statement to be taken. Comparatively, for FY10 cases sampled where there was a victim identified, it took an average of 9 days to complete statements or interviews for the alleged victim.

For FY17 cases we sampled where there was a specific alleged perpetrator identified, it took an average of 45 days from the reporting of an incident for the alleged perpetrator to be interviewed or a written statement to be taken. Comparatively, 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.

Open cases and average caseloads have increased dramatically since our 2010 audit.

Open cases and average caseloads have increased dramatically since our 2010 audit. Overall, open cases increased from 485 total cases as of August 2010 to 1,797 as of August 2017. For the investigative bureaus, caseload averages as of August 2010 ranged from a high of 23 cases per investigator in the Metro Bureau to a low of 12 in the South Bureau. For August 2017, caseload averages ranged from a high of 65 cases per investigator in the Metro Bureau to a low of 29 in the North Bureau. (pages 19-30)

THOROUGHNESS OF INVESTIGATIONS

OIG case reports we reviewed generally were thorough, comprehensive, and addressed the allegation. However, in our sample of investigations, we found that injury reports were not in the case file for 5 of 32 (16%) investigations sampled where there was an allegation of an injury being sustained. Photographs were not in the case file for 10 of 30 (33%) investigations sampled. Medical records, treatment plans, or progress notes were also missing in 4 of 130 investigations sampled (3%).

We reviewed a sample of FY17 closed cases to determine whether there was a statement or interview with the alleged victim and the alleged perpetrator.

Of the 130 cases we reviewed, 4 cases (3%) involved an alleged victim who was verbal and the case file did not contain a written statement or interview with the alleged victim. Six cases (5%) did not contain documentation of a written statement or interview with the alleged perpetrator.

All of the cases we reviewed contained a Case Tracking Form and a Case Routing and Approval Form. Although all of the cases sampled contained these forms, for 36 of 130 (28%) case files reviewed, the Case Tracking Form was not complete. For 26 of 130 (20%) case files reviewed, the Case Routing and Approval Form was incomplete. (pages 31-34)

The number of abuse and neglect investigations closed has increased substantially since FY10 (from 2,162 in FY10 to 3,601 in FY17); however, the substantiation rate has remained consistent.

ACTIONS, SANCTIONS, AND RECOMMENDATIONS

The number of abuse and neglect investigations closed has increased substantially since FY10 (from 2,162 in FY10 to 3,601 in FY17); however, the substantiation rate has remained consistent. The substantiation rate for abuse and neglect investigations closed for FY10 was 12 percent, while it was 13 percent for FY17.

DHS, in some cases, still takes an extended amount of time to receive and approve the actions taken by community agencies or State-operated facilities. State-operated facilities and community agencies are required to submit a written response to DHS for all substantiated cases of abuse and neglect, or cases with other administrative issues within 30 calendar days from receipt of the investigative report. In our sample of investigations, there were 20 cases that required a written response. Of the 20 cases in our sample that required a written response, 1 of 20 (5%) took more than six months from the date the case was completed until the written response was approved by DHS. For 4 of 20 investigations sampled (20%), the OIG could not provide an approved written response. These four investigations had been completed for an average of 180 days as of September 1, 2017, with a range of between 106 days to 289 days since the case was completed.

During FY16 and FY17, the OIG did not recommend any sanctions regarding community agencies or State-operated facilities. The OIG has not recommended a sanction related to a State-operated facility for at least the past 24 years (1994-2017). During FY09, the OIG recommended that DHS' Division of Developmental Disabilities take immediate action against one community agency, up to and including sanctions. (pages 35-43)

OTHER ISSUES

In September 2017, a board member resigned leaving the Board with only three members. Four members are needed for a quorum.

The Quality Care Board (Board) did not have seven members during FY16 and FY17 as is required by statute. For FY16, the Board also did not meet quarterly as required by statute and did not always have a quorum at all of the meetings that were held. As of October 2017, the OIG was unable to provide approved meeting minutes for scheduled meetings in February 2017 or May 2017 and, therefore, we could not determine whether these meetings were held or whether there was a quorum present to conduct business. In September 2017, a board member resigned leaving the Board with only three members. Four members are needed for a quorum. A lack of membership on the Board was also an issue in the previous audit released in 2010. The statutory requirement for having two members of the Board be a person with a disability or the parent of someone with a disability was not being met.

The Board cannot fulfill its statutory responsibilities "to monitor and oversee the operations, policies, and procedures of the Inspector General" with chronic vacancies, expired terms, and a lack of input from persons with a disability or a parent of such person.

The OIG could not provide documentation to show that investigators had received the required initial training courses delineated in OIG directives. Further, a number of classes that fall under required initial training for investigators are no longer available because of the discontinuation of the NetLearning system. Training information provided by the DHS Division of Mental Health and the Division of Developmental Disabilities showed that some employees at State-operated facilities were not receiving training in prevention and reporting of abuse and neglect (Rule 50 training). DHS does not monitor community agencies for compliance with training requirements.

The Act requires the Inspector General to conduct unannounced site visits to each facility at least annually (20 ILCS 1305/1-17(i)). FY16 and FY17 site visit information provided by the OIG showed a reduction in time spent on site, number of areas reviewed, and findings. In FY15, all 14 unannounced site visits were conducted over a two-day period. In FY16, 5 of the 14 visits were conducted over a two-day period. In FY17, 5 of the 14 were two-day visits. The FY15 unannounced site visits covered four different areas, two of which were medically related, and resulted in 51 findings. In FY16, two areas were examined, neither was medically related, and the site visits resulted in 15 findings. For FY17, three areas were examined resulting in a total of seven findings. (pages 45-56)

RECOMMENDATIONS

The audit report contains a total of 13 recommendations to the Office of the Inspector General and the Department of Human Services. The OIG and DHS generally agreed with the recommendations in the report. Appendix E to the audit report contains the agency responses.

This performance audit was conducted by staff of the Office of the Auditor General.

SIGNED ORIGINAL ON FILE

AMEEN DADA
Division Director

This report is transmitted in accordance with Section 3-14 of the Illinois State Auditing Act.

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

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Chapter One

INTRODUCTION AND BACKGROUND

REPORT CONCLUSIONS

The Department of Human Services Act (Act) (20 ILCS 1305/1-17(w)) directs the Auditor General to conduct a program audit of the Department of Human Services (DHS), 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. This is the 12th audit we have conducted of the OIG since 1990.

The Act requires the OIG to investigate allegations of abuse and neglect that occur in mental health and developmental disability facilities operated by DHS. The Act also requires the OIG to investigate allegations of abuse and neglect that occur in community agencies licensed, certified, or funded by DHS to provide mental health and developmental disability services (20 ILCS 1305/1-17(a)).

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Total allegations of abuse and neglect reported to the OIG have increased since our 2010 audit. In FY10, 2,468 allegations were reported. Of the 2,468 allegations reported in our 2010 audit, 967 allegations were reported at State-operated facilities and 1,501 allegations were reported at community agencies. In FY17, allegations of abuse and neglect increased to 3,698 or 50 percent. The increase in the number of allegations was primarily driven by an increase in allegations reported at community agencies. **Allegations reported at community agencies increased from 1,501 in FY10 to 2,714 in FY17 or 81 percent**.

The timeliness of completion for OIG investigations has deteriorated significantly since our audit for FY10.

While the Act requires the OIG to investigate allegations of abuse and neglect, other State agencies, including the Illinois State Police, the Department of Children and Family Services (DCFS), and the Department of Public Health, may 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, the agreement with DCFS contains outdated statutory cites and definitions that need updating.

Timeliness of Investigations

The timeliness of completion for OIG investigations has deteriorated significantly since our FY10 audit. For FY10, 85 percent of closed cases were completed within the 60 working

day requirement. For FY17, 50 percent of closed cases were completed within 60 working days. **This represents a decrease of 35 percent since the previous audit.** In May 2017, the OIG's administrative rules were amended to remove the requirement that investigations be completed within 60 working days. However, this requirement is still included in the OIG's Directives.

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For FY17 cases we sampled where there was a victim identified, **it took an average of 26 days** from the reporting of an incident for the alleged victim to be interviewed or a statement to be taken. Comparatively, **for FY10** cases sampled where there was a victim identified, **it took an average of 9 days** to complete statements or interviews for the alleged victim.

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DHS, in some cases, still takes an extended amount of time to receive and approve the actions taken by the community agencies or State-operated facilities. State-operated facilities and community agencies are required to submit a written response to DHS for all substantiated cases of abuse and neglect, or cases with other administrative issues within 30 calendar days from receipt of the investigative report. In our sample of investigations, there were 20 cases that required a written response. Of the 20 cases in our sample that required a written response, 1 of 20 (5%) took more than six months from the date the case was completed until the written response was approved by DHS. For 4 of 20 investigations sampled (20%), the OIG could not provide an approved written response. These four investigations had been completed for an average of 180 days as of September 1, 2017, with a range of between 106 days to 289 days since the case was completed.

During FY16 and FY17, the OIG did not recommend any sanctions regarding community agencies or State-operated facilities. The OIG has not recommended a sanction related to a State-operated facility for at least the past 24 years (1994-2017). During FY09, the OIG recommended that DHS' Division of Developmental Disabilities take immediate action against one community agency, up to and including sanctions.

Other Issues

The Quality Care Board (Board) did not have seven members during FY16 and FY17 as is required by statute. For FY16, the Board also did not meet quarterly as required by statute and did not always have a quorum at all of the meetings that were held. As of October 2017, the OIG was unable to provide approved meeting minutes for scheduled meetings in February 2017 or May 2017 and, therefore, we could not determine whether these meetings were held or whether there was a quorum present to conduct business. In September 2017, a board member resigned leaving the Board with only three members. Four members are needed for a quorum. A lack of membership on the Board was also an issue in the previous audit released in 2010. The statutory requirement for having two members of the Board be a person with a disability or the parent of someone with a disability was not being met. The Board cannot fulfill its statutory responsibilities "to monitor and oversee the operations, policies, and procedures of the Inspector General" with chronic vacancies, expired terms, and a lack of input from persons with a disability or a parent of such person.

The OIG could not provide documentation to show that investigators had received the required initial training courses delineated in OIG directives. Further, a number of classes that fall under required initial training for investigators are no longer available because of the discontinuation of the NetLearning system. Training information provided by the DHS Division of Mental Health and the Division of Developmental Disabilities showed that some employees at State-operated facilities were not receiving training in prevention and reporting of abuse and neglect (Rule 50 training). DHS does not monitor community agencies for compliance with training requirements.

The Board cannot fulfill its statutory responsibilities "to monitor and oversee the operations, policies, and procedures of the Inspector General" with chronic vacancies, expired terms, and a lack of input from persons with a disability or a parent of such person. (20 ILCS 1305/1-17(u))

The Act requires the Inspector General to conduct unannounced site visits to each facility at least annually (20 ILCS 1305/1-17(i)). FY16 and FY17 site visit information provided by the OIG showed a reduction in time spent on site, number of areas reviewed, and findings. In FY15, all 14 unannounced site visits were conducted over a two-day period. In FY16, 5 of the 14 visits were conducted over a two-day period. In FY17, 5 of the 14 were two-day visits. The FY15 unannounced site visits covered four different areas, two of which were medically related, and resulted in 51 findings. In FY16, two areas were examined, neither was medically related, and the site visits resulted in 15 findings. For FY17, three areas were examined resulting in a total of seven findings.

INTRODUCTION

The Department of Human Services Act (Act) directs the Auditor General to conduct a program audit of the Department of Human Services (DHS), Office of the Inspector General (OIG) on an as needed basis. Section 1-17(w) of the Act that establishes the authority for this audit can be seen in Appendix A. 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 audit is required to be released no later than January 1 following the audit period (20 ILCS 1305/1-17(w)).

BACKGROUND

The Act requires the OIG to investigate allegations of abuse and neglect that occur in mental health and developmental disability facilities operated by DHS. The Act also authorizes the OIG to conduct investigations at community agencies licensed, certified, or funded by DHS to provide mental health and developmental disability services (20 ILCS 1305/1-17).

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 and 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.

OIG ORGANIZATION

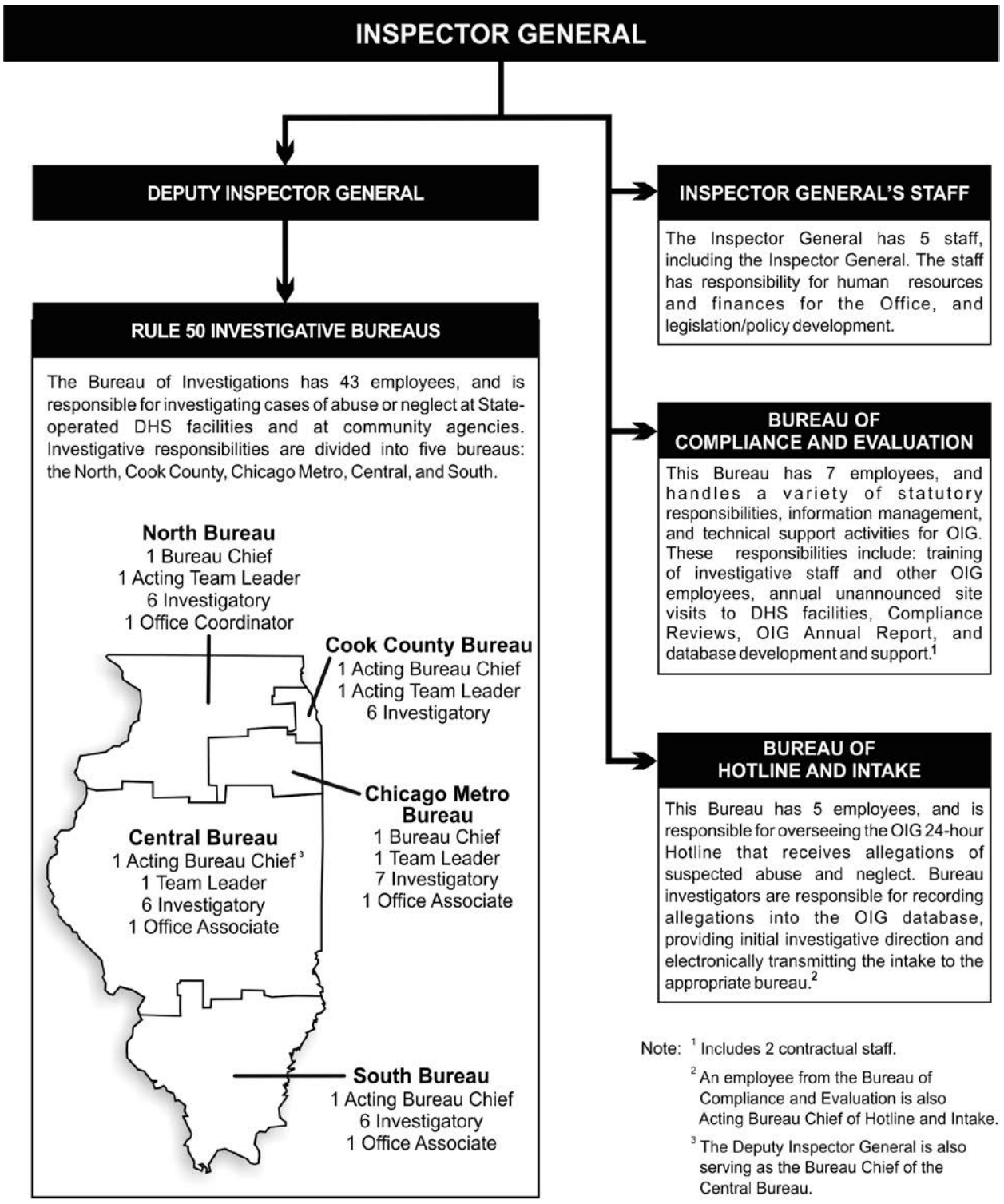
The Inspector General reports to the Secretary of DHS and the Governor. The Inspector General as of June 30, 2017, Michael McCotter, was appointed to be the Acting Inspector General by former Governor Pat Quinn on December 7, 2012. Mr. McCotter was confirmed by the Illinois Senate to the position of Inspector General on May 8, 2013. Prior to being appointed as Inspector General, Mr. McCotter conducted a review of the OIG's investigative procedures, policies, and cases. A report was issued in October 2012, including recommended reforms related to the Domestic Abuse Program. This is the first audit we have conducted since the current Inspector General was appointed to the office.

Although we were able to establish that the OIG has a mission statement, the OIG no longer has a current written strategic plan containing goals and objectives. Therefore, it is unclear how the OIG is evaluating its performance or how the organization's goals and objectives are being communicated to staff.

The OIG has reorganized somewhat since our last audit, which covered the period FY09-FY10. According to OIG officials, these changes were made over the past several years. Exhibit 1-1 shows the OIG organization as of July 2017. Some of these organizational changes include:

- There is no longer a Domestic Abuse Bureau;
- A Cook County Investigative Bureau was added; and
- Investigative staff are now located around the State at various locations.

