STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PROGRAM AUDIT

OFFICE OF THE INSPECTOR GENERAL
DEPARTMENT OF HUMAN SERVICES

DECEMBER 2002

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

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

The audit was conducted pursuant to Section 30/6.8 of the Abused and Neglected Long Term Care Facility Residents Reporting Act. This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

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

WILLIAM G. HOLLAND
Auditor General

Springfield, Illinois
December 2002

REPORT DIGEST

PROGRAM AUDIT OF

THE DEPARTMENT OF HUMAN SERVICES

OFFICE OF THE INSPECTOR GENERAL

Released: December 2002

State of Illinois
Office of the Auditor General

WILLIAM G. HOLLAND
AUDITOR GENERAL

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SYNOPSIS

This is our seventh audit of the Office of the Inspector General's (OIG's) effectiveness in investigating allegations of abuse or neglect. In Fiscal Year 2002, the Department of Human Services (DHS) operated 19 State facilities and licensed, certified, or funded over 400 community agencies. In this audit we reported that:

- Timeliness of investigations has improved significantly since our last audit. In Fiscal Year 2002, 46 percent of cases were completed within 60 calendar days while in Fiscal Year 2000 only 25 percent were completed within the 60-day requirement. Although progress has been made, additional work is needed. Untimely investigations have been an issue in all seven OIG audits conducted by the Office of the Auditor General.

- The Inspector General and State Police need an interagency agreement that stipulates responsibilities for investigations. The current guidance relates to allegations involving State employees but not other allegations against non-State employees where evidence indicates a possible criminal act.

- The Deputy Inspector General did not review all substantiated cases of abuse or neglect as required by OIG's investigative guidance. Twelve of the eighteen substantiated cases in our testing were not reviewed by the Inspector General, the Deputy Inspector General, or a designee.

- Alleged incidents of abuse or neglect are not being reported to the OIG by facilities and community agencies in the time frames required by OIG administrative rule. During the second half of Fiscal Year 2002, 16 percent of facility cases and 50 percent of community agency cases were not reported within the OIG's reporting requirement.

- Although training of OIG investigators had improved in our last OIG audit, there were again problems in this audit period. In our previous OIG audits, we have had seven total recommendations on training in four of the audits.

REPORT CONCLUSIONS

The Abused and Neglected Long Term Care Facility Residents Reporting Act (Act) requires the Office of the Inspector General (OIG) to investigate allegations of abuse and neglect that occur in facilities operated by the Department of Human Services (DHS), as well as community agencies licensed, certified, or funded by DHS. In Fiscal Year 2002, DHS operated 19 State facilities and licensed, certified, or funded over 400 community agencies. Additionally, the Act requires the Office of the Auditor General to conduct a biennial program audit of the Inspector General's compliance with the Act. This is the seventh audit conducted of the OIG since 1990.

Timeliness of investigations has improved significantly since our last audit. In Fiscal Year 2002, 46 percent of cases were completed within 60 calendar days while in Fiscal Year 2000 only 25 percent were completed within the 60-day requirement. In addition, the number of cases taking more than 200 days to complete has also decreased from 547 in Fiscal Year 2000 to 41 in Fiscal Year 2002. Although progress has been made, additional work is needed. Untimely investigations have been an issue in all seven OIG audits conducted by the Office of the Auditor General.

OIG case reports generally were thorough, comprehensive, and addressed the allegation. All case files in our sample contained a case report and a library sheet. Progress notes were obtained in cases where they were pertinent.

The Inspector General and State Police need an interagency agreement that stipulates responsibilities for investigations. The OIG and Illinois State Police's relationship has been guided by Administrative Order 1999-3 to investigate all criminal allegations of State employees who work at any agency under the control of the Governor. The Administrative Order provides guidance related to allegations involving State employees but not other allegations against non-State employees where evidence indicates a possible criminal act.

Alleged incidents of abuse or neglect are not being reported to the OIG by facilities and community agencies in the time frames required by OIG administrative rule. During the second half of Fiscal Year 2002, 16 percent of facility cases and 50 percent of community agency cases were not reported within the OIG's reporting requirement.

We found that various changes in investigative guidance and administrative rules may have left investigative staff unclear on appropriate definitions and investigative requirements. During Fiscal

Year 2002, the Inspector General's Office operated under three versions of administrative rule 50. In addition, the OIG had memos, Directives, and Guidelines that were all in effect during portions of this audit period.

The Deputy Inspector General did not review all substantiated cases of abuse or neglect as required by OIG's investigative guidance. Our fieldwork sample contained 18 substantiated cases of abuse or neglect. Twelve of the 18 substantiated investigations were completed by community agencies. None of these 12 cases were reviewed by the Inspector General, the Deputy Inspector General, or a designee.

Although training of OIG investigators had improved in our last OIG audit, there were again problems in this audit period. In our previous OIG audits, we have had seven total recommendations on training in four of the audits. We again recommended that the Inspector General should ensure that all OIG investigators meet training requirements as set forth by OIG investigative guidance.

The Quality Care Board did not meet statutory requirements for meeting quarterly. In Fiscal Year 2001, the Board only met twice and in Fiscal Year 2002, the Board met three times. This is the first OIG audit where the Board has not met as required by the Act. However, it appeared that the Board was following other requirements established by the statutes.

BACKGROUND

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

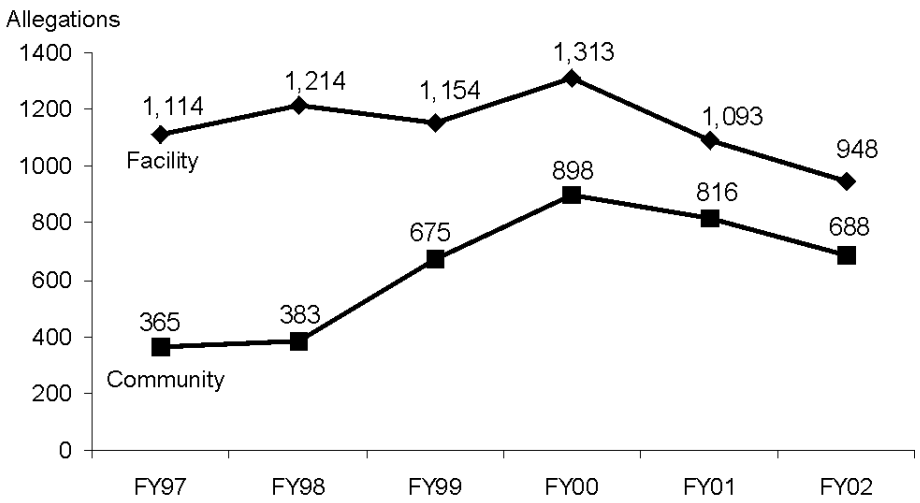
As of April 2002, the OIG had 68 staff. This represents an increase of nine positions over staffing levels reported in our 2000 OIG audit. However, investigative staff for abuse or neglect investigations have decreased from 39 in FY 2000 to 27 in FY 2002. The largest organizational unit within the OIG is the Bureau of Investigation. The Bureau of Investigation is responsible for conducting investigations of allegations of abuse or neglect. Each region has a Bureau Chief, an

Investigative Team Leader who is responsible primarily for case file review, and additional investigatory staff.