Exhibit 1-1
OIG ORGANIZATIONAL CHART
As of July 2017



Note: [1] Includes 2 contractual staff.
[2] An employee from the Bureau of Compliance and Evaluation is also Acting Bureau Chief of Hotline and Intake.
[3] The Deputy Inspector General is also serving as the Bureau Chief of the Central Bureau.

Source: OAG analysis of DHS OIG organizational charts and staffing information.

Prior to July 1, 2013, the OIG's Bureau of Domestic Abuse investigated allegations of abuse and neglect related to adults in domestic settings. Pursuant to P.A. 98-0049 (effective July 1, 2013) the OIG's responsibility for investigating domestic cases under the Department of Human Service Act (20 ILCS 1305) and the Abuse of Adults with Disabilities Intervention Act (20 ILCS 2435), involving adults with disabilities, was transferred to the Department on Aging. Under a new statute, the Adult Protective Services Act (320 ILCS 20), the **Department on Aging has jurisdiction to investigate allegations of abuse, neglect, and financial exploitation of adults living in their own homes and adults with disabilities aged 18-59 who live in domestic settings in the community.**

As of July 1, 2017, the OIG had five investigative bureaus, which all report to the Deputy Inspector General. In our FY10 audit, we reported that the OIG had four investigative bureaus (North, Chicago Metro, Central, and South). According to OIG officials, the Cook County Investigative Bureau was added in 2013. The OIG also has a Bureau of Hotline and Intake and a Bureau of Compliance and Evaluation that includes Clinical Coordinators that conduct death reviews.

According to OIG officials, the number of investigators dropped significantly prior to FY16. During FY16, the OIG hired a large number of new employees (18 employees were hired between July 1, 2015 and June 30, 2016). After hiring these employees, the headcount provided by the OIG for the current audit period shows that the number of employees is now similar to our previous audit. As of July 2017, the OIG had a total of 60 employees, including 2 contractual employees. In July 2010, the OIG had a total of 59 employees.

The five OIG bureaus that conduct investigations of allegations at State facilities and community agencies are broken down by region. According to information provided by the OIG, as of October 2017:

- The Cook County Bureau is responsible for 2 facilities (Chicago-Read MHC and Madden MHC) and 1,285 program sites operated by 81 agencies in Cook County;
- The North Bureau is responsible for 3 facilities (Elgin MHC, Kiley DC, and Mabley DC) and 931 program sites operated by 190 agencies in 20 counties in northern and northwestern Illinois;
- The Chicago Metro Bureau is responsible for 2 facilities (Shapiro DC and Ludeman DC) and 723 program sites operated by 91 agencies in 5 counties in the northeastern part of the State;
- The Central Bureau is responsible for 3 facilities (Fox DC, McFarland MHC, and Alton DC) and 1,060 program sites operated by 101 community agencies in 47 counties in the central part of the State; and
- The South Bureau is responsible for 4 facilities (Chester MHC, Choate MHC/DC, and Murray DC) and 553 program sites operated by 78 community agencies in 29 counties in the southern section of the State.

Exhibit 1-2 summarizes the five OIG bureaus and the number of counties, facilities, agencies, and program sites each is responsible for investigating.

For FY17, there were a total of 421 community agencies with 4,552 program sites (i.e. CILAs, group homes, day programs, etc.) that were under the investigative jurisdiction of the OIG. This represents an increase of 1,079 program sites since our last audit or 31 percent. In

our previous audit, we reported that there were 376 agencies operating 3,473 programs. As is shown in Exhibit 1-2, OIG investigators in many cases are responsible for hundreds of program sites. For instance, the Central Bureau has 6 investigators that are responsible for allegations reported for a 47 county area including 3 State-operated facilities and 1,060 community agency program locations (or about 177 locations per investigator).

Exhibit 1-2
OVERVIEW OF OIG INVESTIGATIVE BUREAUS AND RESPONSIBILITIES
As of July 2017

OIG Bureau	Number of Investigators	Counties	State Facilities	Community Agencies	Program Sites
Cook County	7	1	2	81	1,285
North	7	20	3	190	931
Chicago Metro	7	5	2	91	723
Central	6	47	3	101	1,060
South	7	29	4	78	553
Total	**34**[2]	**102**	**14**	**421**[1]	**4,552**[1]

Note:
[1] Some agencies operate program sites in multiple OIG bureaus. Therefore, the count of agency and program sites by bureau includes some duplication and column totals may not add.
[2] Number of investigators includes Internal Security Investigators (ISI II) title employees including those in "acting" positions as Team Leader or Bureau Chief.

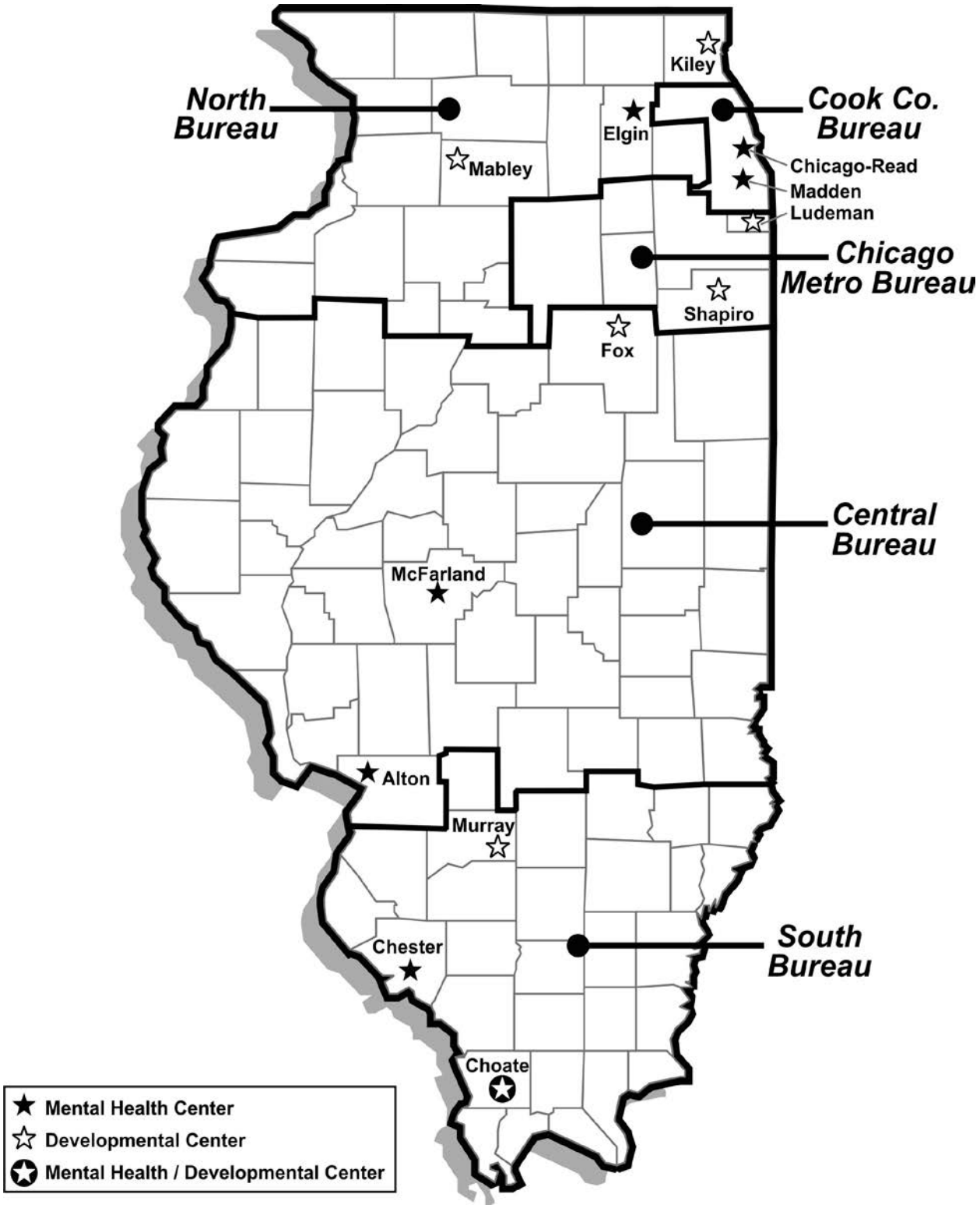
Source: OAG analysis and OIG data.

OIG Investigative Bureaus

As is shown in Exhibit 1-3, the responsibility for OIG investigations is divided into five regional bureaus.

- The **Cook County** Bureau is located at Madden Mental Health Center with investigators located at Madden Mental Health Center and a DHS Teen Site.
- The **North** Bureau is located at Madden Mental Health Center with investigators located at Madden Mental Health Center, Elgin Mental Health Center, Mabley Developmental Center, Kiley Developmental Center, and Rockford.
- The **Chicago Metro** Bureau is located at Madden Mental Health Center with investigators located at Madden Mental Health Center, the Illinois Veterans Home in Manteno, and a DHS Teen Site.
- The **Central** Bureau is located at McFarland Mental Health Center with investigators located at McFarland Mental Health Center, Alton, Bloomington, Jacksonville, and Central Mattoon/Coles County.
- The **South** Bureau is located at Choate Mental Health and Developmental Center with investigators located at Choate Mental Health Center, Murray Developmental Center, Mt. Vernon, and St. Clair County.

Exhibit 1-3
DHS OPERATED FACILITIES AND OIG INVESTIGATIVE BUREAUS



Source: OAG analysis of OIG organizational charts and DHS facility locations.

As of July 2017, there were a total of 43 employees in the five investigative bureaus: Cook (8), North (9), Chicago Metro (10), Central (8), and South (8). All of the investigative bureaus report to the Deputy Inspector General. Other bureaus at the OIG include the:

- **Bureau of Hotline and Intake**: Includes Hotline personnel who take calls reporting allegations of abuse and neglect. The July 2017 headcount in this Bureau was five.
- **Bureau of Compliance and Evaluation**: Includes functions such as information management and training. Also, includes clinical coordinators that are responsible for investigations of deaths or serious injuries in State-operated facilities or community agencies. The total headcount in this Bureau in July 2017 was seven, which included two contractual employees.

In addition to the seven bureaus discussed above, there is the Inspector General's staff. There are a total of five employees including the Inspector General. The Inspector General's staff includes the human resources, finance, and policy development staff.

STATE-OPERATED FACILITY POPULATIONS

In FY17, DHS operated a total of 14 facilities in Illinois. Six locations served the developmentally disabled, six locations served the mentally ill, and one location served both.

The number of individuals being served in State-operated facilities has significantly decreased since our last audit. Exhibit 1-4 shows the number of unduplicated residents served at State-operated facilities for the period FY10 through FY17. **Overall, the total number of unduplicated residents at all facilities has declined by 45 percent. Since FY10, the number served at State mental health centers has decreased by 50 percent.**

Exhibit 1-4
UNDUPLICATED INDIVIDUALS SERVED AT STATE FACILITIES
FY10 through FY17

Year	Developmental Centers	Mental Health Centers	Total
FY10	2,485	10,237	12,722
FY11	2,279	9,469	11,748
FY12	2,037	8,960	10,997
FY13	1,918	6,829	8,747
FY14	1,854	6,762	8,616
FY15	1,798	5,709	7,507
FY16	1,897	5,459	7,356
FY17	1,878	5,109	6,987

Source: OIG annual reports and DHS data.

DHS has closed four facilities since January 2010. These facilities include:

- Howe Developmental Center (closed June 21, 2010);
- Tinley Park Mental Health Center (closed June 30, 2012);
- Singer Mental Health Center (closed October 31, 2012); and
- Jacksonville Developmental Center (closed November 27, 2012).

According to DHS OIG officials, clients from these four facilities were either moved to another facility or were placed in a community agency.

Trends in Reporting Allegations of Abuse and Neglect

Total allegations of abuse and neglect reported to the OIG have continued to increase since our 2010 audit. In FY10, 2,468 allegations were reported (1,877 abuse and 591 neglect). Between FY11 and FY17 allegations of abuse and neglect increased from 2,255 to 3,698 or 64 percent.

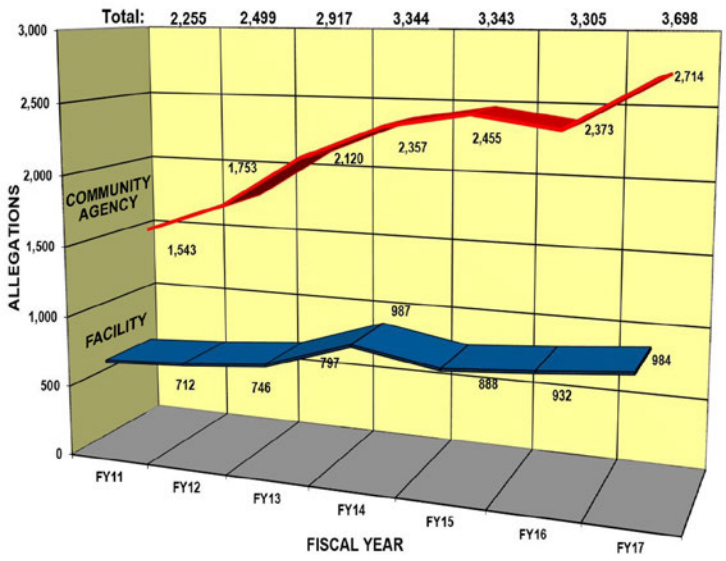
The increase in the number of allegations was primarily driven by an increase in allegations at community agencies.

As is shown in Exhibit 1-5, allegations reported by community agencies increased from 1,543 in FY11 to 2,714 in FY17 or 76 percent. Of the 2,468 allegations reported in our 2010 audit, 967 allegations were reported at State facilities and 1,501 allegations were reported at community agencies.

Allegations of abuse and neglect reported at State facilities also increased from 712 in FY11 to 984 in FY17. This increase occurred while the population of residents at State facilities decreased from 11,748 in FY11 to 6,987 in FY17.

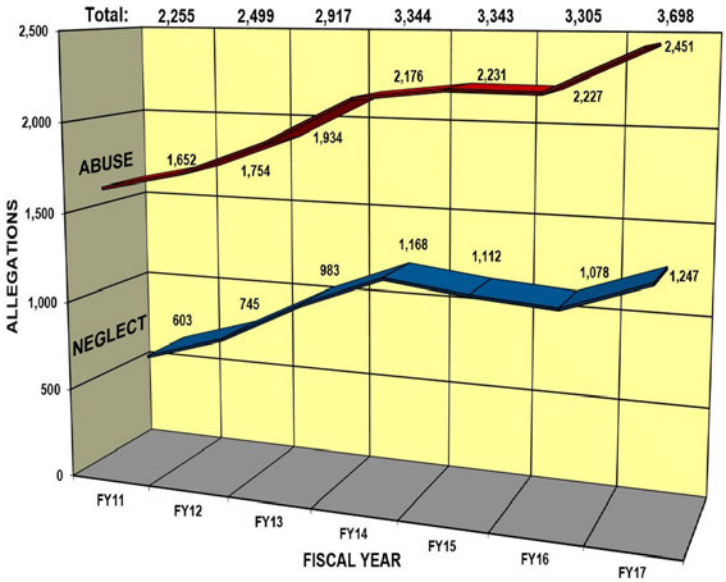
Exhibit 1-6 shows the allegations reported for the period FY11-FY17 by the type of allegation. Although allegations of both abuse and neglect have increased, allegations of neglect have more than doubled. For FY11 there were 1,652 allegations of abuse and 603 allegations of neglect. For FY17, there were 2,451 allegations of abuse and

Exhibit 1-5
ABUSE AND NEGLECT ALLEGATIONS REPORTED TO OIG BY TYPE OF FACILITY
FY2011 through FY2017



Source: OIG data summarized by OAG.

Exhibit 1-6
TRENDS IN REPORTING ABUSE AND NEGLECT
FY2011 through FY2017



Source: OIG data summarized by OAG.

1,247 allegations of neglect.

We asked OIG officials about the trends in the reporting of allegations. According to an OIG official, the DHS Division of Developmental Disabilities and Division of Mental Health, spurred on by the Secretary, have both been making a push toward better reporting and more oversight.

OIG INVESTIGATION PROCESS

The investigation process begins when an allegation is reported to the OIG Hotline. The Department of Human Services Act requires that suspected abuse and neglect be reported by phone to the OIG Hotline no later than 4 hours after the initial discovery of the incident. The OIG Hotline investigator determines whether the allegation meets the definition of abuse and neglect. If abuse and neglect is suspected, the case is 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, trained facility or community agency personnel may collect physical evidence and take initial statements from those involved in the incident.