In FY 2002, the Department of Human Services operated 19 facilities Statewide which served 13,680 individuals. Nine facilities served the developmentally disabled, eight facilities served the mentally ill, and two facilities served both. In FY 2003 two facilities and half of a third were closed. In addition, DHS licenses, certifies, or provides funding for over 400 community agency programs that provided services to approximately 24,500 individuals with developmental disabilities and approximately 160,000 individuals with mental illness in FY 2002.

In FY 2002, a total of 1,636 allegations of abuse or neglect were reported to the OIG (948 from State facilities and 688 from community agencies). Digest Exhibit 1 summarizes abuse or neglect allegations reported to the OIG from the two sources for FY 1997 to FY 2002. For perspective, a note to the exhibit contains DHS statistics on the numbers of individuals served in State facilities and by community agencies.

Digest Exhibit 1
TOTAL ABUSE OR NEGLECT ALLEGATIONS REPORTED TO OIG



Note: State facilities served 3,388 individuals with developmental disabilities and 10,292 individuals with mental illness in FY 2002. Community agencies served 24,500 individuals with developmental disabilities and 160,000 individuals with mental illness in FY 2002.

Source: OAG analysis of OIG data.

In the past, the Office of the Auditor General has conducted six audits of the OIG to assess the effectiveness of their investigations into allegations of abuse and neglect, as directed under 210 ILCS 30/6.8. These audits were released in 1990, 1993, 1994, 1996, 1998, and 2000. (pages 2, 4, 12, 13)

This is the seventh audit related to the Office of the Inspector General.

Changes in Investigative Guidance

Various changes in investigative guidance may have left investigative staff unclear on appropriate definitions and investigative requirements. In past audits of the Inspector General's Office we have reviewed a number of different versions of guidance that investigators are to follow. In this audit, we did our testing from cases closed in Fiscal Year 2002. During that time period the old version of administrative rule 50 was in effect from July to December; then an emergency rule was in effect from January through part of May; and finally a new version of rule 50 was in effect for part of May through June.

In addition, the OIG had memos, Directives, and Guidelines that were all in effect during portions of this audit period. Investigative Guidelines were a portion of the investigative guidance that was in effect during our last OIG audit which was released in December of 2000. But by January of 2001 several memos were issued to change investigative guidance. Then, in January to March 2002 a number of Directives came out to change investigative guidance. Some Directives followed similar memos. For example, a memo on a case management system was issued in January of 2001 and was followed with a Directive in February of 2002. Directives sometimes rescinded or amended portions of the Guidelines, but portions of the Guidelines were still in effect when we were completing our fieldwork. We recommended that the Inspector General assure that clear and consistent investigative guidance is available for investigators which allows investigative effectiveness to be judged over time. (pages 7-9)

OTHER STATE AGENCIES

Neither the OIG nor State Police are fulfilling statutory responsibilities established under the Abused and Neglected Long Term Care Facility Residents Reporting Act. The Inspector General and State Police need an interagency agreement that stipulates responsibilities for investigations. The OIG and Illinois State Police's relationship has been guided by Administrative Order 1999-3 to investigate all criminal allegations of State employees who work at any agency under the control of the Governor. The Administrative Order provides guidance related to allegations involving State employees but not other allegations against non-State employees where evidence indicates a possible criminal act. The OIG should assure that allegations at community agencies, where a possible criminal act has been committed, are referred as required. (pages 10-11)

INVESTIGATION TIMELINESS

In FY 2002 46 percent of OIG investigations were completed within 60 days.

While overall timeliness of investigations has been an issue in the previous six OIG audits, there has been noteworthy improvement in FY 2001 and 2002. One of the clearest indicators of this improvement is that in FY 2002, 46 percent of investigations were completed in 60 days while in FY 2000 only 25 percent were completed within 60 days. Although improvement is still needed, significant progress was made. Digest Exhibit 2 shows timeliness data for OIG investigations for the last six fiscal years.

The number of cases taking more than 200 days to complete decreased from 547 in FY 2000 to 41 in FY2002.

The number of cases taking more than 200 days to complete has also decreased significantly from FY 2000. In FY 2000, 547 cases took longer than 200 days to complete. By FY 2002, the cases taking longer than 200 days to complete decreased to 41. Investigations at State facilities completed during FY 2002 accounted for 46 percent (19 of 41) of the cases that took longer than 200 days to complete and community agency investigations accounted for 54 percent (22 of 41).

Digest Exhibit 2
CALENDAR DAYS TO COMPLETE
ABUSE OR NEGLECT INVESTIGATIONS
Fiscal Years 1997-2002

Days to Complete Cases	FY 1997 % of Cases	FY 1998 % of Cases	FY 1999 % of Cases	FY 2000 % of Cases	FY 2001 % of Cases	FY 2002 % of Cases
0-60	**41%**	**14%**	**21%**	**25%**	**49%**	**46%**
61-90	27%	19%	10%	18%	18%	31%
91-120	17%	16%	11%	14%	11%	13%
121-180	12%	29%	23%	16%	10%	6%
181-200	2%	6%	6%	4%	2%	1%
>200	1%	16%	30%	23%	10%	3%
Total > 60 days	**59%**	**86%**	**79%**	**75%**	**51%**	**54%**
Total Cases	964	1,308	1,507	2,341	1,883	1,442

Source: OAG analysis of OIG data.

Although timeliness has improved since our last audit, the OIG does not have a good method to document for all cases what is preventing completion of cases that go over the 60-day completion requirement and to assure that cases continue to have investigative progress. In January 2001, the Inspector General issued a memo saying that a case management system would be implemented February 1, 2001. In February 2002, an

OIG Directive was issued that established the policy for the case management system along with the authority, responsibilities and related procedures. The system is not electronic but a paper based system where each investigator submits one form for each case if it is not completed within 30 days and within 45 days of assignment. Team leaders review the investigators' reports, sign off on them and submit a monthly report on them to their supervisor, the Bureau Chief. Bureau Chiefs then submit a monthly report to the Deputy Inspector General which shows all cases more than 45 days old. This report should include the reason for the delay, the actions needed to complete the investigation, and the expected date of completion.

Our analysis showed that, February 2002 reports that Bureau Chiefs prepared did not contain all of the cases over 45 days old. Less than 30 percent of cases over 45 days old were included on the case management reports. When the reports are incomplete, Bureau Chiefs cannot rely on them to adequately monitor timeliness. We recommended that the Inspector General continue to work to improve the timeliness in investigations of abuse and neglect. (pages 15-21)

TIMELY REPORTING OF ALLEGATIONS

Alleged incidents of abuse and neglect are not being reported to the OIG by facilities and community agencies in the time frames required by OIG administrative rule. Improvement in time to report incidents was not realized until the second half of FY 2002 when the OIG revised the reporting requirement from one to four hours after discovery of the incident. In the first half of FY 2002, the reporting times by facilities and community agencies were almost identical to the times from the 2000 OIG audit. We recommended that the Inspector General work with State facilities and community agencies to ensure that allegations of abuse or neglect are reported within the time frame specified in State law and OIG administrative rules. (pages 22, 23)

INVESTIGATION THOROUGHNESS

OIG case reports generally were thorough, comprehensive, and addressed the allegation.

OIG case reports generally were thorough, comprehensive, and addressed the allegation. All case files in our sample contained a case report and a library sheet. Additionally, progress notes were obtained in cases where they were pertinent. We did find that photographs were not taken in 5 of 11 cases where an injury report indicated that an injury was sustained.

The Deputy Inspector General did not review all substantiated cases of abuse or neglect as required by OIG's investigative guidance.

Our fieldwork sample contained 18 substantiated cases of abuse or neglect. Twelve of the 18 substantiated investigations were completed by community agencies. None of these 12 cases were reviewed by the Inspector General, the Deputy Inspector General, or a designee. We recommended that the Inspector General assure that all cases requiring review by the Inspector General, the Deputy Inspector General, or a designee receive that review.

Community Agency Investigations

In general, investigations by the community agencies were complete and thorough in our sample of cases from FY 2002. However, the Inspector General has made two policy changes related to community agency investigations.

The Inspector General has made two policy changes related to community agency investigations.

- Community agencies now must accept the community agency protocol developed by the OIG and be properly trained or they will not be allowed to conduct <u>any</u> investigations for the OIG.

- As of January 1, 2002, OIG administrative rules were changed so that community agencies can investigate only abuse cases that allege mental injury.

In addition, facilities and community agencies may still investigate reportable incidents that do not meet the definition of abuse and neglect.

There were 304 cases reported in FY 2002 that were investigated by community agencies. In the first half of the fiscal year (between July 1, 2001 and December 31, 2001), 279 cases were investigated by community agencies. The second half of the fiscal year (between January 1, 2002 and June 30, 2002) only 25 cases were investigated by community agencies. The significant decrease in community agency investigations is likely due to policy changes noted above.

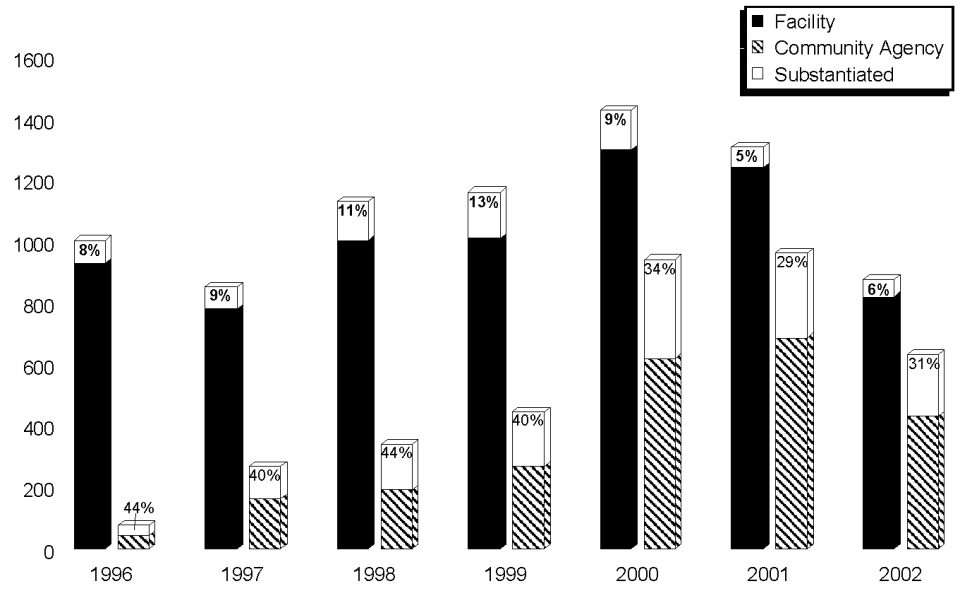
We reviewed the 25 cases that were investigated by community agencies from the second half of FY 2002 to see if the community agencies had adopted OIG investigative protocols. We found one community agency that investigated 3 of the 25 cases but had not adopted the OIG Investigative protocol as required by OIG administrative rule. (pages 25-29)

SUBSTANTIATED ABUSE AND NEGLECT CASES

OIG substantiated abuse or neglect in 253 of 1,503 allegations of abuse or neglect in FY 2002.

In FY 2002, the OIG closed a total of 1,503 investigations of allegations of abuse or neglect. The OIG substantiated 253 of the abuse or neglect allegations, resulting in a 17 percent substantiation rate. Digest Exhibit 3 shows the past seven years' closed cases and substantiation rates for allegations classified as abuse and neglect. The exhibit breaks out both facility and community agency allegations and substantiated cases of abuse and neglect. The data includes substantiated cases investigated by OIG that were classified as abuse or neglect at intake. (pages 31-33)

Digest Exhibit 3
ABUSE AND NEGLECT CASES CLOSED AND SUBSTANTIATED FOR FACILITIES AND COMMUNITY AGENCIES
(Allegations Categorized as Abuse or Neglect at Intake)
Fiscal Years 1996 to 2002



Note: State facilities served 3,388 individuals with developmental disabilities and 10,292 individuals with mental illness in FY 2002. Community agencies served 24,500 individuals with developmental disabilities and 160,000 individuals with mental illness in FY 2002.