Allegations are assigned, based on location, to one of five OIG investigative bureaus. OIG directives require the Bureau Chief to assign the case to an investigator within one working day. The OIG no longer requires investigators to complete an investigative plan within three working days of the assignment unless it is during the investigator's probationary period. When the investigator completes an investigation, an investigative report is developed in accordance with OIG directives and is forwarded to the Investigative Team Leader or 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.

For substantiated cases, the Investigative Team Leader or Bureau Chief is required to complete a Supervisory Review Checklist and complete the Elemental Review Sheet started by the assigned investigator. Once the Bureau Chief reviews and approves a substantiated case of physical abuse, sexual abuse, or egregious neglect, the report will then be sent to the Inspector General or his/her designee for review. According to Rule 50 (59 Ill. Adm. Code 50), the investigative report shall be submitted to the Inspector General within 60 working days of the assignment unless there are extenuating circumstances. **In May 2017, the 60 working day requirement and all case file requirements for investigations were removed from the OIG's administrative rules.** The requirement to complete cases within 60 working days is, however, still included in the OIG's directives.

For cases that involve medical issues, the OIG directives require that the investigators contact a Clinical Coordinator for a consultation. The OIG investigator must also consult with a Clinical Coordinator prior to rendering a conclusion in a case involving a medical issue.

Case closure is a two-step process: first, the investigation is completed and the investigative report is mailed; second, after the reconsideration period has ended and any additional action has been taken, the case is administratively closed.

To begin the reconsideration process, 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 (59 Ill. Adm.

Code 50.60). 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 for reconsideration must include new information that could change the finding.

For unsubstantiated cases without recommendations, a letter of finding is sent to the facility or community agency. If the case is substantiated or contains recommendations, the OIG sends the facility or community agency a copy of the investigative report that includes the OIG's finding in the case. The OIG is also required by rule to send a copy of the finding in all cases to the complainant, the individual that was allegedly abused or neglected, and the person alleged to have committed the offense. The investigative report and the investigation are considered closed 30 calendar days after being provided to the facility or agency.

The Inspector General is required by the Act to provide a complete investigative report within 10 business days to the Secretary of the Department of Human Services when abuse or neglect is substantiated or administrative action is recommended (20 ILCS 1305/1-17(m)). For any case in which the OIG substantiates abuse or neglect or makes one or more 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 Director of the applicable DHS division (Mental Health or Developmental Disabilities) is required to approve the written response (59 Ill. Adm. Code 50.80).

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 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 behavior that results in sexual contact, intimate physical contact, sexual behavior, or intimate physical behavior. Sexual abuse also includes:

- an employee's actions that result in the sending or showing of sexually explicit images to an individual via computer, cellular phone, electronic mail, portable electronic device, or other media, with or without contact with the individual; or
- an employee's posting of sexually explicit images of an individual online or elsewhere, whether or not there is contact with the individual. Sexual abuse does not include allowing individuals to, of their volition, view movies or images of a sexual nature or read text containing sexual content unless the individual's guardian prohibits the viewing of those movies or images or reading of that material.

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.

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 50.10.

Community Agencies and Investigations

During our previous audit (FY10) of the OIG, community agencies under the jurisdiction of the OIG could apply for an approved protocol, which authorized the agency to conduct certain investigations. According to OIG officials, as of December 31, 2015, community agencies were no longer allowed to perform investigations. However, community agency staff still have basic incident management responsibilities, including securing the scene, gathering evidence, and taking initial written statements (responsibilities under 59 Ill. Adm. Code 50.30(f)).

Death Reviews

The Department of Human Services Act requires that absent an allegation of abuse and neglect, deaths are to be reported by phone to the OIG Hotline within 24 hours after initial discovery. This includes any death at a facility or agency or any death occurring within 14 calendar days after discharge or transfer of an individual from a residential program or facility.

The responsibility for death reviews is shared between the OIG Clinical Coordinators and the investigative bureaus. If the Clinical Coordinator determines that there may be an allegation of abuse and neglect associated with a death review, the appropriate Bureau Chief is notified, and the case is referred to an OIG investigator. 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 and neglect, the Coordinator will notify the Bureau Chief and assume primary responsibility for the review. This includes conducting necessary interviews, collecting relevant documentation, and completing the death report. For these cases the Bureau Chief is also the final reviewer.

Health Care Worker Registry

If an investigation substantiates an allegation of physical abuse, sexual abuse, egregious neglect, or financial exploitation, the Inspector General is required by the Department of Human Services Act to report the identity of the accused employee and finding to the Health Care Worker Registry. The Health Care Worker Registry is discussed further in Chapter Four of this report.

REPORTING ALLEGATIONS

Total allegations of abuse and neglect reported to the OIG have increased significantly since our previous audit for FY10. In FY10 there were a total of 2,468 allegations reported (1,877 abuse and 591 neglect). In FY17, 3,698 allegations were reported (2,451 abuse and 1,247 neglect), which represents a 50 percent increase in allegations since FY10. According to an OIG official, the Division of Developmental Disabilities and the Division of Mental Health, spurred on by the Secretary, have both been making a push toward better reporting and more oversight.

Reporting to the OIG Hotline

DHS facilities and community agencies are required by the Department of Human Services Act to report allegations of abuse and neglect within four hours of discovery of an incident by calling the OIG Hotline. An OIG Hotline investigator makes an assessment as to whether the allegation is reportable and whether it 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 appropriate investigative bureau 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. The OIG's administrative rules (59 Ill. Adm. Code 50.20) require 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 and 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 ISP 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)).

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 (20 ILCS 1305/1-17(g)).

The OIG's administrative rules stipulate that *"when two or more State agencies could investigate an allegation of abuse and 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)"* (59 Ill. Adm. Code 50.30). The Inspector General has clarified the investigatory roles with the Illinois State Police and Department of Public Health through interagency agreements. Although there is an agreement with the Department of Children and Family Services, it was executed in November 2000 and contains outdated language. According to OIG officials, they are continuing to try to update the agreement.

Illinois State Police

The Department of Human Services Act requires the OIG to report to the Illinois State Police (ISP) within 24 hours after determining that a reported allegation of suspected abuse and neglect indicates that any possible criminal act has been committed or that special expertise is required in the investigation. The OIG is required to notify the Department of State Police or the appropriate law enforcement entity, or ensure that such notification is made. 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)).

The OIG executed a new agreement with the ISP in April 2016 that clarifies the reporting and investigative responsibilities of each agency. The agreement not only requires reporting by the OIG to the State Police within 24 hours of determining that a possible criminal act has been committed, but also requires that when the ISP receives an allegation of abuse or neglect and declines, the ISP must notify the OIG within 24 hours.

When allegations are investigated by the ISP, the OIG may conduct a separate investigation after the State Police investigation is completed. The State Police only look at the criminal aspects of the incident; it is up to the OIG to examine any administrative issues relating to the incident.

Department of Public Health

The Abused and Neglected Long-Term Care Facility Residents Reporting Act (210 ILCS 30) requires the Illinois Department of Public Health (DPH) to conduct investigations of suspected abuse and neglect at DPH-licensed Long-Term Care Facilities. This includes any long-term care institution participating in the Medicare or Medicaid programs, including State facilities operated by DHS and community mental health centers.

The Abused and Neglected Long-Term Care Facility Residents Reporting Act requires all persons who provide direct care services or have direct contact with residents to report all incidents of suspected abuse and neglect to DPH immediately. DPH investigations focus on quality of care issues, such as allegations of actual or potential harm to patients, patient rights, infection control, and medication errors. DPH also investigates allegations of harm or potential harm due to an unsafe physical (building) environment.

The current interagency agreement between the OIG and DPH was executed in March 2012. The agreement clarifies the responsibilities for of each agency and generally delineates that:

- The OIG will refer allegations and reports of incidents received regarding DPH-licensed long-term care facilities to the DPH Long-Term Care Residents Reporting Hotline; and
- DPH will refer all allegations and reports of incidents occurring at programs within DHS-OIG's jurisdiction to the OIG.

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 and neglect of all persons under the age of 18 to the Department of Children and Family Services (DCFS). An interagency agreement was executed by DCFS and the OIG in November 2000. According to DHS officials, the agreement has not been terminated and is therefore still effective at this time.

The interagency 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. The agreement between DHS and DCFS contains outdated statutory cites that should be updated.

INTERAGENCY AGREEMENTS	
RECOMMENDATION 1	***The Office of the Inspector General should consider updating its interagency agreement with the Department of Children and Family Services.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Disagree - OIG has met with DCFS about updating the current agreement. However, since there has been little jurisdictional overlap since FY2010, DCFS does not see the need for an updated agreement. Information in our database indicates there has not been an OIG investigation involving an individual under the age of 18 in the last three fiscal years. Based on this, OIG does not see a need to update the outdated interagency agreement with DCFS and will move to terminate that agreement. OIG will continue to coordinate and cooperate with DCFS if any jurisdictional overlap occurs. ***Auditor Comment #1*** ***The OIG's current agreement with DCFS was signed in November 2000 and contains outdated statutory cites. This audit randomly sampled 130 investigations closed by the OIG in FY17. One of the investigations sampled involved an individual over the age of 18 in which the investigation was eventually referred to DCFS after the OIG determined that it was out of its jurisdiction.***

STATUS OF RECOMMENDATIONS FROM PREVIOUS AUDIT

The previous audit of the OIG, released in December 2010, contained a total of nine recommendations; seven to the OIG, one to DHS, and one to both the DHS and the OIG. Follow up for these recommendations was conducted as part of the DHS Compliance Examinations conducted by the Office of the Auditor General for the two years ended June 30, 2011, June 30, 2013, and June 30, 2015. This audit follows up on any remaining recommendations that were not implemented. Any repeated recommendations are contained in this report.

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 sufficient, appropriate evidence to provide 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. A detailed methodology for the audit is presented in Appendix B.

The Office of the Auditor General has conducted 11 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, 2008, and 2010.

An exit conference to discuss the draft audit report was held with officials from the Department of Human Services Office of the Inspector General on November 16, 2017. Those in attendance included:

DHS Office of the Inspector General
Mike McCotter, Inspector General
Bill Diggins, Deputy Inspector General
Amy Tarr, Policy Development Manager
Mark Krauss, BCE Bureau Chief

Department of Human Services
Amy DeWeese, Chief Internal Auditor
Albert Okwuegbunam, Internal Auditor
Sunday Odele, Internal Auditor

Office of the Auditor General:
Mike Paoni, Audit Manager
Patrick Rynders, Audit Supervisor
Brian Bratton, Audit Staff
Alison Storm, Audit Staff

Chapter Two

TIMELINESS OF ABUSE AND NEGLECT INVESTIGATIONS

CHAPTER CONCLUSIONS

The timeliness of completion for OIG investigations has deteriorated significantly since our FY10 audit. For FY10, 85 percent of closed cases were completed within the 60 working day requirement. For FY17, 50 percent of closed cases were completed within 60 working days. **This represents a decrease of 35 percent since the previous audit.** In May 2017, the OIG's administrative rules were amended to remove the requirement that investigations be completed within 60 working days. However, this requirement is still included in the OIG's Directives.

Although FY17 data provided by the OIG showed improvement in timely reporting of allegations of abuse and neglect, timeliness could not be determined for 20 percent of facility allegations and 22 percent of community allegations. This was because the incident discovered time/date was reported as unknown, was inaccurate, or the time/date recorded was not specific. For FY17, the percent of allegations not reported within the statutorily required four hours was 11 percent at community agencies and 5 percent at State-operated facilities. **Compared to FY10, late reporting at State facilities has decreased or improved from 10 percent in FY10 to 5 percent in FY17**. For community agencies, late reporting improved from 13 percent in FY10 to 11 percent in FY17.

The OIG needs to improve the timeliness of investigator assignment and supervisory approval.

- OIG directives require that investigations be assigned to an investigator within one working day of the Bureau Chief or Investigative Team Leader (ITL) receiving the intake. For investigations closed during FY17, 96 percent (3,643 of 3,797) were initially assigned within one working day of the allegations being added to the OIG database. However, when compared to the date reported, nearly 50 percent (1,891 of 3,797) of investigations took two or more working days to be assigned to an investigator.
- OIG directives require the ITL or Bureau Chief to review cases within seven working days of receipt absent extenuating circumstances. For cases closed in FY17, 55 percent (2,079 of 3,797) were approved within 7 working days of submission.

The time it takes to obtain a written statement or interview from the alleged victim and perpetrator has increased since our last audit in FY10. 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.

For FY17 cases we sampled where there was a victim identified, **it took an average of 26 days** from the reporting of an incident for the alleged victim to be interviewed or a statement to be taken. Comparatively, **for FY10** cases sampled where there was a victim identified, **it took an average of 9 days** to complete statements or interviews for the alleged victim.

For FY17 cases we sampled where there was a specific alleged perpetrator identified, **it took an average of 45 days** from the reporting of an incident for the alleged perpetrator to be interviewed or a written statement to be taken. Comparatively, **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.

Open cases and average caseloads have increased dramatically since our 2010 audit. Overall, open cases increased from 485 total cases as of August 2010 to 1,797 as of August 2017. For the investigative bureaus, caseload averages as of August 2010 ranged from a high of 23 cases per investigator in the Metro Bureau to a low of 12 in the South Bureau. For August 2017, caseload averages ranged from a high of 65 cases per investigator in the Metro Bureau to a low of 29 in the North Bureau.

REPORTING ALLEGATIONS

According to data provided by the OIG, the timeliness of reporting allegations of abuse and neglect has improved since our FY10 audit. 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 and neglect (20 ILCS 1305/1-17(k)).

Exhibit 2-1
ALLEGATIONS OF ABUSE AND NEGLECT NOT REPORTED WITHIN FOUR HOURS OF DISCOVERY
FY10, FY16, and FY17

Fiscal Year	Facility	Community Agency
FY10	10%	13%
FY16	7%	13%
FY17	5%	11%

Source: OAG analysis of OIG data.

Exhibit 2-1 shows allegations of abuse and neglect not reported within four hours of discovery for State-operated facilities and community agencies for FY10 and for the audit period FY16-FY17. For FY17, the percent of allegations not reported within the statutorily required four hours was 11 percent at community agencies and 5 percent at State-operated facilities. Compared to FY10, late reporting at State-operated facilities has improved from 10 percent in FY10 to 5 percent in FY17. For community agencies, late reporting has improved slightly from 13 percent in FY10 to 11 percent in FY17. Our review of FY17 closed investigations showed that the OIG also continues to cite late reporting in its investigations when it occurs.

Even though the timeliness of incident reporting appears to have improved, there were also a significant percent of allegations for which we could not determine if the incident was reported within the required four hours.

- **State-Operated Facility Reporting** – Timeliness could not be determined for 20 percent of FY17 facility allegations because the incident discovered time/date was reported as unknown, or the incident time recorded was not specific (i.e. “one week ago” or “ongoing”).
- **Community Agency Reporting** – Timeliness of reporting could not be determined for 22 percent of FY17 agency allegations because the incident discovered time/date was reported as unknown or the incident time was not specific (i.e. “ongoing,” “night,” “early morning,” around noon, etc.).

While there are clearly situations in which a specific incident date and time may not be attainable, the OIG should make further efforts to ascertain a specific date and time that the reporter discovered or was informed of the allegation or incident. Without accurately gathering this information at intake, it is impossible to know whether these allegations are being reported in accordance with the four hour reporting requirement in the Department of Human Services Act and the OIG's administrative rules.

ALLEGATION REPORTING	
RECOMMENDATION 2	***The Office of the Inspector General should:*** • ***Improve the collection of information regarding the date and time an incident is discovered; and*** • ***Continue to work with State-operated facilities and community agencies to improve the number of allegations of abuse and neglect that are reported within the four-hour time frame specified in the Department of Human Services Act and OIG's administrative rules.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree - While OIG does not have control over what the caller knows about the time and date of discovery of an allegation, OIG Intake investigators will continue to gather as much thorough and detailed information from the caller as possible by asking appropriate, specific questions. OIG will also remind community agencies and facilities of the four hour requirement to report allegations of abuse/neglect and to provide detailed information about the time and date of discovery, if they know it, when calling in a report to the OIG hotline.

INVESTIGATION TIMELINESS

The effectiveness of an investigation is diminished if it is not conducted in a timely manner. Timely initiation and completion of investigations is critical for an effective investigation.

Timeliness of Assignment

The OIG should improve the timeliness of investigator assignments and reassignments. The OIG should also improve the timeliness of data entry and notification of Bureau Chiefs and Investigative Team Leaders (ITLs).

OIG directives require that investigations be assigned to an investigator within one working day of the Bureau Chief or ITL receiving the intake. For investigations closed during FY17, 96 percent (3,643 of 3,797) were initially assigned within one working day of the allegations being added to the OIG database. Four percent (154 of 3,797) were assigned between 2 and 193 days of the allegation being entered.