Source: OAG analysis of OIG data.

ACTIONS, SANCTIONS, AND RECOMMENDATIONS

We again recommended that the OIG establish a process to insure that all written responses are completed and received.

Although the Office of the Inspector General is statutorily responsible for requiring facilities and community agencies to submit written responses for substantiated cases, they have not established a process to insure that all written responses are completed and received. In our 2000 OIG audit and in this audit, we recommended that the OIG establish a process to track and follow-up on cases that did not provide a written response.

Over the past nine fiscal years (1994 to 2002) the Inspector General has not used sanctions against facilities. The Act (210 ILCS 30/6.2) gives the Inspector General broad authority to recommend sanctions. In our 2000 OIG audit, the OIG's Guidelines included criteria for sanctions. At the close of this audit, the Inspector General was working to develop a new Directive that specifies criteria when sanctions could be recommended.

Digest Exhibit 4 shows the 260 substantiated cases by the type of action taken and by the investigating agency. Administrative action was taken in 78 percent of the cases (202 of 260) and was the most frequently used action in both OIG and community agency investigations.

Digest Exhibit 4
ACTIONS TAKEN ON SUBSTANTIATED CASES
(All Allegations Regardless of Category at Intake) FY 2002

Action	Investigated by		Total
	OIG	Community Agency	
Administrative Action	66	136	202
General Retraining	4	3	7
Policy Creation/Revision	2	4	6
Procedural Clarification	1	0	1
Specific Staff Retraining	8	9	17
Facility Structural Change	0	0	0
Program Changes	0	1	1
Legal Review	0	0	0
None	24	2	26
Total Substantiated	105	155	260

Source: OAG analysis of OIG data.

Administrative actions include, but are not limited to suspension, termination, reprimand, and retraining. (pages 34-38)

OTHER ISSUES

Although training of OIG investigators had improved in our last OIG audit, there were again issues noted in this audit period. In our previous OIG audits, we have had seven total recommendations on training in four of the audits. We again recommended that the Inspector General should ensure that all OIG investigators meet training requirements as set forth by OIG investigative guidance.

During Fiscal Years 2001 and 2002, the Quality Care Board did not meet statutory requirements for meeting quarterly. In Fiscal Year 2001, the Board only met twice and in Fiscal Year 2002, the Board met three times. This is the first OIG audit where the Board has not met as required by the Act. However, it appeared that the Board was following other requirements established by the statutes. We recommended that the Inspector General work with the Quality Care Board to assure that the Board meets quarterly as required by statute. (pages 41-44)

RECOMMENDATIONS

The audit report contains eight total recommendations, seven related to the Office of the Inspector General and one recommendation to both the Office of the Inspector General and the Illinois State Police. The OIG and State Police generally agreed with the recommendations. Appendix E to the audit report contains the Inspector General's and the State Police's complete responses.

WILLIAM G. HOLLAND
Auditor General

WGH\EKW

December 2002

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Chapter One

INTRODUCTION AND BACKGROUND

REPORT CONCLUSIONS

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BACKGROUND

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

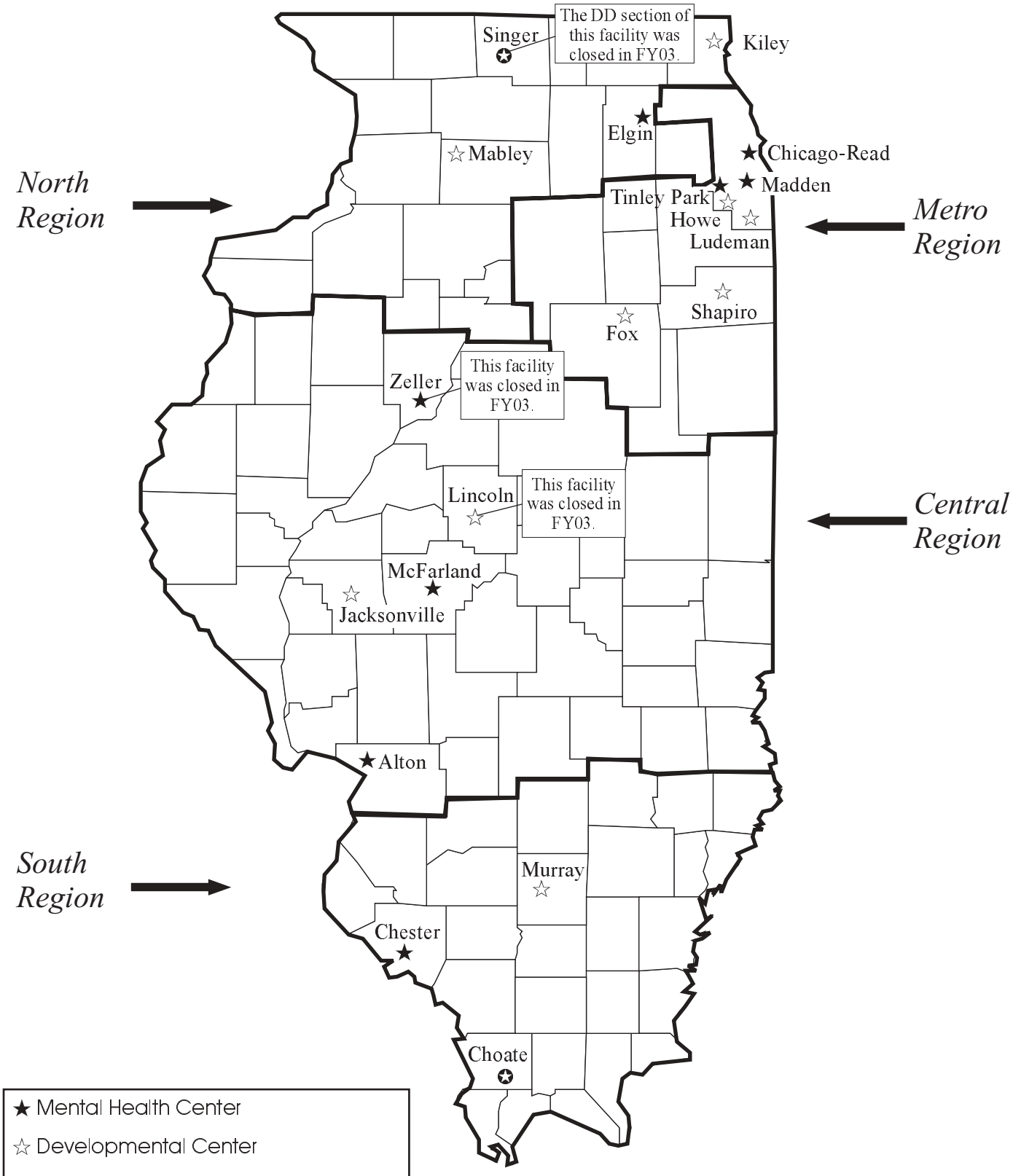
The 1995 amendment to the Act also required the OIG to promulgate rules to establish requirements for investigations that delineate how the OIG would interact with the licensing unit of DHS. These administrative rules (59 Ill. Adm. Code 50) were adopted October 19, 1998. The rules require that facilities and community agencies report incidents of alleged abuse or neglect to the OIG. Since our last OIG audit these administrative rules were revised again with an emergency rule and then a final rule effective May 24, 2002.

The Inspector General is located within the Department of Human Services and is appointed by the Governor and confirmed by the Senate for a four-year term. The current Inspector General was appointed by the Governor in July 2000.

In FY 2002, the Department of Human Services operated 19 facilities Statewide which served 13,680 individuals. Nine facilities served the developmentally disabled, eight facilities served the mentally ill, and two facilities served both. In Fiscal Year 2003 two facilities and half of a third were closed. Exhibit 1-1 shows the location of the 19 facilities, the three closed

Exhibit 1-1

DHS OPERATED RESIDENT FACILITIES AND OIG REGIONS



Source: OIG data summarized by OAG.

facilities, and indicates whether the facilities are part of the OIG's North, Metro, Central, or South region.

In addition, DHS licenses, certifies, or provides funding for over 400 community agency programs that provided services to the developmentally disabled and the mentally ill in community settings within Illinois. These community agency programs provide transportation services, workshops, or community living arrangements. In FY 2002, approximately 24,500 individuals with developmental disabilities and approximately 160,000 individuals with mental illness were served in community agencies required to report to the OIG.

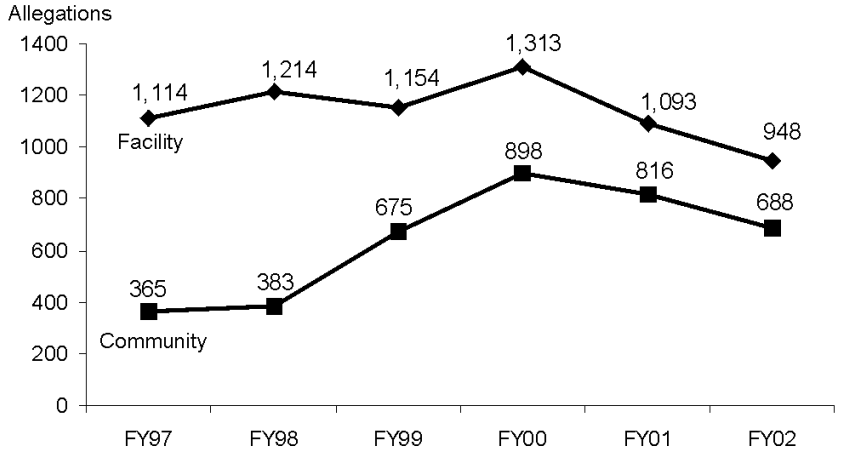
OIG Organization

As of April 2002, the OIG had 68 staff. This represents an increase of nine positions over staffing levels reported in our 2000 OIG audit. However, investigative staff for abuse or neglect investigations have decreased from 39 in FY 2000 to 27 in FY 2002. The largest organizational unit within the OIG is the Bureau of Investigation. The Bureau of Investigation is responsible for conducting investigations of allegations of abuse or neglect. As shown on Exhibit 1-3, the OIG has established four regions within the Bureau of Investigations. Each region has a Bureau Chief, an Investigative Team Leader who is responsible primarily for case file review, and additional investigatory staff. As of April 2002, the Bureau of Investigations had a total of 36 staff, 27 of whom had some investigatory responsibilities. Exhibit 1-3 shows the organizational structure of the OIG and the number of staff in each of the bureaus. In our last audit the OIG had an appropriation of $4.2 million for FY 2000. In FY 2001 the appropriation was $4.6 million and in FY 2002 the appropriation was $6 million.

Trends in Allegations of Abuse or Neglect

In FY 2002, a total of 1,636 allegations of abuse or neglect were reported to the OIG (948 from State facilities and 688 from community agencies). Exhibit 1-2 summarizes abuse or neglect allegations reported to the OIG from the two sources for Fiscal Years 1997 to 2002. For perspective, a note to the exhibit contains DHS statistics on the numbers of individuals served in State facilities and by community agencies.