However, when compared to the date reported, 50 percent (1,891 of 3,797) of investigations took two or more working days to be assigned to an investigator. Five percent

(196 of 3,797) took 5 or more working days to assign to an investigator from the date the allegation was reported. Part of the reason for this delay is that approximately 35 percent (1,337 of 3,797) of the cases closed in FY17 took two working days or longer to enter into the database. Of these, 128 cases took between 5 and 32 working days before being initially entered into the database.

The OIG initially provided auditors with the last assignment date for investigations closed in FY17. We reviewed 140 cases in which the last assignment date was more than 100 days after the allegation was reported to the hotline. Additional data provided by the OIG for these cases showed that these 140 investigations were assigned or reassigned a total of 308 times. Four investigations were assigned only once while the remaining 136 investigations were assigned between 2 and 5 times. For example, one case was initially assigned within 1 day after it was reported, reassigned 362 days after it was reported, and reassigned again 806 days after it was reported. According to OIG officials, investigations may be reassigned due to caseload, transfer of cases between clinical and investigative staff, and because of investigators on leave.

Timeliness is Critical to Effective Investigations

- Victims who have disabilities may forget what happened or be unable to recount what happened consistently.
- Physical evidence may be lost.
- The scene of the incident may no longer be intact.
- Injuries to the victim may have healed or no longer be visible.
- Witnesses may forget or "go missing."
- Alleged perpetrators have time to re-construct their "stories" of what occurred.
- Victims may feel abandoned by long delays in investigating.
- Delays in investigating may discourage reporters from filing reports.

INVESTIGATOR ASSIGNMENT	
RECOMMENDATION 3	***The Office of the Inspector General should work to improve the timeliness of:*** • ***Initial entry of cases into the OIG database;*** • ***Case notification to Bureau Chiefs and Investigative Team Leaders; and*** • ***Assignment and reassignment of cases to investigators.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree - If a case has not been assigned within one day and before it goes to two days, the database has been modified to automatically assign it to the respective bureau chief and send them an e-mail detailing the assignment, which requires them to take any needed action. There is sometimes a delay between the time an allegation is called in to the time the bureau chief receives the intake due to the need to make follow-up contact with the caller to get more detail or clarify already provided details to determine if it is a reportable incident. In order to facilitate the entering of cases into the database, OIG is developing a web-based intake that will allow agencies/facilities to directly enter cases. The intake is then pulled into the OIG database where it is reviewed and processed by Intake staff. This should eliminate the necessity of calling complainants back. OIG is also meeting with the answering service to develop a way to receive more detailed information when they answer calls, allowing Intake staff to better prioritize calls. Over the past two years, OIG reassigned cases, some multiple times, due to changes in personnel status and attempts to equalize caseloads. Stabilization of our personnel situation and case management practices implemented over the past several years should reduce the overall need to reassign cases multiple times.

Timeliness of Investigations

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. Generally, 60 working days works out to over 80 calendar days. As in previous audits we will continue to use both calendar and working days in our analyses so that comparisons can be made over time. **Effective May 26, 2017, the OIG's administrative rules were amended to remove the requirement that investigative reports be completed within 60 working days**. This requirement is, however, still included in the OIG's Directives (INV-017).

Exhibit 2-2
CALENDAR DAYS TO COMPLETE ABUSE AND NEGLECT INVESTIGATIONS
FY10, FY16, and FY17

Days to Complete Cases	FY10 % of Cases	FY16 % of Cases	FY17 % of Cases
0-60 days	**69%**	**32%**	**37%**
61-90 days	17%	11%	13%
91-120 days	8%	10%	10%
121-180 days	4%	17%	12%
181-200 days	0%	3%	3%
>200 days	2%	27%	25%
Percent > 60 days	**31%**	**68%**	**63%**
Total Cases Closed	**2,150**	**3,226**	**3,589**

Source: OAG analysis of OIG data.

Timeliness of investigations has been an issue in all of the 11 previous OIG audits. For FY10, 69 percent of cases were completed within 60 calendar days with an average calendar days to complete an investigation of 57 days. For FY17, only 37 percent of cases were completed within 60 calendar days with an average calendar days to complete of 152 days.

Exhibit 2-2 shows the percentage of cases completed in terms of ranges of the number of **calendar days** to completion for FY10 compared to FY16 and FY17. 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.

We also looked at the percent of cases completed within **60 working days**. With the more lenient working day standard, the OIG completed 79 percent of its FY09 cases and 85 percent of its FY10 cases within 60 working days. For FY16 and FY17, this dropped to 42 percent and 50 percent of cases, respectively, when using the 60 working day standard.

According to the OIG, there are several causes of the decrease in timeliness including:

- Increased allegations;
- An increase in the number of CILAs across the State (OIG is responsible for more sites, and they are more spread out);
- Shortage of staff; and
- A longer time for new investigators to learn the job and be self-sufficient in the duties, due to the hiring and evaluation process.

Investigations Over 200 Days

The number of OIG investigations taking more than 200 calendar days to complete increased significantly for FY17 compared to the previous audit. Exhibit 2-3 shows the types of allegations taking more than 200 calendar days to complete for FY10, FY16, and FY17. As is shown in the exhibit, in FY10 there were a total of 51 closed investigations that took more than 200 days to complete, of which 38 (75%) were death cases. For FY16, this increased to 888 cases with the majority of those cases being for physical abuse and neglect. For FY17 there were a total of 920 cases closed that took more than 200 days to complete.

Exhibit 2-3
CLOSED CASES
OVER 200 CALENDAR DAYS TO COMPLETE
BY TYPE OF ALLEGATION
FY10, FY16, and FY17

Type of Allegation	FY10	FY16	FY17
Physical Abuse	1	305	283
Neglect	11	398	451
Verbal Abuse	1	23	25
Death	38	24	25
Sexual Abuse	0	22	21
Exploitation	0	47	34
Mental Injury/Psychological Abuse	0	69	81
Total	**51**	**888**	**920**

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

Source: OAG analysis of OIG data.

Clinical Coordinators

The OIG's Clinical Coordinators become involved in investigations for cases that involve medical issues, as well as death cases. As of June 30, 2016, the OIG had four Clinical Coordinators (two full-time and two contractual staff).

During FY16, the Clinical Bureau closed a total of 223 cases, taking an average of 142 calendar days to complete. The Clinical Bureau primarily handles death cases, but during FY16 the bureau was assigned five neglect allegations. These five cases increased the average completion time significantly. Excluding these neglect cases, the average completion time decreases to 122 calendar days. During FY17, the Clinical Bureau closed 173 cases, with an average of 73 calendar days to complete. This is a significant improvement over the 166 average days to complete a case in FY10.

Death Reviews and Investigations

The Department of Human Services Act requires the Inspector General to review all reportable deaths including those for which there is no allegation of abuse or neglect. Reportable deaths are required to be reported within 24 hours after initial discovery by phone to the Office of the Inspector General hotline for each of the following:

> (i) Any death of an individual occurring within 14 calendar days after discharge or transfer of the individual from a residential program or facility;
>
> (ii) Any death of an individual occurring within 24 hours after deflection from a residential program or facility; and
>
> (iii) Any other death of an individual occurring at an agency or facility or at any Department funded site.

Death reviews are usually assigned to a Clinical Coordinator but may also be assigned to investigative bureaus if there is an allegation of abuse or neglect. Cases closed during FY16 included 236 death reviews and investigations (218 were assigned to Clinical and 18 to investigative bureaus). These 236 death reviews and investigations took on average 143 calendar days (97 working days) to complete. Of these 236 death cases, 17 were substantiated neglect. Substantiated cases took an average of 693 calendar days (472 working days) to complete.

Cases closed during FY17 included 196 death reviews and investigations (173 were assigned to Clinical and 23 to investigative bureaus). These 196 death reviews and investigations took on average 112 calendar days (76 working days) to complete. Of these 196 death cases, 11 were substantiated neglect. Substantiated cases took an average of 468 calendar days (318 working days) to complete. According to OIG officials, death cases can 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 consultation may be needed.

Timeliness of Investigative Interviews

The time it takes to obtain a statement from or interview the alleged victim and perpetrator has increased since our last audit in FY10. 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. Delays in getting detailed interviews from those involved, especially from the alleged victim, increase the risk of losing information and weakening the evidence obtained.

For the FY17 cases we sampled where there was a victim identified, it took an average of 26 days from the reporting of an incident for the victim to have a statement taken or interviews to be performed. Within the sample there were two cases which impacted the average time significantly. In one case it took 466 days to interview or obtain a written statement from the alleged victim and another which took 568 days. If these two cases are excluded the average time is reduced to 16 days. Our FY10 audit found that it took an average of 9 days to obtain a statement or interview from the alleged victim. In 5 of 92 (5%) cases where a verbal victim was identified, statements and interviews from the alleged victim were not in the case file and, therefore, we could not document that the alleged victim was interviewed.

For FY17 cases we sampled, it took an average of 45 days from the reporting of an incident for the alleged perpetrator to be interviewed or a statement to be taken. Within the sample, there were 4 cases that took over 200 days to interview the alleged perpetrator, which impacted the average time significantly. For one case it took 540 days from the reporting of the incident for the first interview or statement from the alleged perpetrator to be taken and for another it took 626 days. If these four cases are excluded, the average time is reduced to 28 days. Our FY10 audit found that it took an average of 17 days to obtain a statement or interview from the alleged perpetrator.

TIMELINESS OF INVESTIGATIONS	
RECOMMENDATION 4	***The Office of the Inspector General should work to improve the timeliness of investigations of abuse and neglect including the time it takes to interview alleged victims and perpetrators.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree - As noted in the Audit report, the number of investigations opened continues to increase year after year which, with staff shortages, has impacted OIG's overall timeliness in completing investigations and completing interviews with the victim and accused. From FY16 to FY17, OIG completed more investigations in less time and we plan on continuing this trend going forward as our staffing issues have improved and we have increased case management oversight.

Timeliness of Supervisory Review and Approval

The timeliness of case file reviews has declined since our last audit in FY10. This is especially true for substantiated cases.

OIG directives require the Investigative Team Leader (ITL) or Bureau Chief to review cases within seven working days of receipt absent extenuating circumstances. For cases closed in FY17, 55 percent (2,079 of 3,797) were approved within 7 working days of submission. If the case is substantiated physical abuse, sexual abuse or egregious neglect, the case is reviewed by the Inspector General or his designee.

Exhibit 2-4 shows the average days to review for substantiated cases have risen from an average of 27 days to review and approve in FY10 to 88 days in FY17. For the South Bureau, the average days to review for substantiated cases has risen from 21 days on average to 187 days. As of June 30, 2017, the South Bureau did

Exhibit 2-4
AVERAGE CALENDAR DAYS FROM DATE SUBMITTED FOR REVIEW TO FINAL APPROVAL
By Investigative Bureau
FY10, FY16, and FY17

	Cases Substantiated[1]			Cases Not Substantiated[1]		
Bureau	**FY10**	**FY16**	**FY17**	**FY10**	**FY16**	**FY17**
Cook[2]	-	104	108	-	13	13
North	20	17	19	6	1	1
Metro	37	43	34	13	9	8
Central	30	92	89	16	75	40
South	21	55	187	4	20	30
Total Avg.	**27**	**58**	**88**	**10**	**24**	**19**

Notes:
[1] Days may include time when the Bureau Chief sends the case back to the investigator for further investigation.
[2] The Cook Bureau did not exist in FY10.
Source: OAG analysis of OIG data.

not have a Bureau Chief or ITL. An Internal Security Investigator (ISI II) has been serving as Acting Bureau Chief.

The ITL or the Bureau Chief may send the case back to the investigator for further investigation. Prior to February 2017, the directives stated that the investigator would 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. In February 2017, the OIG increased the time allowed for resubmission of the case to 10 working days. Once the Bureau Chief reviews and approves a substantiated case, OIG directives require that it be forwarded to the Deputy Inspector General for review and approval.

The Inspector General is required to 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 signed the case as reviewed. Improvements in the time it takes to review substantiated cases could have a substantial effect on the overall timeliness of case completion at the OIG.

TIMELINESS OF SUPERVISORY REVIEW	
RECOMMENDATION 5	***The Office of the Inspector General should ensure that investigations are reviewed by the Investigative Team Leader or Bureau Chief within seven working days of receipt, absent extenuating circumstances, as is required by OIG directives.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree - Timely review of investigations is critical in completing timely, thorough investigations. The timeliness of review is determined by numerous factors including the number of investigations opened, the complexity of the investigation and the skill level of the assigned investigator. The seven day timeframe that is required in current directives has been in place for a number of years and will be re-evaluated in light of the circumstances OIG works under today. We will review the required case review timeframes to ensure the appropriate amount of time is given based on the needs of that investigation to ensure a thorough and quality investigation is completed and revise the directives accordingly.

OTHER TIMELINESS ISSUES

There are several factors that may affect timeliness of case completion. 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 assignment, timeliness of investigative interviews, and timeliness of case file review may also increase the time it takes to complete cases.

Referrals to Illinois State Police and Local Law Enforcement

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 Illinois State Police (ISP) 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 ISP conducted an investigation. The ISP investigation is a criminal investigation and the OIG investigation is administrative. According to the 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 ISP. 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
FY10, FY16, and FY17

Disposition	Number of Cases		
	FY10	FY16	FY17
Referred back to OIG without investigation	34	33	33
Declined by Prosecutor	3	2	2
Not Sustained	1	0	0
Conviction	0	2	0
Unfounded	0	0	0
Dismissed	0	1	0
Admin. Closed	5	17	0
Total	**43**	**55**	**35**

Source: Illinois State Police (unaudited).

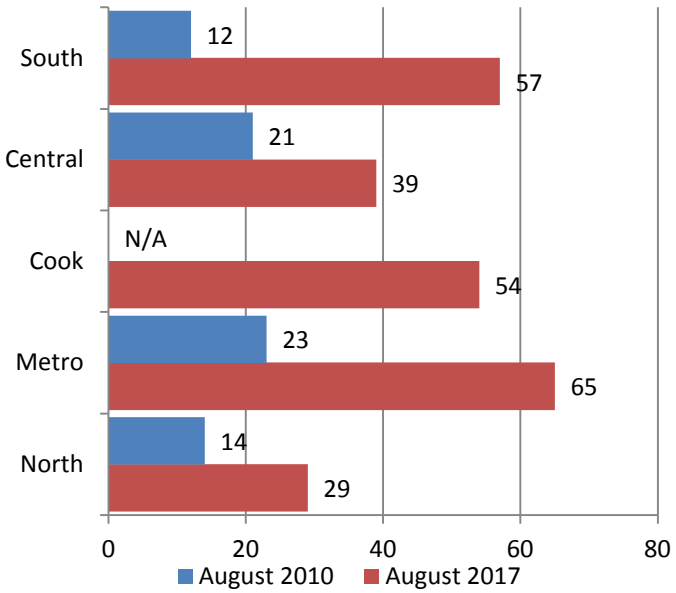
We judgmentally selected five investigations in which the Illinois State Police or Local Law Enforcement (LLE) was notified from the population of investigations closed during FY17. The OIG provided the "Checklist for Notification to the State Police/LLE" form for each investigation showing that the incident was reported within 24 hours of the determination that a criminal act may have occurred.

Open Cases and Investigator Caseloads

Open cases and average caseloads have increased significantly since our 2010 audit. Overall, open cases increased from 485 total cases as of August 2010 to 1,797 as of August 2017.

Exhibit 2-6 shows the caseloads by bureau for 2010 and 2017. Caseload averages as of August 2010 ranged from a high of 23 cases per investigator in the Metro Bureau to a low of 12 in the South Bureau. For August 2017, caseload averages ranged from a high of 65 cases per investigator in the Metro Bureau to a low of 29 in the North Bureau. The Cook investigative bureau was added since the previous audit; therefore, there is no comparable data for that bureau. Without the addition of the Cook Bureau, caseloads would have been even higher for the North and Metro bureaus. Further, the average age of ongoing investigations as of August 2017 ranged from a high of 178 calendar days on average in the Metro Bureau to a low of 88 calendar days on average in the Central Bureau.

Exhibit 2-6
INVESTIGATOR CASELOADS
By Bureau as of August 2010 and 2017



Note: The Cook Bureau was added after August 2010.

Source: OIG data summarized by OAG.

Chapter Three

THOROUGHNESS OF ABUSE AND NEGLECT INVESTIGATIONS

CHAPTER CONCLUSIONS

OIG case reports we reviewed generally were thorough, comprehensive, and addressed the allegation. However, in our sample of investigations, we found that injury reports were not in the case file for 5 of 32 (16%) investigations sampled where there was an allegation of an injury being sustained. Photographs were not in the case file for 10 of 30 (33%) investigations sampled. Medical records, treatment plans, or progress notes were also missing in 4 of 130 investigations sampled (3%).

We reviewed a sample of FY17 closed cases to determine whether there was a statement or interview with the alleged victim and the alleged perpetrator. Of the 130 cases we reviewed, 4 cases (3%) involved an alleged victim who was verbal and the case file did not contain a written statement or interview with the alleged victim. Six cases (5%) did not contain documentation of a written statement or interview with the alleged perpetrator.