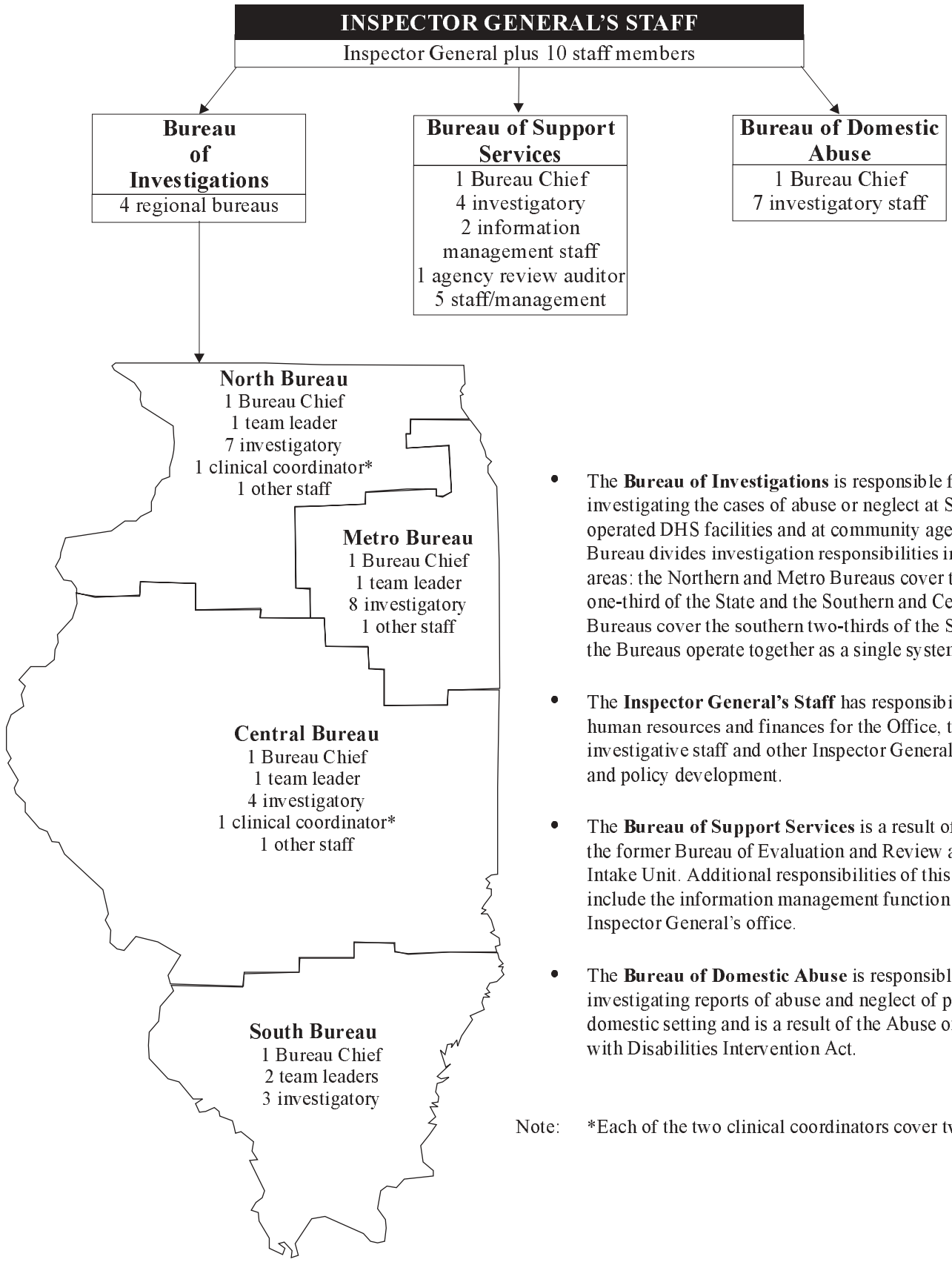
Exhibit 1-2
TOTAL ABUSE OR NEGLECT ALLEGATIONS REPORTED TO OIG



Note: State facilities served 3,388 individuals with developmental disabilities and 10,292 individuals with mental illness in FY 2002. Community agencies served 24,500 individuals with developmental disabilities and 160,000 individuals with mental illness in FY 2002.

Source: OAG analysis of OIG data.

Exhibit 1-3
OIG ORGANIZATIONAL CHART
As of April 2002



- The **Bureau of Investigations** is responsible for investigating the cases of abuse or neglect at State-operated DHS facilities and at community agencies. The Bureau divides investigation responsibilities into four areas: the Northern and Metro Bureaus cover the northern one-third of the State and the Southern and Central Bureaus cover the southern two-thirds of the State. All of the Bureaus operate together as a single system.

- The **Inspector General's Staff** has responsibility for human resources and finances for the Office, training of investigative staff and other Inspector General employees, and policy development.

- The **Bureau of Support Services** is a result of combining the former Bureau of Evaluation and Review and the Intake Unit. Additional responsibilities of this Bureau include the information management function for the Inspector General's office.

- The **Bureau of Domestic Abuse** is responsible for investigating reports of abuse and neglect of persons in a domestic setting and is a result of the Abuse of Adults with Disabilities Intervention Act.

Note: *Each of the two clinical coordinators cover two bureaus.

Source: OIG data summarized by OAG.

OIG INVESTIGATIONS

In Fiscal Year 2002 the Inspector General made a very significant change in which cases the OIG will investigate. During most of our audit period, the OIG used four levels of OIG investigatory involvement in investigations: conducted, led, directed, and reviewed. OIG conducted investigations had the highest level of investigator involvement. Under the other three levels, many of the investigative responsibilities were delegated to community agency or facility staff and were reviewed by OIG.

The OIG no longer uses this four level system. Under the new system the OIG will investigate all allegations of abuse and neglect at State facilities and community agencies unless the report is of mental injuries. This should increase the number of investigations for which OIG is responsible. However, the OIG will not investigate injury cases that do not allege abuse or neglect. This change should reduce the number of cases the OIG investigates, but the overall effect of these two changes is not known.

During our audit period, the investigation process began when an allegation was reported to the OIG Hotline or the field investigator and the OIG Incident Report Form was completed by OIG Intake staff. The case was then assigned to the investigator responsible for that facility or region (for community agencies). Depending on the allegation and the direction by the OIG investigator, the facility or community agency personnel collected physical evidence and took initial statements from those involved in the incident about the alleged abuse or neglect.

The responsibility for death investigations is shared between the OIG Clinical Coordinators and the Bureau of Investigations. If the Clinical Coordinator determines the death was attributed to abuse or neglect, the Bureau Chief is notified and an OIG investigator is assigned. The Clinical Coordinator assists with the investigation, but the standard OIG investigation process is followed.

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

For cases that involve medical issues, OIG investigative guidance requires that an OIG Clinical Coordinator be contacted to consult, participate in the investigation, request consultation from DHS Clinical Services, and provide an opinion to be included in the report. All substantiated and unsubstantiated cases involving medical issues are to be forwarded to the Inspector General or designee for review.

The OIG sends community agencies and facilities a copy of the investigative report that includes the OIG's finding in the case. 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. If any of these parties disagrees with the finding or wants more information, they have 15 days from the receipt of the investigative report to request in

writing reconsideration or clarification. All requests must include new information that could change the finding.

If the case contains substantiated findings or recommendations, the community agencies or facilities are required within 30 days to submit a written response that addresses the actions that they will take. If reconsideration was requested and denied, the community agency or facility shall submit a written response to the Inspector General within 15 days after the receipt of the clarification or denial of reconsideration.