All of the cases we reviewed contained a Case Tracking Form and a Case Routing and Approval Form. Although all of the cases sampled contained these forms, for 36 of 130 (28%) case files reviewed, the Case Tracking Form was not complete. For 26 of 130 (20%) case files reviewed, the Case Routing and Approval Form was incomplete.

INVESTIGATION THOROUGHNESS

In addition to timeliness, essential components of an abuse and 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 statements, interview summaries, documents, photographs, and other physical evidence.

The directives 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 succeeding photographs are necessary. The case files we sampled from FY17 were generally thorough and contained the appropriate documentation. However, some files were missing documentation that should have been gathered during the investigation.

Prior to May 26, 2017, OIG administrative rules required 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)). **Effective May 26, 2017, the OIG's administrative rules were amended and all case file requirements were deleted**.

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:

- **Injury Report:** An injury report was not in the case file for 5 of 32 (16%) investigations sampled where there was an allegation of an injury being sustained. For example, in one case, a nonverbal individual returned home from a day program three times within a week with injuries. There were bruises and scratches on the individual's chest, and both hands were swollen, but there was no evidence in the case file documenting that the agency had conducted a medical exam or completed an injury report. In another case, an individual who was blind and frail was attacked twice by another individual. The report stated the individual was kicked in the face and chest. Although the information in the OIG database states that the attacked individual was taken to the emergency room, there was no documentation in the case file to show that the victim was examined or received treatment.
- **Photographs:** Photographs were not in the case file for 10 of 30 (33%) investigations sampled where there was an allegation of an injury being sustained. For example, in one case, an individual was observed to have a swollen hand upon arriving at a new CILA. The individual did not receive any treatment for the injury at the prior residence. Although the individual was taken to a medical facility for the injuries, no photographs were taken. In a different case, an individual suffered a swollen nose due to being hit by another individual while being loaded on a bus. In the interview, the victim confirmed being examined and that pictures were taken. However, there were no photographs in the case file.
- **Medical Records/Treatment Plans/Progress Notes:** Medical records, treatment plans, or progress notes were missing in 4 of 130 investigations sampled. Medical records, treatment plans, and progress notes may provide valuable information about an alleged victim that could not otherwise be collected. This information could lead to a deeper insight into how an incident adversely affected the alleged victim. Without relevant documentation about the alleged victim's diagnoses (i.e., phobias, supervision requirement, etc.), it would be much more difficult to assess whether certain actions are detrimental.
- **Restraint/Seclusion Records:** Of the 130 cases sampled, 6 involved the use of restraints. Documentation showing that the use of restraints was properly implemented and monitored was included in the case file.

Interview Thoroughness

Investigative interviews are essential fact finding instruments used by the investigators to determine what happened related to an allegation. Interviews often identify the involved parties (victims, perpetrators, and witnesses). At the completion of the investigation, an investigative report is produced 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 a sample of FY17 closed cases to see if they included a statement or interview with the alleged victim and the alleged perpetrator. Of the 130 cases we reviewed, 4 cases (3%) involved a victim who was verbal and the case file did not contain a written statement

or interview with the alleged victim. According to OIG responses, in one case the victim refused to cooperate; in another case, the victim was discharged a day after the allegation; and for a third case, the allegation was out of the jurisdiction of the OIG and therefore, no interview was conducted. For the final case, there were agency emails discussing the allegation and discussions with the alleged victims by agency staff; however, the victims were not questioned by agency staff until 10 months after the allegation occurred.

Six cases (5%) did not contain documentation of a written statement or interview with the alleged perpetrator. According to OIG responses: for one case the alleged perpetrators were not interviewed; for another case the alleged perpetrators were interviewed but the interviews were not in the file; for a third case the alleged perpetrator refused to be interviewed at the advice of an attorney. For two cases, the allegations were out of the jurisdiction of the OIG and, therefore, no interviews were conducted. For the final case, there were agency emails discussing the allegation and discussions with the alleged victim.

INVESTIGATION DOCUMENTATION	
RECOMMENDATION 6	***The Office of the Inspector General should improve the collection of investigation documentation including photographs of injuries, injury reports/medical examinations, and statements or interviews with the alleged victim and alleged perpetrator.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree - OIG will provide further training to investigative staff to ensure all appropriate documentation is collected based on the needs of the investigation and to better document when and why certain documentation could not be collected or certain interviews could not be completed.

CASE MONITORING AND SUPERVISORY REVIEW

Supervisory review is an essential element of 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. This documentation includes the Case Tracking Form and the Case Routing and Approval Form.

- **Case Tracking Form** - All case files in our sample contained a Case Tracking Form as required by OIG investigative directives. Although the Case Tracking Form was in the file, there were instances in which the information on the tracking sheet was

incomplete. For 36 of 130 (28%) investigation files reviewed, the Case Tracking Form was not complete. The Case Tracking Form identifies information such as the case number, investigative agency, bureau, and allegation. This form's main purpose is to track the OIG's actions throughout the investigation. Dates for when the investigative report was received, when it was reviewed, and when the case was closed are all tracked on this form. It is also used to document the case finding and recommended action.

- **Case Routing and Approval Form** - All of the 130 cases reviewed contained a Case Routing and Approval Form. However, for 26 cases (20%) the form was incomplete. After a case is submitted for review, the review progress is documented through the Case Routing and 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.

CASE TRACKING AND APPROVAL FORMS	
RECOMMENDATION 7	***The Office of the Inspector General should ensure that all Case Tracking Forms and Case Routing and Approval Forms are completed.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree - OIG will reinforce to management and administrative staff that these forms need to be fully completed and they must be reviewed for completeness at the time of case closure as required by directive.

Investigative Reports

All of the cases we reviewed contained an investigative report. The OIG investigative reports we tested were generally thorough, comprehensive, and addressed the allegation. A well-written investigative report is essential to an effective investigation because it often provides a basis for management's decision on the action recommended in the case. Once the investigator completes the investigative report, it is reviewed by management who must approve 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. The report should address all relevant aspects of the investigation and reveal what the investigation accomplished.

Chapter Four

ACTIONS, SANCTIONS, AND RECOMMENDATIONS

CHAPTER CONCLUSIONS

The number of abuse and neglect investigations closed has increased substantially since FY10 (from 2,162 in FY10 to 3,601 in FY17); however, the substantiation rate has remained consistent. The substantiation rate for abuse and neglect investigations closed for FY10 was 12 percent, while it was 13 percent for FY17.

DHS, in some cases, still takes an extended amount of time to receive and approve the actions taken by the community agencies or State-operated facilities. State-operated facilities and community agencies are required to submit a written response to DHS for all substantiated cases of abuse and neglect, or cases with other administrative issues within 30 calendar days from receipt of the investigative report. In our sample of investigations, there were 20 cases that required a written response. Of the 20 cases in our sample that required a written response, 1 of 20 (5%) took more than six months from the date the case was completed until the written response was approved by DHS. For 4 of 20 investigations sampled (20%), the OIG could not provide an approved written response. These four investigations had been completed for an average of 180 days as of September 1, 2017, with a range of between 106 days to 289 days since the case was completed.

During FY16 and FY17, the OIG did not recommend any sanctions regarding community agencies or State-operated facilities. The OIG has not recommended a sanction related to a State-operated facility for at least the past 24 years (1994-2017). During FY09, the OIG recommended that DHS' Division of Developmental Disabilities take immediate action against one community agency, up to and including sanctions.

SUBSTANTIATED ABUSE AND NEGLECT CASES

The number of abuse and neglect investigations closed has increased substantially since FY10; however, the substantiation rate has remained consistent. As is shown in Exhibit 4-1, the substantiated rate for abuse and neglect investigations closed was 13 percent overall for FY17. The overall rate in FY10 was 12 percent. In FY17, the OIG closed a total of 3,601 investigations of allegations of abuse and neglect. During FY17, the OIG substantiated 471 cases of these abuse and neglect allegations, resulting in a 13 percent substantiation rate.

Exhibit 4-1
ABUSE AND NEGLECT INVESTIGATIONS CLOSED AND SUBSTANTIATED
FY10, FY16, & FY17

Year	Location	Closed Cases	Substantiated Cases	Substantiated Percent
FY10	State Facility	870	45	5%
FY10	Agency	1,292	213	16%
FY10	**Total**	**2,162**	**258**	**12%**
FY16	State Facility	990	48	5%
FY16	Agency	2,329	315	14%
FY16	**Total**	**3,319**	**363**	**11%**
FY17	State Facility	857	52	6%
FY17	Agency	2,744	419	15%
FY17	**Total**	**3,601**	**471**	**13%**

Source: OAG analysis of OIG data.

However, the substantiation rate at community agencies is nearly triple that of the rate at State-operated facilities. The substantiation rate for allegations at community agencies for investigations closed in FY17 was 15 percent. In FY10, the rate was 16 percent. For State-operated facilities, the rate for FY17 was 6 percent compared to 5 percent for FY10.

RECOMMENDED ACTIONS

Because of the increase in closed cases, there has also been an increase in the number of recommended actions for FY17, when compared to FY10. As is shown in Exhibit 4-2, for FY17, there were 482 substantiated cases. For FY10, there were 261 substantiated cases.

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 and neglect is substantiated, unsubstantiated, or unfounded. There may also be investigations that are unfounded or unsubstantiated with other issues that have a recommendation. The case is reviewed, and a preliminary report is sent to the State-operated facility or community agency notifying it of the results of the investigation.

If the allegation is substantiated or if 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/Revision. The OIG may also report the individual to the Health Care Worker Registry. This is discussed later in this Chapter.

Exhibit 4-2
RECOMMENDED ACTIONS FOR SUBSTANTIATED CASES
(All Allegations Regardless of Category at Intake)[1]
FY10 and FY17 Closed Cases

RECOMMENDED ACTION	FY10	FY17
No Action	53	116
Retraining	42	144
Policy Creation or Revision	16	36
Other Administrative Action	87	90
Referral to Other Agency	1	1
Health Care Worker Registry	62	95[2]
Total Substantiated	**261**	**482**

Notes:
[1] Exhibit 4-2 includes 11 death cases not included in Exhibit 4-1 because they were not categorized as abuse and neglect at intake.
[2] Includes one case investigated by the Illinois State Police.

Source: OAG analysis of OIG data.

After the recommendation is sent, the facility or community agency generally takes some action to resolve the issues related to the case. Exhibit 4-2 shows substantiated cases in FY10 and FY17 by the type of recommended action.

For FY17, retraining was the most recommended action in substantiated cases. Retraining was recommended in 144 of 482 substantiated cases or 30 percent. Data provided by the OIG showed that for 116 of 482 (24%) substantiated investigations closed in FY17, the OIG recommended "No Action." We reviewed investigations data provided by the OIG for cases with a recommendation of "No Action" and found that for 82 of the 116 (71%) there had been a written response approved, which means some action(s) were taken. According to an OIG official, there is no reason for these cases to have a recommendation of "No Action" in the database.

The number of cases in which the recommended action was a referral to the Health Care Worker Registry increased from 62 in FY10 to 95 in FY17. Other administrative action was recommended for 90 investigations closed in FY17. Appendix C shows the number of cases closed and a substantiation rate by facility for FY10, FY16, and FY17.

ACTIONS TAKEN

Ensuring appropriate corrective actions are taken is critical to the effectiveness of investigations of abuse and neglect. Without the implementation of corrective actions, clients may remain in an unsafe environment.

The OIG provided data regarding the actions taken for the 482 investigations closed in FY17 where abuse, neglect, or exploitation was substantiated. Exhibit 4-3 shows the actions taken for these cases by the type of allegation (abuse, neglect, or exploitation). As a result of the OIG substantiating these cases, 242 employees were discharged, 27 employees were suspended, and 59 employees resigned. Other actions included re-trainings (148), group trainings (82), written reprimands (58), and procedural changes (43).

For 76 cases, there had been no action or the action was pending. The OIG does not add the actions to the database until an approved written response is received from the appropriate DHS division. Therefore, there could be further actions on some of the 482 cases that were substantiated in FY17.

Exhibit 4-3
SUBSTANTIATED INVESTIGATIONS BY TYPE OF ALLEGATION AND ACTIONS TAKEN
FY17 Cases Closed

Action Taken	Substantiated Category: Abuse	Neglect	Exploitation	Total
Administrative Change	2	11	0	**13**
Counseling	5	21	0	**26**
Discharged	121	115	6	**242**
Fired (other cause)	0	8	0	**8**
Group Training	22	60	0	**82**
Hab./Treatment Change	2	4	0	**6**
Nothing	4	11	1	**16**
Oral Reprimand	3	5	1	**9**
Performance Eval.	0	1	0	**1**
Policy Change	0	28	0	**28**
Procedural Change	8	35	0	**43**
Reassignment	3	3	0	**6**
Resignation	16	42	1	**59**
Retirement	3	4	0	**7**
Re-Training	51	95	2	**148**
Reviewed	4	30	0	**34**
Structural Repair	1	1	0	**2**
Structural Upgrade	0	3	0	**3**
Supervision	2	4	0	**6**
Suspension	17	10	0	**27**
Transferred	3	3	0	**6**
Written Reprimand	21	36	1	**58**
Pending/No Action	27	48	1	**76**
Totals	**315**	**578**	**13**	**906**

Note: FY17 closed investigations included 482 substantiated cases of abuse, neglect, or exploitation. For these 482 substantiated cases there were 906 actions taken. Some cases may involve multiple actions or actions against multiple employees.

Source: OAG analysis of OIG data.

OIG SUBSTANTIATED CASES AND WRITTEN RESPONSES

For investigative reports, the Department of Human Services Act (Act) requires:

> *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)).*

For written responses, 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)).*

The Act requires that substantiated cases, as well as unsubstantiated or unfounded investigations where the 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. According to 59 Ill. Adm. Code 50.80(a), the facility or agency is directed to submit a written response to the respective DHS program division for approval.

The OIG is required by the Department of Human Services Act to monitor compliance through a random review of approved written responses. The Inspector General is also required to review any implementation that takes more than 120 days (20 ILCS 1305/1-17(q)). The OIG is required by rule to conduct compliance reviews, at a minimum, quarterly on a random 10 percent sample of approved written responses received. The OIG is also required to review all written responses that take more than 120 days after approval to complete (59 Ill. Adm. Code 50.80(d)).

Exhibit 4-4
WRITTEN RESPONSE COMPLIANCE REVIEWS CONDUCTED
2009-2010 and 2016-2017[1]

Location	2009	2010	2016	2017
Agency	166	136	106	132
Facility	28	43	40	38
Total	**194**	**179**	**146**	**170**

Notes:
[1] Time period includes May through April each year.

Source: OIG compliance review data.

For FY16, OIG received a total of 984 written responses approved by DHS. As shown in Exhibit 4-4, for the same period, the OIG conducted reviews of 146 written responses (106 from community agencies and 40 from State facilities).

For FY17, OIG received a total of 986 written responses approved by DHS. For the same period, the OIG conducted reviews of 170 written responses (132 from community agencies and 38 from State facilities). Exhibit 4-4 shows the number of reviews of written responses conducted by the OIG. For FY09 and FY10, the OIG reviewed 194 and 179 respectively.

DHS Approval of Written Responses

The Department of Human Services Act requires 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 must file a written response. The response includes the implementation and completion dates of the actions. The Secretary of DHS is required by the Act to accept or reject the written response. If the written response is not filed within the allotted 30 calendar day period, the Secretary of DHS shall determine the appropriate corrective action to be taken (20 ILCS 1305/1-17(n) and (p)).

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.

DHS, in some instances, still takes an extended amount of time to receive and approve the actions taken by the agency or facility. Overall there were 20 cases in our sample that required a written response. Of the 20 cases in our sample that required a written response, 1 of 20 (5%) took more than 6 months from the date the case was completed until the written response was approved by DHS. For 4 of 20 (20%) investigations we sampled, we could not obtain an approved written response. These 4 investigations had been completed for an average of 180 days as of September 1, 2017. These investigations had a range of 106 days to 289 days since the case was completed.

Our previous audit contained a recommendation to DHS to ensure that written responses are approved in a timely manner. If DHS does not receive and approve written responses and corrective actions 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 8	***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 Department has worked with the facilities and community agencies to meet the 30 day response requirement. The Department will continue its efforts 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 State-operated 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 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, it 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 agency or facility. After a request for reconsideration or clarification is received from an agency or facility, the Inspector General will notify the 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.

During FY16, the OIG received 134 requests to reconsider the findings of 119 investigations, 70 percent of which were substantiated cases. Of the 134 requests, the OIG granted 19 (involving 12 cases) and denied 115 (involving 107 cases) as no new information was provided. Of the 12 cases granted reconsiderations, the OIG revised three case reports. Of those three reports, two had changes in findings or issues.

During FY17, the OIG received 150 requests to reconsider the findings of 133 investigations, 67 percent of which were substantiated cases. Of the 150 requests, the OIG granted 21 and denied 129 as no new information was provided. Of the cases granted reconsiderations, the OIG revised one case report with no changes in the finding or issues.

HEALTH CARE WORKER REGISTRY

The Department of Public Health maintains the Health Care Worker Registry (Registry). The Registry lists individuals so 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. The Registry also 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 service aides) or has access to long-term care resident's 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 their 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, sexual abuse, or egregious neglect. These individuals are barred from working with people who have mental or developmental disabilities. The Illinois Department of Public Health (DPH) 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.

According to the OIG's FY16 Annual Report, the OIG made 63 referrals for substantiated cases to the Health Care Worker Registry in FY16. According to data provided by the OIG, 95 referrals were made in FY17.

Exhibit 4-5 shows the number of appeals for FY16 and FY17 and the disposition of the cases as of October 2017. Health Care Worker Registry appeals provided by the OIG show a total of 18 appeals for FY16 and 35 appeals for FY17.

Exhibit 4-5
HEALTH CARE WORKER REGISTRY APPEALS
FY16 and FY17

	FY16	FY17
Petitioner **Lost** Appeal (Referred to Registry)	2	4
Appeal **Dismissed** (Referred to Registry)	3	5
Petitioner **Won** Appeal (Not Referred)	6	4
Stipulation Order (Not Referred)	3	2
Pending	4	20
Total	**18**	**35**

Source: OIG data.

Stipulated Motions to Dismiss Process

The stipulated motion to dismiss process is triggered by a petition under Section 50.90 of the OIG's administrative rules (Health Care Worker Registry Appeal) 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. As is shown in Exhibit 4-5, the OIG chose not to refer a case to the Registry based on a stipulation order in a total of five cases for FY16 and FY17.

RECOMMENDING SANCTIONS

During FY16 and FY17, the OIG did not recommend sanctions regarding community agencies or State-operated facilities. OIG has not recommended a sanction related to a State-operated facility for at least the past 24 years (1994-2017). 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. In May 2017, the OIG's administrative rules were amended and its ability to recommend sanctions to the Illinois Department of Public Health was removed (59 Ill. Adm. Code 50.70).

The OIG's administrative rules allow the Inspector General to recommend to the Secretary of DHS that sanctions be imposed against State-operated facilities or community agencies to protect residents. The OIG may recommend sanctions including: termination of licensing, funding, or certification of a facility (59 Ill. Adm. Code 50.70(f)).

If the Secretary of DHS issues a sanction, the Department of Human Services Act allows the Inspector General to seek the assistance of the Attorney General of Illinois or the State's Attorney for imposing sanctions (20 ILCS 1305/1-17(r)).

The Inspector General has established a directive that specifies criteria regarding when to recommend sanctions to the Secretary of DHS. Most recently updated in February 2017, 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 Secretary of the Department of Human Services (DHS):

1. *A determination of imminent danger to the well-being of the individual(s);*
2. *A community agency or a State-operated facility has repeatedly failed to respond to critical recommendations made by the Inspector General that impacts the well-being of individuals served;*
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 033)*

According to OIG officials, no sanctions have been recommended to the Secretary of DHS regarding State-operated facilities or community agencies since our previous audit in 2010.

Chapter Five

OTHER ISSUES

CHAPTER CONCLUSIONS

The Quality Care Board (Board) did not have seven members during FY16 and FY17 as is required by statute. For FY16, the Board also did not meet quarterly as required by statute and did not always have a quorum at all the meetings that were held. As of October 2017, the OIG was unable to provide approved meeting minutes for scheduled meetings in February 2017 or May 2017 and, therefore, we could not determine whether these meetings were held or whether there was a quorum present to conduct business. In September 2017, a board member resigned leaving the Board with only three members. Four members are needed for a quorum. A lack of membership on the Board was also an issue in the previous audit released in 2010. Also, the statutory requirement for having two members of the Board be a person with a disability or the parent of someone with a disability was not being met. The Board cannot fulfill its statutory responsibilities "to monitor and oversee the operations, policies, and procedures of the Inspector General" with chronic vacancies, expired terms, and a lack of input from persons with a disability or a parent of such person.

The OIG could not provide documentation to show that investigators had received the required initial training courses delineated in OIG directives. Further, a number of classes that fall under required initial training for investigators are no longer available because of the discontinuation of the NetLearning system. Training information provided by the DHS Division of Mental Health and the Division of Developmental Disabilities showed that some employees at State-operated facilities were not receiving training in prevention and reporting of abuse and neglect (Rule 50 training). DHS does not monitor community agencies for compliance with training requirements.

The Act requires the Inspector General to conduct unannounced site visits to each facility at least annually (20 ILCS 1305/1-17(i)). FY16 and FY17 site visit information provided by the OIG showed a reduction in time spent on site, number of areas reviewed, and findings. In FY15, all 14 unannounced site visits were conducted over a two-day period. In FY16, 5 of the 14 visits were conducted over a two-day period. In FY17, 5 of the 14 were two-day visits. The FY15 unannounced site visits covered four different areas, two of which were medically related, and resulted in 51 findings. In FY16, two areas were examined, neither was medically related, and the site visits resulted in 15 findings. For FY17, three areas were examined resulting in a total of seven findings.

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 (20 ILCS 1305/1-17(u)). The 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:

- Provide independent, expert consultation to the Inspector General on policies and protocols for investigations of alleged abuse and neglect;
- Review existing regulations relating to the operation of facilities;
- Advise the Inspector General on the content of training activities; and
- Recommend policies concerning methods for improving intergovernmental relationships between the Office of the Inspector General and other State or federal offices (20 ILCS 1305/1-17(u)).

The Department of Human Services Act requires that there be a Quality Care Board composed of seven members appointed by the Governor with the advice and consent of the Senate.

In September 2017, a board member resigned leaving the Board with only three members. Four members are needed for a quorum.

Board Membership

The Board continues to have problems maintaining seven members as required by statute. We recommended in our previous audit released in 2010 that 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 the statutory membership requirement. The Department of Human Services Act requires that there be a Quality Care Board composed of **seven members appointed by the Governor with the advice and consent of the Senate**.

During FY16 and FY17 the Board had four members and as of March 18, 2017, all four members were serving on expired terms. According to documentation provided by the OIG, those four members will remain until replaced. In September 2017, a board member resigned leaving the Board with only three members. Four members are needed for a quorum. Exhibit 5-1 shows the members currently serving on the Board, their term status, and expiration dates.

Exhibit 5-1
QUALITY CARE BOARD MEMBERSHIP
As of June 30, 2017

Board Member	Appointed	Expiration Date	Status
Susan M. Keegan (Chair)	9/28/2012	11/3/2015	Expired
Thane Dykstra	08/19/10	11/3/2013	Expired
Untress Lamont Quinn	9/28/2012	11/3/2013	Expired
Neil Posner	11/8/2013	3/18/2017	**Resigned**[1]
Vacant	**N/A**	**N/A**	**Vacant**
Vacant	**N/A**	**N/A**	**Vacant**
Vacant	**N/A**	**N/A**	**Vacant**

Note:

[1] According to OIG officials this member resigned in September 2017.

Source: DHS Office of the Inspector General.

Two members of the Board are required to be persons with a disability or a parent of such person, per statute (20 ILCS 1305/1-17(u)). According to documentation provided by the OIG, the Board consists of three attorneys and one industry member. The statutory requirement for

board membership is not being met. We followed up with the OIG to determine whether two of the members were a person with a disability or parent of an individual with a disability. The OIG could not provide documentation that this statutory requirement was being met and responded that, to their knowledge, there were no members who were a person with a disability or parent of an individual with a disability. In a December 19, 2016, Board meeting, the Chairperson stated that the board was in violation due to not meeting the criteria of board membership.

Board meeting minutes show that Board members and the OIG staff have made numerous attempts to urge the Governor's Office to appoint individuals to the vacancies and have also expressed interest in being reappointed to the Board. According to meeting minutes from the February 11, 2016, Board meeting, the Chairperson suggested that the then Secretary-designee for DHS may be able to help fill the needed Board appointments. The Deputy Inspector General stated that he would contact the Chief of Staff. However, there was no further information in the Board minutes regarding this action. According to Board meeting minutes, the Board Chairperson had also contacted the Governor's Office concerning vacancies and expired terms prior to the September 15, 2015, meeting, and again prior to the April 14, 2016 meeting. Although a meeting was scheduled with the Governor's Office for July 20, 2016, approximately nine months after initial contact, the meeting was cancelled because the representative from the Governor's Office was not present. The official from the Governor's Office stated to the Board Chairperson that the appointments are difficult to fill. As of September 29, 2016, the Chairperson had submitted the names of potential Board members to the Governor's Office, but she had not heard anything about the appointments.

At the December 19, 2016, Board meeting, the Secretary of DHS stated he was working with the Governor's Office to fill board vacancies. He also stated that the process of filling vacancies on boards is lengthy and takes due diligence. During the same meeting, the Chairperson expressed concern about the Board not being in statutory compliance with Board membership requirements. During the same meeting, the Board voted and passed a motion to create a committee to compile another list of candidates interested and qualified to serve on the Board.

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. The Board cannot fully function as directed by statute "to monitor and oversee the operations, policies, and procedures of the Inspector General" (20 ILCS 1305/1-17(u)) with chronic vacancies, expired terms, and lack of input from persons with a disability or a parent of such person. With only three members, all serving on expired terms, and four vacancies as of September 2017, the Board does not have a quorum and, therefore, cannot conduct official business at quarterly meetings.

Quarterly Meetings

The Board did not always meet quarterly as is required by the Department of Human Services Act and did not always have a quorum present so that the Board could conduct business. The Act requires four Board members be present to constitute a quorum, which allows the Board to conduct its business (20 ILCS 1305/1-17(u)).

In FY16, the Board only held three meetings (all by teleconference). The meetings were held in September 2015, February 2016, and April 2016. Two of the three meetings held (the February 2016 and April 2016 meetings) failed to have quorums.

Exhibit 5-2
QUALITY CARE BOARD MEETINGS
FY16 and FY17

Meeting Date	Members Attending	Quorum?
FY16		
9/15/2015	4	Yes
2/11/2016	3	No
4/14/2016	3	No
FY17		
7/21/2016	4	Yes
9/29/2016	4	Yes[1]
12/19/2016	4	Yes
2/9/2017[2]	-	-
5/11/2017[2]	-	-

Notes:

[1] One member left the meeting after approval of previous meeting's minutes, which resulted in no longer having a quorum for the remainder of the meeting.

[2] As of October 2017, we have been unable to obtain approved meeting minutes for the February or May 2017 meetings.

Source: Quality Care Board Meeting Minutes.

The Board had five meetings scheduled during FY17. The scheduled FY17 meetings were to be held in July 2016, September 2016, December 2016, February 2017, and May 2017. The July 2016 and December 2016 meetings had four members in attendance constituting a quorum. The September 2016 meeting had four members in attendance at the start of the meeting, which constituted a quorum; however, once the Board voted to approve the minutes of a previous meeting, one member excused himself from the meeting leaving three members, which did not constitute a quorum. As of October 2017, we have been unable to obtain approved meeting minutes for the February 2017 meeting or the May 2017 meeting and, therefore, cannot document that these meetings were held or whether a quorum was present. However, according to an OIG official, a quorum was not present to conduct business at these meetings.

In February 2017, the OIG updated and amended its agency directives. These changes included reducing the number of annual trainings required for OIG investigators and making changes to the requirements for unannounced site visits among others. In May 2017, the OIG amended its administrative rules making changes such as eliminating the requirement to complete investigations within 60 working days and eliminating all case file requirements. We reviewed available Quality Care Board meeting minutes and could not document that these changes were discussed with the members of the Board before being implemented.

The Board cannot fulfill its statutory responsibilities to monitor and oversee the operations, policies, and procedures of the Inspector General if it does not meet quarterly. The Board also cannot function effectively if it is unable to obtain a quorum for these meetings so business can be conducted and decisions can be made.

According to OIG officials, the OIG has notified the Secretary's Office and the Governor's Office of the need to fill these positions and has facilitated contact between the Board, the Secretary's Office, and the Governor's Office on this topic.

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 appoint members to the Quality Care Board in order to fulfill statutory membership requirements (20 ILCS 1305/1-17(u)).*** ***Once members are appointed, the Quality Care Board should comply with the Department of Human Services Act and meet quarterly as required.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree - OIG will continue to work with the Secretary and the Governor's Office to appoint members as required. We will also work with the QCB Chairperson to help them schedule timely meetings each quarter.

TRAINING

The Department of Human Services Act (20 ILCS 1305/1-17(h)) contains requirements related to OIG training programs. The Act requires the Inspector General to:

- *Establish a comprehensive program to ensure that every person authorized to conduct investigations receives ongoing training relative to investigation techniques, communication skills, and the appropriate means of interacting with persons receiving treatment for mental illness, developmental disability, or both mental illness and developmental disability, and*

- *Establish and conduct periodic training programs for facility and agency employees concerning the prevention and reporting of any one or more of the following: mental abuse, physical abuse, sexual abuse, neglect, egregious neglect, or financial exploitation. Nothing in this Section shall be deemed to prevent the Office of Inspector General from conducting any other training as determined by the Inspector General to be necessary or helpful.*

Investigator Training

The OIG could not provide documentation to show that employees had received the required initial training courses delineated in OIG directives. Further, a number of classes that fall under required initial training for investigators are no longer available because of the discontinuation of the NetLearning system (a computer-based learning system).

We first received a download of the FY11 through FY17 training to date on May 22, 2017. The download contained the fiscal year in which the training occurred, the date of the training, the class title, and the employee's name. Auditors were unable to reconcile the classes each employee had taken to the required training classes listed in the OIG training directive because the class titles did not correspond with the list of required trainings in the OIG directive. In many instances, it appeared that employees were short of meeting the initial training requirements, based on the total number of classes attended compared to the number of classes required. It was determined that the accuracy of the analysis was uncertain because of the

different names of the required classes per directive and the names of the classes which were attended by the OIG investigators.

Auditors requested a second download of the training received by OIG employees. The download contained an additional field that would show which training class corresponded with the training required by directive. Auditors received an updated training download on June 2, 2017. The OIG provided additional documentation including the availability of required trainings, training procedures, and a sample training schedule. According to documentation provided, 9 of the 33 classes required by the OIG directives for new investigators were offered through the NetLearning system, which is no longer available, and 2 required classes were discontinued. In total 11 of 33 (33%) classes were discontinued.

After reviewing the updated training information, auditors concluded that they could not determine if all OIG staff received the training required by the OIG's directives. For 21 of the 46 classes listed in the OIG Training Directive, there was not a corresponding class title in the updated training download. Based upon the analysis conducted with this information, 14 of the 15 new OIG investigative hires did not receive the required training in FY16. One new investigative hire was excluded from our analysis because the investigator was hired close to the end of the fiscal year. Since auditors were unable to fully reconcile the training classes received against the training requirements listed in the OIG's directives, the accuracy of the analysis could not be determined.

According to an OIG official, a number of classes required by the OIG's directives have been discontinued either due to age of the material, or because they were on the NetLearning system that is no longer available. Other classes have been combined under one heading. Among the classes that have been discontinued are:

- Legal Issues (i.e. Mental Health and the Law) - when DHS legal staff reviewed the VHS tape, which was 24 years old, OIG was advised that it was useless and its use as a training tool should be discontinued;
- Patient Safety - was located on the now discontinued NetLearning system;
- Infection Control - was located on the now discontinued NetLearning system;
- Injury Assessment - was located on the now discontinued NetLearning system; however, according to OIG officials this training is now a part of the Clinical Coordinator Function training; and
- Restraint and Seclusion - was located on the now discontinued NetLearning system.

Ensuring that new investigators receive the proper training is a crucial step in ensuring that investigations of abuse and neglect are being conducted effectively. Without proper training, the risk of overlooking a critical component of the investigation or arriving at an incorrect conclusion about an allegation is increased.

INVESTIGATOR TRAINING	
RECOMMENDATION 10	***The Office of the Inspector General should:*** • ***Ensure that training required per the OIG directives is available and provided to investigative staff; and*** • ***Develop management reports to more effectively track training to ensure that each employee has received the required training.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree - OIG is meeting on a regular basis with other Inspector Generals to discuss common issues and needs, including pooling training resources in order to offer more opportunities to our investigators. The class records in the database will be condensed to eliminate multiple listings and bi-monthly reports will be added to the automated database to monitor staff training.

The OIG updated its directives on February 27, 2017. The requirement for continuing education for OIG investigators was lowered from five classes to three. However, for the majority of the audit period, OIG employees were required to participate in five continuing education training classes annually. The data provided showed that the investigative employees appeared to meet the required continuing education training for FY16.