CHANGES IN INVESTIGATIVE GUIDANCE

Various changes in investigative guidance may have left investigative staff unclear on appropriate definitions and investigative requirements. In past audits of the Inspector General's Office we have reviewed a number of different versions of guidance that investigators are to follow. In this audit we did our testing from cases closed in Fiscal Year 2002. During that time period, the old version of administrative rule 50 was in effect from July to December, and then an emergency rule was in effect from January through part of May, and finally a new version of rule 50 was in effect for part of May through June.

In addition, the OIG had memos, Directives, and Guidelines that were all in effect during portions of this audit period. Investigative Guidelines were a portion of the investigative guidance that was in effect during our last OIG audit which was released in December of 2000. But by January of 2001 several memos were issued to change investigative guidance. Then, in January to March 2002 a number of Directives came out to change investigative guidance. Some Directives followed similar memos. For example, a memo on a case management system was issued in January of 2001 and was followed with a Directive in February of 2002. Directives sometimes rescinded or amended portions of the Guidelines, but portions of the Guidelines were still in effect when we were completing our fieldwork.

Among the changes in investigative guidance for this audit are that some of the elements, which were required elements for certain investigations, are now left to the judgement of the investigator. For example, Guidelines contained sections on conduct of the investigation and the investigative plan, which discussed the investigations, evidence, and the types of evidence that could be collected. With a Directive, the two sections on conduct of the investigation and the investigative plan were rescinded. The new replacement Directive does not discuss the types of evidence to be collected.

Another change that has been made in the administrative rule was to change the timeliness requirement from 60 calendar days to 60 working days. For analytical purposes we will continue to analyze timeliness using 60 calendar days so that OIG timeliness can be evaluated over time. Without considering the change in counting days, for FY 2002 OIG timeliness had improved. In FY 2002, 46 percent of cases were completed within 60 calendar days while in 2000 only 25 percent were completed in 60 calendar days. More details on investigative timeliness are included in Chapter Two of this report.

Defining Abuse and Neglect

Another example of changing guidance was in the definitions of abuse and neglect. "Abuse" is defined in the statute as: any physical injury, sexual abuse, or mental injury inflicted on a resident other than by accidental means. Statutorily, "neglect" is: a failure in a long term care facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition (210 ILCS 30/3). Over the past several years, three versions of abuse and neglect definitions have been:

1. Through departmental policy, abuse was defined more narrowly than the statutory definition. The policy limited OIG investigations to allegations of abuse or neglect of an individual by an employee.

2. Through OIG Guidelines and administrative rules, the OIG's definition of abuse expanded to include both resident abuse by an employee and abuse with a serious injury by another person who is not an employee. The rule also expanded the definition of neglect to include and explain, among other elements, endangering an individual with or without an injury, absence from a program, and inappropriate sexual conduct that would result in neglect.

3. When the administrative rule was revised with an emergency rule in January 2002 and a final rule in May 2002 the definitions of abuse and neglect were changed so that they matched the statutory definition.

When the Investigative Guidelines were established in 1997 they had similar and lengthy definitions of abuse and neglect. In July 2002, an OIG memo rescinded the section of the Guidelines that defined abuse and neglect. When we were completing our audit fieldwork, no definitions had been issued in Directives.

Our prior OIG audits have recommended developing investigative guidance and have recommended changes and additions to that guidance. Although the OIG officials should continue to work to make investigative guidance meaningful for investigators, they should also consider maintaining baseline criteria and guidance so that reductions or improvements in investigative effectiveness can be monitored over time. They also should assure that continued changes in investigative guidance help investigations staff, particularly less experienced staff, and not confuse them.

CLARIFYING INVESTIGATIVE GUIDANCE	
RECOMMENDATION 1	***The Inspector General should assure that clear and consistent investigative guidance is available for investigators which allows investigative effectiveness to be judged over time.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	The first Inspector General with command law enforcement experience and an investigative background was appointed beginning FY-2001. During the evaluation period of the Office of the Inspector General, between July 2000 and January 2001, it was determined that the Investigative Guidelines were very vague and without consistent investigative direction. Beginning March 2001, Investigative Guidelines began to be converted into Investigative Directives. To ensure that clear and consistent investigative guidance was followed during the conversion period the following procedure was implemented. When inconsistencies in the Guidelines were discovered a memorandum outlining the changes in the investigative procedures was issued until a new directive was established. Investigative standards are and should be based on clear and definitive operational procedures and not questionable or unclear operational procedures. This change from Guidelines to Directives was done to ensure accountability and that investigative procedures were clear and consistent throughout all of the investigative bureaus.

OTHER STATE AGENCIES

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

Illinois State Police

Neither the OIG nor State Police are fulfilling statutory responsibilities established under the Abused and Neglected Long Term Care Facility Residents Reporting Act. The Act requires:

> The Inspector General shall within 24 hours after receiving a report of suspected abuse or neglect determine whether the evidence indicates that any possible criminal act has been committed. If he determines that a possible criminal act has been committed, or that special expertise is required in the investigation, he shall immediately notify the Department of State Police. (210 ILCS 30/6.2 b)

The OIG and Illinois State Police's relationship has been guided by Administrative Order 1999-3 to investigate all criminal allegations of State employees who work at any agency under the control of the Governor. The Administrative Order provides guidance related to allegations involving State employees but not other allegations against non-State employees where evidence indicates a possible criminal act. An OIG official reported that State Police does not want non-State employee reports. A State Police official said that facility employees understand the procedure and just reach out to the local jurisdiction. However, the Act also covers abuse and neglect allegations from community agencies and no agreement has been established dealing with non-State employee allegations. The Abused and Neglected Long Term Care Facility Residents Reporting Act, in the same section, requires that when OIG notifies State Police of cases with possible criminal acts then:

> The Department of State Police shall investigate any report indicating a possible murder, rape, or other felony (210 ILCS 30/6.2 b).

Even in cases investigated by Illinois State Police, OIG may conduct a separate investigation after the State Police investigation is completed. State Police officials stated that this is because they only look at the criminal aspects of the incident; it is up to the OIG to examine any administrative issues relating to the incident.