Rule 50 Training

DHS should ensure that all employees at State-operated facilities and community agencies receive training in prevention and reporting of abuse and neglect (Rule 50). Training information provided by the DHS Division of Mental Health and the Division of Developmental Disabilities showed that some employees at facilities operated by the State were not receiving Rule 50 training. Although provider agreements require community agencies to ensure that staff are provided training in Rule 50, DHS does not maintain information regarding community agency employees and 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 facility and agency employees concerning the prevention and reporting of any one or more of the following: mental abuse, physical abuse, sexual abuse, neglect, egregious neglect, or financial exploitation."* 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-operated facilities are required to have Rule 50 training biennially (59 Ill. Adm. Code 50.20(d)(2)).

The Act 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.

For the State-operated facilities, the DHS Division of Developmental Disabilities and the DHS Division of Mental Health monitor training. According to DHS officials, compliance with training requirements for Rule 50 is monitored through the use of its OneNet system.

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 for FY16 and FY17 (see Exhibit 5-3). Information provided by the Division of Mental Health showed that only 2 of 7 facilities had 100 percent of staff trained in Rule 50 in both FY16 and FY17. Information provided by the Division of Developmental Disabilities also showed that only 2 of 7 facilities had 100 percent of staff trained in Rule 50 for both FY16 and FY17.

Exhibit 5-3
DHS RULE 50 TRAINING BY FACILITY
FY16 and FY17

Facility	% of Staff Trained in Rule 50	
MH Facilities	**FY16**	**FY17**
Alton	100%	100%
Chester	83%	93%
Chicago-Read	62%	93%
Choate	98%	98%
Elgin	100%	92%
Madden	99%	99%
McFarland	100%	100%
DD Facilities	**FY16**	**FY17**
Ann Kiley	100%	93%
Fox	100%	100%
Ludeman	99%	86%
Murray	95%	82%
Shapiro	100%	100%
Choate	90%	97%
Mabley	98%	99%

Source: DHS Division of Mental Health and Division of Developmental Disabilities (unaudited).

In our previous audit, we reported that the Division of Mental Health provided information for the period July 1, 2008, to June 30, 2010, showing that of the 9 State-operated mental health facilities, 7 had 100 percent of staff trained in Rule 50, while the other 2 facilities had 99 percent of staff trained in Rule 50. The Division of Developmental Disabilities provided information that showed that of the 8 State-operated developmental disability facilities, 4 had 100 percent of staff trained in Rule 50, while the other 4 facilities ranged from 93 percent to 99 percent of staff trained.

Beginning in FY09, training was 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. We reviewed the FY17 provider agreements for community agencies and found that these agreements contain a requirement that agency staff receive training in Rule 50. However, DHS does not monitor agencies for compliance with training requirements. As discussed in our previous audit, according to OIG officials, the amount of resources that it would take to monitor compliance with Rule 50 at community agencies would be prohibitive.

PREVENTION AND REPORTING TRAINING	
RECOMMENDATION 11	***The Department of Human Services should ensure that all employees at State-operated facilities and community agencies receive training in prevention and reporting as is required by the Act (20 ILCS 1305/1-17(h)).***
DEPARTMENT OF HUMAN SERVICES RESPONSE	The Department accepts the recommendation. The Department is complying with the required training and will continue its efforts to ensure that all employees at State-operated facilities and community agencies receive training in prevention and reporting as is required by the Act (20 ILCS 1305/1-17(h)).

UNANNOUNCED SITE VISITS

The Department of Human Services Act (20 ILCS 1305/1-17(i)) requires the Inspector General to conduct unannounced site visits to each facility at least annually for the purpose of reviewing and making recommendations on systematic issues relative to preventing, reporting, investigating, and responding to all of the following: mental abuse, physical abuse, sexual abuse, neglect, egregious neglect, or financial exploitation.

According to documents provided by the OIG, site visit protocol changed in FY15. The OIG FY15 Annual Report states that this was done because of many factors including additional responsibilities, as well as contractual and staffing constraints. According to the FY15 Annual Report, these changes would make more efficient use of existing staff resources, as well as add a fresh approach to OIG's statutory responsibilities. This new approach was more of a "tracer methodology," whereby staff took relevant issues and followed them through from the beginning of the admissions process through discharge. Although the protocol was changed, the OIG directives for site visits were not changed until FY17 (February 27, 2017).

The FY16 and FY17 site visit information provided by the OIG shows a reduction in time spent, number of areas reviewed, and findings. Many site visits for FY16 and FY17 were performed over one day rather than two. In FY15, all 14 unannounced site visits were conducted over a two-day period. In FY16, 5 of the 14 visits were conducted over a two-day period. In FY17, 5 of the 14 were two-day visits (see Exhibit 5-4). Spending less time at the facilities may impact the depth of the review that can be conducted.

The timing of some unannounced site visits we reviewed did not follow OIG directives during FY16 and FY17 because they were conducted in the same month as those visits conducted in the two preceding years. According to OIG Directive BCE 003 (prior to February 27, 2017), an unannounced site visit shall be planned at the beginning of the fiscal year and scheduled so that no site visit is in the same month as the previous two fiscal years. This directive makes the timing of the site visits less predictable, which will impact a facility's ability to prepare for the visit in advance. Advanced preparation may give a different representation of the facility's practices relative to preventing, reporting, investigating and responding to abuse, neglect, and exploitation versus everyday practices without advanced preparation for review. Elgin, Kiley, Ludeman, and Murray all had visits in repeat months during FY15 and FY16. Ludeman's site visits in FY15 and FY16 were on the exact same dates (See Exhibit 5-4). The OIG deleted this requirement from its directives effective February 27, 2017.

Exhibit 5-4
UNANNOUNCED SITE VISIT DATES
FY15, FY16, and FY17

Facility	FY15	FY16	FY17
Alton Mental Health Center	January 22 & 23	April 20	October 25
Chester Mental Health Center	March 18 & 19	June 23	June 16
Chicago-Read Mental Health Center	March 9 & 10	December 2 & 3	November 16-17
Choate Developmental Center	November 12 & 13	May 4 & 5	December 14
Choate Mental Health Center	November 13 & 14	May 4 & 5	December 15
Elgin Mental Health Center	May 12 & 13	May 26	December 20 & 22
Fox Developmental Center	May 18 & 19	April 29	May 23
Kiley Developmental Center	April 22 & 23	May 26	June 6-7
Ludeman Developmental Center	January 28 & 29	January 28 & 29	May 16-17
Mabley Developmental Center	September 4 & 5	May 19	May 10
Madden Mental Health Center	September 17 & 18	December 3 & 4	November 17-18
McFarland Mental Health Center	January 15 & 16	November 28	October 13
Murray Developmental Center	June 23 & 24	June 20	May 25
Shapiro Developmental Center	January 29 & 30	May 31	May 17
Total Recommendations	**51**	**15**	**7**

Note: Dates do not include follow up visits conducted after the initial unannounced visit date.

Source: OIG FY15 Annual Report and OAG analysis of FY16 and FY17 site visits.

For 12 of 14 unannounced site visits conducted in FY16, a Clinical Coordinator was not present as was required by the OIG directives. For FY17, a Clinical Coordinator did not attend any of the visits. The OIG deleted the requirements that Clinical Coordinators are to attend unannounced site visits from its directives effective February 27, 2017. The absence of a medical professional from planning and attending site visits impacts the types of areas that can be examined. Reducing the number and types of areas examined during site visits decreases the depth of the reviews conducted and may increase the risk that some areas may be overlooked or not included for review for a substantial amount of time. No longer requiring Clinical Coordinators to be a part of site visits and the reduction of areas reviewed during site visits may decrease the overall effectiveness of unannounced site visits because a reviewer with medical expertise may no longer be involved.

The number of areas examined during site visits has decreased and the number of recommendations made has decreased substantially. In addition, the types of areas examined (non-medical vs. medical) and the specificity of the areas examined have changed. During site visits in FY10-FY14, at least six areas were examined each year, three of which were medically related. The FY15 unannounced site visits covered four different areas, two of which were medically related, and resulted in 51 findings. In FY16, only two areas were examined (neither was medically related) and resulted in 15 findings. For FY17, each facility had 3 total areas examined with only 7 total findings in 14 unannounced site visits (see Exhibit 5-4).

Timeliness of Site Visits and Reports

One FY16 unannounced site visit was not completed in a timely manner. The OIG did not complete the FY16 unannounced site visit of Murray Developmental Center until FY17. OIG staff initially visited Murray Developmental Center on June 20, 2016. However, a report was not prepared until October 7, 2016 (80 working days after the initial visit). According to OIG officials, because of the large amount of repeat recommendations, the OIG agreed to another site visit date with the facility, which took place on September 20, 2016. Therefore the site visit was not completed until FY17.

OIG directives require that within 60 days of the completion of the site visit, a draft report is to be sent to the Inspector General or his/her designee for review and signature. Our review of FY16 and FY17 site visits found that all reports were submitted within 60 working days.

UNANNOUNCED SITE VISITS	
RECOMMENDATION 12	***The Office of the Inspector General should ensure that all unannounced site visits are completed annually as required by the Department of Human Services Act (20 ILCS 1305/1-17(i)).***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree - As noted in the Audit report, only one unannounced site visit was completed outside the timeframes of the statute. This was due to a unique set of circumstances present at that facility at that time which required OIG to take longer to fully review and make appropriate recommendations prior to closing the site visit. OIG will monitor the site visit protocol to make sure all site visits are completed per directive.

OIG DATA

The OIG was able to provide auditors with downloads from its investigations database for FY16 and FY17. Although the data provided by the OIG was generally complete and reliable enough for our analysis and sample selection for testing, we identified several instances in which the OIG could improve the quality of its data. We found that:

- The discovery date and time in the OIG database is not always specific/accurate. In some cases the date and time were recorded in the wrong field, while in others a range of time or an estimate time ("around") is given. In a few cases it appears the date recorded is the date the incident occurred and not when it was discovered. This could lead to the appearance that reporting is not timely in some cases in which it may actually be timely.
- There are cases in the database in which the incident was reported to local law enforcement or Illinois State Police (ISP), but a date was not included in the OIG database regarding when the case was reported to the local law enforcement agency or ISP.

- There were 116 investigations closed in FY17 that were substantiated in which the recommendation was "No Action" in the database. For substantiated investigations there should, with few exceptions, be an associated recommended action.

OIG DATA	
RECOMMENDATION 13	***The Office of the Inspector General should work to improve the quality and accuracy of the information contained in the OIG investigative database.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree - OIG is in the process of hiring new staff to monitor the database and develop procedures to do trend analysis on data entry. Current QA procedures will be revised and others added to monitor quality on a weekly/monthly basis as necessary. OIG will also reinforce with all staff the importance of accurate entry of all data into the database.

APPENDICES

APPENDIX A
Audit Authority
(20 ILCS 1305/1-17(w))

Appendix A
AUDIT AUTHORITY
DEPARTMENT OF HUMAN SERVICES ACT
20 ILCS 1305

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.

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 State-operated facility or community 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 compliance with requirements in the Department of Human Services Act including establishing training, conducting unannounced site visits, and Quality Care Board membership and meetings.

This audit covers the period FY16 and FY17. Initial work began on this audit in January 2017 and fieldwork was concluded in August 2017. We interviewed or contacted representatives from the DHS Inspector General's Office, DHS Division of Developmental Disabilities, DHS Division of Mental Health, and the Illinois State Police. We also reviewed documents and data from the Inspector General's Office, the DHS Division of Developmental Disabilities, the DHS Division of Mental Health, and the Illinois State Police. We examined the current OIG organizational structure, policies and procedures, investigations process, case review process, and investigation requirements. We also reviewed internal controls over the investigation process. We reviewed backgrounds for 15 investigators hired during FY16 and reviewed investigator personnel records. Additionally, our audit work included follow-up on any previous OIG audit recommendations.

We analyzed investigations data provided by the OIG from its electronic database from fiscal years 2016 and 2017. We tested a sample of cases closed from FY17 and analyzed electronic data provided by the OIG for FY16 and FY17.

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.

Testing and Analytical Procedures

In order to test case files for thoroughness of investigation methods, we selected a sample of cases closed in FY17. 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. We took a random sample of the investigations closed in FY17 with a confidence level of at least 90 percent and an acceptable error rate of 10 percent. Our random sample was stratified into two categories:

- Investigations conducted at State-operated facilities (including death reviews and other investigations). The total population of investigations closed at State facilities in FY17 was 891. We sampled 63 of these investigations; and
- Investigations conducted at the community agencies (including death reviews and other investigations). The total population of investigations closed at community agencies in FY17 was 2,915. We sampled 67 of these investigations.

We also performed analyses based on an electronic database of OIG reported cases from fiscal years 2016 and 2017 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

FY10, FY16, and FY17

Appendix C
RATE OF SUBSTANTIATED ABUSE OR NEGLECT CASES BY FACILITY
(Includes Allegations Categorized as Abuse, Neglect or Death at Intake)
FY10, FY16, and FY17

	Fiscal Year 2017			Fiscal Year 2016			Fiscal Year 2010		
Facility/Agency	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	63	1	2%	90	2	2%	79	1	1%
Chester	105	10	10%	115	5	4%	219	2	1%
Chicago-Read	12	0	0%	45	2	4%	25	0	0%
Choate	140	6	4%	197	6	3%	89	10	11%
Elgin	186	7	4%	160	5	3%	78	4	5%
Fox	11	1	9%	14	1	7%	11	1	9%
Howe[2]	N/A	N/A	N/A	N/A	N/A	N/A	53	8	15%
Jacksonville[2]	N/A	N/A	N/A	N/A	N/A	N/A	91	4	4%
Kiley	110	7	6%	69	3	4%	23	2	9%
Ludeman	53	5	9%	71	5	7%	40	2	5%
Mabley	20	4	20%	22	3	14%	7	3	43%
Madden	40	4	10%	51	2	4%	24	0	0%
McFarland	74	5	7%	82	4	5%	52	4	8%
Murray	25	2	8%	34	5	15%	30	1	3%
Shapiro	47	0	0%	86	8	9%	33	1	3%
Singer[2]	N/A	N/A	N/A	N/A	N/A	N/A	34	1	3%
Tinley Park[2]	N/A	N/A	N/A	N/A	N/A	N/A	12	1	8%
Community Agencies[1]	2,911	430	15%	2,519	329	13%	1,404	216	15%
Totals	**3,797**	**482**	**13%**	**3,555**	**380**	**11%**	**2,304**	**261**	**11%**

Notes:

[1] Aggregate numbers from all Community Agencies.

[2] Howe Developmental Center closed in 2010. Jacksonville Developmental Center, Singer Mental Health Center, and Tinley Park Mental Health Center closed in 2012.

Source: OAG analysis of OIG data.

APPENDIX D

Allegations by Facility
FY10, FY16, and FY17

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
FY10, FY16, and FY17

Location	Abuse Allegations								
	A1 physical abuse - imminent danger			A2 physical abuse - serious injury			A3 other physical abuse		
	FY17	FY16	FY10	FY17	FY16	FY10	FY17	FY16	FY10
DD Facilities									
Fox	0	0	0	3	0	0	5	6	1
Howe[2]	N/A	N/A	0	N/A	N/A	1	N/A	N/A	17
Jacksonville[2]	N/A	N/A	0	N/A	N/A	3	N/A	N/A	67
Kiley	0	0	0	1	2	0	78	46	10
Ludeman	0	0	0	2	3	2	29	31	34
Mabley	0	0	0	1	1	0	10	18	7
Murray	0	0	0	1	0	0	16	12	20
Shapiro	0	0	1	3	3	2	40	46	32
MH Facilities									
Alton	0	0	1	0	3	1	24	37	32
Chester	0	0	0	2	3	3	76	70	137
Chicago-Read	0	0	0	1	1	1	7	11	11
Elgin	0	1	0	3	1	0	42	67	21
Madden	0	0	0	2	2	0	16	29	16
McFarland	0	0	0	0	0	0	17	20	23
Singer[2]	N/A	N/A	0	N/A	N/A	0	N/A	N/A	16
Tinley Park[2]	N/A	N/A	0	N/A	N/A	0	N/A	N/A	2
Dual Facility									
Choate	3	1	0	5	1	1	88	86	65
Community Agencies[1]	0	0	1	44	30	11	891	828	634
Totals	**3**	**2**	**3**	**68**	**50**	**25**	**1,339**	**1,307**	**1,145**

Notes:
[1] Aggregate numbers from all Community Agencies.

[2] Howe Developmental Center closed in 2010. Jacksonville Developmental Center, Singer Mental Health Center, and Tinley Park Mental Health Center closed in 2012.

Source: OAG analysis of OIG data.

Appendix D
ALLEGATIONS BY FACILITY
FY10, FY16, and FY17

Abuse Allegations											
A4 sexual abuse			**A5 verbal abuse**			**A6 psychological abuse**			**A7 financial exploitation**		
FY17	**FY16**	**FY10**	**FY17**	**FY16**	**FY10**	**FY17**	**FY16**	**FY10**	**FY17**	**FY16**	**FY10**
0	1	0	0	0	0	0	1	1	0	0	0
N/A	N/A	1	N/A	N/A	0	N/A	N/A	3	N/A	N/A	0
N/A	N/A	0	N/A	N/A	16	N/A	N/A	6	N/A	N/A	1
4	2	0	12	4	2	9	4	5	0	1	0
0	3	2	1	0	1	2	1	1	1	1	0
0	0	0	0	2	0	0	1	0	0	0	0
1	0	0	2	0	4	3	1	1	0	0	0
1	2	0	0	1	4	2	4	7	0	0	0
7	7	16	10	5	28	12	9	11	2	1	0
8	5	19	14	9	25	20	24	17	6	1	0
5	4	3	2	4	8	1	3	3	0	1	0
29	15	12	17	17	17	26	29	9	7	8	0
5	5	1	4	1	8	6	5	4	0	1	0
10	15	8	7	2	7	17	9	5	3	3	0
N/A	N/A	5	N/A	N/A	4	N/A	N/A	1	N/A	N/A	1
N/A	N/A	3	N/A	N/A	2	N/A	N/A	2	N/A	N/A	0
7	12	1	7	8	10	27	25	6	3	2	1
91	85	72	145	115	201	341	311	109	164	98	30
168	**156**	**143**	**221**	**168**	**337**	**466**	**427**	**191**	**186**	**117**	**33**

Appendix D
ALLEGATIONS BY FACILITY
FY10, FY16, and FY17

Location	Neglect Allegations								
	N1 neglect-imminent danger			N2 neglect-serious injury			N3 neglect-non-serious injury		
	FY17	FY16	FY10	FY17	FY16	FY10	FY17	FY16	FY10
DD Facilities									
Fox	0	0	0	1	1	2	2	0	1
Howe[2]	N/A	N/A	0	N/A	N/A	6	N/A	N/A	4
Jacksonville[2]	N/A	N/A	1	N/A	N/A	1	N/A	N/A	3
Kiley	0	0	0	0	0	1	1	0	2
Ludeman	0	0	0	4	4	0	7	7	4
Mabley	0	0	0	0	0	1	1	1	0
Murray	0	0	0	0	1	0	0	2	1
Shapiro	0	0	0	0	0	2	0	1	1
MH Facilities									
Alton	0	0	0	1	1	1	5	3	2
Chester	1	0	0	5	1	0	7	0	3
Chicago-Read	0	0	0	0	0	0	1	0	3
Elgin	0	0	0	0	6	4	10	15	10
Madden	0	0	0	0	1	1	0	2	4
McFarland	0	0	0	1	3	2	4	0	3
Singer[2]	N/A	N/A	0	N/A	N/A	0	N/A	N/A	2
Tinley Park[2]	N/A	N/A	0	N/A	N/A	1	N/A	N/A	1
Dual Facility									
Choate	0	0	0	1	3	1	5	3	8
Community Agencies[1]	2	0	3	115	104	64	142	129	147
Totals	**3**	**0**	**4**	**128**	**125**	**87**	**185**	**163**	**199**

Notes:
[1] Aggregate numbers from all Community Agencies.

[2] Howe Developmental Center closed in 2010. Jacksonville Developmental Center, Singer Mental Health Center, and Tinley Park Mental Health Center closed in 2012.

Source: OAG analysis of OIG data.

Appendix D
ALLEGATIONS BY FACILITY
FY10, FY16, and FY17

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**		
FY17	**FY16**	**FY10**	**FY17**	**FY16**	**FY10**	**FY17**	**FY16**	**FY10**	**FY17**	**FY16**	**FY10**
0	0	0	0	0	0	0	0	0	1	1	2
N/A	N/A	4	N/A	N/A	1	N/A	N/A	0	N/A	N/A	4
N/A	N/A	0	N/A	N/A	0	N/A	N/A	0	N/A	N/A	3
2	1	2	0	1	0	0	0	0	18	1	4
4	0	0	0	0	1	0	0	0	9	7	1
0	0	0	0	0	0	0	0	0	7	3	2
1	0	0	1	0	0	0	0	0	2	4	7
0	0	0	0	0	0	0	0	0	4	1	0
0	0	0	2	0	0	0	0	0	4	9	3
0	0	0	3	0	0	0	0	1	16	12	5
0	0	0	0	0	2	0	0	0	3	5	5
1	1	0	0	3	1	0	0	0	31	30	7
0	0	0	1	1	0	0	0	0	8	9	5
0	1	0	0	0	0	0	0	0	15	11	0
N/A	N/A	0	N/A	N/A	1	N/A	N/A	0	N/A	N/A	2
N/A	N/A	0	N/A	N/A	0	N/A	N/A	0	N/A	N/A	1
2	0	1	2	2	0	0	0	0	15	14	7
66	42	11	20	15	19	0	0	3	693	616	196
76	**45**	**18**	**29**	**22**	**25**	**0**	**0**	**4**	**826**	**723**	**254**

Appendix D
ALLEGATIONS BY FACILITY
FY10, FY16, and FY17

Location	Death Allegations								
	D1 suicide in program			D2 suicide within 14 days after discharge			D4 death in residential program		
	FY17	FY16	FY10	FY17	FY16	FY10	FY17	FY16	FY10
DD Facilities									
Fox	0	0	0	0	0	0	2	0	1
Howe[2]	N/A	N/A	0	N/A	N/A	0	N/A	N/A	2
Jacksonville[2]	N/A	N/A	0	N/A	N/A	0	N/A	N/A	1
Kiley	0	0	0	0	0	0	0	0	0
Ludeman	0	0	0	0	0	0	1	0	0
Mabley	0	0	0	0	0	0	3	0	0
Murray	0	0	0	0	0	0	0	2	2
Shapiro	0	0	0	0	0	0	1	4	2
MH Facilities									
Alton	0	0	0	0	0	0	0	0	0
Chester	0	0	0	0	0	0	0	1	2
Chicago-Read	0	0	0	0	0	0	0	1	0
Elgin	0	0	0	0	0	0	2	0	0
Madden	0	0	0	2	0	0	0	0	0
McFarland	0	0	0	0	0	1	0	0	0
Singer[2]	N/A	N/A	0	N/A	N/A	0	N/A	N/A	0
Tinley Park[2]	N/A	N/A	0	N/A	N/A	1	N/A	N/A	0
Dual Facility									
Choate	0	0	0	0	0	0	0	1	3
Community Agencies[1]	0	1	0	1	0	0	80	72	58
Totals	**0**	**1**	**0**	**3**	**0**	**2**	**89**	**81**	**71**

Notes:
[1] Aggregate numbers from all Community Agencies.

[2] Howe Developmental Center closed in 2010. Jacksonville Developmental Center, Singer Mental Health Center, and Tinley Park Mental Health Center closed in 2012.

Source: OAG analysis of OIG data.

Appendix D
ALLEGATIONS BY FACILITY
FY10, FY16, and FY17

Death Allegations

D5 death not in residential program			D6 death due to natural causes in a program			D7 any other reportable deaths		
FY17	**FY16**	**FY10**	**FY17**	**FY16**	**FY10**	**FY17**	**FY16**	**FY10**
1	2	2	0	1	0	0	0	2
N/A	N/A	0	N/A	N/A	1	N/A	N/A	0
N/A	N/A	1	N/A	N/A	1	N/A	N/A	0
2	3	0	0	0	0	0	0	0
1	2	0	1	1	1	0	0	0
0	1	0	0	0	0	0	0	0
2	1	0	0	1	1	0	0	0
7	9	0	0	0	2	0	0	0
0	0	0	0	0	0	0	0	0
1	1	0	0	1	0	0	0	0
1	0	0	0	0	0	0	0	0
0	0	0	1	0	0	0	0	0
0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0
N/A	N/A	0	N/A	N/A	0	N/A	N/A	0
N/A	N/A	0	N/A	N/A	1	N/A	N/A	0
2	0	0	1	0	1	0	0	0
54	85	18	33	37	26	1	1	6
71	**104**	**21**	**36**	**41**	**34**	**1**	**1**	**8**

APPENDIX E

Agency Responses

IDHS

Bruce Rauner, *Governor* • James T. Dimas, *Secretary*

December 1, 2017

Frank J. Mautino
Illinois Auditor General
Iles Park Plaza
740 E. Ash Street
Springfield, IL 62703

Dear Auditor General Mautino,

Thank you for the opportunity to respond to the draft report for the FY17 program audit of the Illinois Department of Human Services Office of the Inspector General. We appreciate the objective and thorough review of our operations conducted by Audit Manager Michael Paoni and his staff. While the audit report correctly highlights areas where we need improvement, it also highlights the challenges OIG has faced over the past several years that gave rise to some of the issues. Also, OIG has improved in some of these areas from FY16 to FY17. We are also pleased that the audit report found that our Investigative Reports were thorough, comprehensive and addressed the allegation.

OIG will continue to improve by building upon the successful changes we have made in our operations over the past several years and implement new strategies based on the recommendations in this report.

Attached are OIG's responses to the recommendations related to this Office. If you have any questions about our responses, please contact me at (312) 814-1033.

Sincerely,

SIGNED ORIGINAL ON FILE

Michael J. McCotter
Inspector General

cc: James Dimas, Secretary
Fred Flather
Mari Bruni, PhD
Greg Fenton
Diane Knaebe
Amy DeWeese

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

Responses to Recommendations Regarding the Office of the Inspector General

Recommendation 1
The Office of the Inspector General should consider updating its interagency agreement with the Department of Children and Family Services.

OIG Response
Disagree - OIG has met with DCFS about updating the current agreement. However, since there has been little jurisdictional overlap since FY2010, DCFS does not see the need for an updated agreement. Information in our database indicates there has not been an OIG investigation involving an individual under the age of 18 in the last three fiscal years. Based on this, OIG does not see a need to update the outdated interagency agreement with DCFS and will move to terminate that agreement. OIG will continue to coordinate and cooperate with DCFS if any jurisdictional overlap occurs.

Recommendation 2
The Office of the Inspector General should:
- *Improve the collection of information regarding the date and time an incident is discovered; and*
- *Continue to work with State-operated facilities and community agencies to improve the number of allegations of abuse and neglect that are reported within the four-hour timeframe specified in the Department of Human Services Act and OIG's administrative rules.*

OIG Response
Agree – While OIG does not have control over what the caller knows about the time and date of discovery of an allegation, OIG Intake investigators will continue to gather as much thorough and detailed information from the caller as possible by asking appropriate, specific questions. OIG will also remind community agencies and facilities of the four hour requirement to report allegations of abuse/neglect and to provide detailed information about the time and date of discovery, if they know it, when calling in a report to the OIG hotline.

Recommendation 3
The Office of the Inspector General should work to improve the timeliness of:
- *Initial entry of cases into the OIG Database;*
- *Case notification to Bureau Chiefs and Investigative Team Leaders; and*
- *Assignment and reassignment of cases to investigators.*

OIG Response
Agree - If a case has not been assigned within one day and before it goes to two days, the database has been modified to automatically assign it to the respective bureau chief and send them an e-mail detailing the assignment, which requires them to take any needed action.

There is sometimes a delay between the time an allegation is called in to the time the bureau chief receives the intake due to the need to make follow-up contact with the caller to get more detail or clarify already provided details to determine if it is a reportable incident. In order to facilitate the entering of cases into the database, OIG is developing a web-based intake that will allow agencies/facilities to directly enter cases. The intake is then pulled into the OIG database where it is reviewed and processed by Intake staff. This should eliminate the necessity of calling complainants back. OIG is also meeting with the answering service to develop a way to receive more detailed information when they answer calls, allowing Intake staff to better prioritize calls.

Auditor Comments

Auditor Comment #1
The OIG's current agreement with DCFS was signed in November 2000 and contains outdated statutory cites. This audit randomly sampled 130 investigations closed by the OIG in FY17. One of the investigations sampled involved an individual over the age of 18 in which the investigation was eventually referred to DCFS after the OIG determined that it was out of its jurisdiction.

Over the past two years, OIG reassigned cases, some multiple times, due to changes in personnel status and attempts to equalize caseloads. Stabilization of our personnel situation and case management practices implemented over the past several years should reduce the overall need to reassign cases multiple times.

Recommendation 4
The Office of the Inspector General should work to improve the timeliness of investigations of abuse and neglect including the time it takes to interview alleged victims and perpetrators.

OIG Response
Agree – As noted in the Audit report, the number of investigations opened continues to increase year after year which, with staff shortages, has impacted OIG's overall timeliness in completing investigations and completing interviews with the victim and accused. From FY16 to FY17, OIG completed more investigations in less time and we plan on continuing this trend going forward as our staffing issues have improved and we have increased case management oversight.

Recommendation 5
The Office of the Inspector General should ensure that investigations are reviewed by the Investigative Team Leader or Bureau Chief within seven days of receipt, absent extenuating circumstances, as is required by OIG directives.

OIG Response
Agree – Timely review of investigations is critical in completing timely, thorough investigations. The timeliness of review is determined by numerous factors including the number of investigations opened, the complexity of the investigation and the skill level of the assigned investigator. The seven day timeframe that is required in current directives has been in place for a number of years and will be re-evaluated in light of the circumstances OIG works under today. We will review the required case review timeframes to ensure the appropriate amount of time is given based on the needs of that investigation to ensure a thorough and quality investigation is completed and revise the directives accordingly.

Recommendation 6
The Office of the Inspector General should improve the collection of investigation documentation including photographs of injuries, injury reports/medical examinations, and statements or interviews with the alleged victim and alleged perpetrator.

OIG Response
Agree – OIG will provide further training to investigative staff to ensure all appropriate documentation is collected based on the needs of the investigation and to better document when and why certain documentation could not be collected or certain interviews could not be completed.

Recommendation 7
The Office of the Inspector General should ensure that all Case Tracking Forms and Case Routing and Approval Forms are completed.

OIG Response
Agree – OIG will reinforce to management and administrative staff that these forms need to be fully completed and they must be reviewed for completeness at the time of case closure as required by directive.

Recommendation 9
The Secretary of the Department of Human Services and the Inspector General should continue to work with the Governor's Office to appoint members to the Quality Care Board in order to fulfill statutory membership requirements (20 ILCS 1305/1-17(u)).

Once the members are appointed, the Quality Care Board should comply with the Department of Human Services Act and meet quarterly as required.

OIG Response
Agree – OIG will continue to work with the Secretary and the Governor's Office to appoint members as required. We will also work with the QCB Chairperson to help them schedule timely meetings each quarter.

Recommendation 10
The Office of the Inspector General should:
- *Ensure that training required per the OIG directives is available and provided to investigative staff; and*
- *Develop management reports to more effectively track training to ensure each employee has received the required training.*

OIG Response
Agree - OIG is meeting on a regular basis with other Inspector Generals to discuss common issues and needs, including pooling training resources in order to offer more opportunities to our investigators. The class records in the database will be condensed to eliminate multiple listings and bi-monthly reports will be added to the automated database to monitor staff training.

Recommendation 12
The Office of the Inspector General should ensure that all unannounced site visits are completed annually as required by the Department of Human Services Act (20 ILCS 13051-17(i)).

OIG Response
Agree – As noted in the Audit report, only one unannounced site visit was completed outside the timeframes of the statute. This was due to a unique set of circumstances present at that facility at that time which required OIG to take longer to fully review and make appropriate recommendations prior to closing the site visit. OIG will monitor the site visit protocol to make sure all site visits are completed per directive.

Recommendation 13
The Office of the Inspector General should work to improve the quality and accuracy of the information in the OIG investigative database.

OIG Response
Agree – OIG is in the process of hiring new staff to monitor the database and develop procedures to do trend analysis on data entry. Current QA procedures will be revised and others added to monitor quality on a weekly/monthly basis as necessary. OIG will also reinforce with all staff the importance of accurate entry of all data into the database.

December 1, 2017

Frank J. Mautino
Illinois Auditor General
Iles Park Plaza
740 E. Ash Street
Springfield, IL 62703

Dear Auditor General Mautino,

Please find attached additional DHS response for recommendations #8 and #11:

Recommendation 8
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.

DHS Response
The Department accepts the recommendation. The Department has worked with the facilities and community agencies to meet the 30 day response requirement. The Department will continue its efforts to ensure that written responses from facilities and community agencies are received and approved in a timely manner.

Recommendation 11
The Department of Human Services should ensure that all employees at State-operated facilities and community agencies receive training in prevention and reporting as is required by the Act (20 ILCS 1305/1-17(h)).

DHS Response
The Department accepts the recommendation. The Department is complying with the required training and will continue its efforts to ensure that all employees at State-operated facilities and community agencies receive training in prevention and reporting as is required by the Act (20 ILCS 1305/1-17(h)).

Sincerely,

SIGNED ORIGINAL ON FILE
Amy Dé Weese, CPA
Chief Internal Auditor

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Bruce Rauner, *Governor* • James T. Dimas, *Secretary*

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