The most recent version of OIG's administrative rule does not require OIG to report all possible criminal acts to State Police as required by statutes. In these new OIG rules, OIG amended the section on reporting to State Police to say State Police **or** local law enforcement authorities, as appropriate. This was changed from **and** local law enforcement authorities, as appropriate. OIG can notify State Police **and** locals but the Abused and Neglected Long Term Care Facility Residents Reporting Act is clear that State Police must be notified of all possible criminal acts.

Although the Act originally limited the OIG's authority to only State facilities, since 1995 the Inspector General's responsibility has included the authority to investigate reports of abuse or neglect at community agencies. The OIG should assure that allegations at community agencies, where a possible criminal act has been committed, are referred as required.

INVESTIGATING CRIMINAL ALLEGATIONS	
RECOMMENDATION 2	***The Office of the Inspector General and State Police should assure that notification and investigation requirements in the Abused and Neglected Long Term Care Facility Residents Reporting Act are satisfied (210 ILCS 30/6.2 b). This should include an interagency agreement that stipulates responsibilities and should include revising the current administrative rules to be consistent with the Act (59 Illinois Administrative Code 50.50 h).***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	The Office of the Inspector General will work with the Illinois State Police to ensure that criminal allegations are reported to the appropriate law enforcement authority. Also, the Office of the Inspector General will further clarify its investigative role with the State Police through a signed interagency agreement to be completed by December 31, 2002. When the Act was originally adopted OIG's authority was limited to State Operated Facilities. After 1995, the Inspector General's responsibilities were expanded to include community agencies. As a result an Administrative Rule was created to further clarify the Act and the Inspector General's responsibilities for reporting criminal allegations in the community agencies.
STATE POLICE RESPONSE	The ISP is working with DHS to establish an interagency agreement which stipulates responsibilities of each agency for the purpose of ensuring reporting procedures, notification protocols and investigation requirements for all matters subject to the Abused and Neglected Long Term Care Facility Residents Reporting Act. Both agencies are also cooperatively developing a system to monitor cases referred to the ISP to ensure the cases are disposed of properly and in a timely manner.

Department of Public Health

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

OIG currently has an interagency agreement with Public Health. Officials at OIG and Public Health met on May 17, 2002 to review the current agreement. It was decided that there was no need for any changes to the agreement at that time.

Department of Children and Family Services

The Abused and Neglected Child Reporting Act (325 ILCS 5/1 *et seq*.) mandates that many persons, including State employees, immediately report incidents of suspected abuse or neglect of all persons under the age of 18 to DCFS. DCFS then has 14 days to investigate and determine if abuse or neglect is indicated and a total of 60 days to conduct the investigation. According to documentation provided to us by OIG, an interagency agreement was executed by DCFS and OIG on November 20, 2000. The agreement has no provision for annual review and is therefore still effective at this time. This agreement specifically states that OIG is to investigate only 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 OIG to notify DCFS upon completion of these investigations and provide a copy of the investigation upon request.

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.

Initial work began on this audit in March 2002 and fieldwork was concluded in October 2002. We interviewed representatives of the Inspector General's Office, the Department of Human Services, the Department of Public Health, State Police, and the Department of Children and Family Services. We reviewed documents at the Inspector General's Office, State Police, DCFS, and Public Health. We examined the current OIG organizational structure, policies and procedures, investigations process, case review process, and documentation requirements. We also reviewed internal controls over the investigation process. We reviewed backgrounds for investigators hired since our last OIG audit and reviewed investigator's training records. We tested a sample of cases from Fiscal Year 2002 and analyzed electronic data from Fiscal Years 2001 and 2002. A more complete description of our testing and analyses are in Appendix B of this report. Our audit work included follow-up on previous OIG audit recommendations.

We assessed risk by reviewing recommendations from all six previous OIG audits, OIG internal documents, policies and procedures, management controls, and the newly adopted OIG administrative rule. We reviewed management controls relating to the audit objectives which were identified in section 6.8 of the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6.8 see Appendix A). This audit identified some weaknesses in those controls which are included as recommendations in this report.

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

The Office of the Auditor General has conducted six prior OIG audits to assess the effectiveness of their investigations into allegations of abuse and neglect, as required by the statute (210 ILCS 30/6.8). These audits were released in 1990, 1993, 1994, 1996, 1998, and 2000. Exhibit 1-4 summarizes the findings for these audits.

There have been findings and recommendations concerning timeliness in all of our OIG audits. Case file documentation and training issues have appeared as findings and recommendations in many of our OIG audits.

Exhibit 1-4
AUDITOR GENERAL PRIOR AUDIT RECOMMENDATIONS CONCERNING THE OIG

Recommended Area for Improvement	Audit Release Date					
	May 1990	April 1993	December 1994	December 1996	December 1998	December 2000
Allegation Reporting						X (1)
Annual Report		X (1)	X (1)			
Case Closure						X (1)
Community Investigations				X (1)	X (1)	X (1)
Data Accuracy			X (1)	X (2)		
Documentation	X (3)	X (1)	X (2)	X (2)		
Duplicate Investigation				X (1)	X (1)	
Interagency Agreements						X (1)
Investigations				X (1)		X (1)
Mission and Goals						X (1)
Monitoring	X (1)			X (1)	X (1)	
Reporting to DPR					X (1)	
Review		X (1)	X (1)	X (1)	X (1)	X (1)
Sanctions				X (1)	X (1)	
Site Visits	X (1)		X (1)			
Staff			X (1)			
Timeliness	X (1)	X (1)	X (1)	X (2)	X (2)	X (1)
Training	X (1)	X (1)		X (3)	X (2)	
Year 2000 Compliance					X (1)	
Matter for Consideration			X (1)			
Total Recommendations	7	5	9	15	11	8

Note: The number in parentheses indicates the number of recommendations in the report on that topic.

Source: 1993, 1994, 1996, 1998, 2000 OIG Audits; and 1990 Abuse and Neglect Program Audit.

REPORT ORGANIZATION

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

- **Chapter Two** examines the timeliness of abuse or neglect investigations.
- **Chapter Three** discusses the thoroughness of abuse or neglect investigations.
- **Chapter Four** reviews actions, sanctions, and recommendations.
- **Chapter Five** discusses OIG investigator training and the Quality Care Board.

Chapter Two

TIMELINESS OF ABUSE OR NEGLECT INVESTIGATIONS

CHAPTER CONCLUSIONS

While overall timeliness of investigations has been an issue in the previous six OIG audits, there has been noteworthy improvement in Fiscal Year 2001 and 2002. One of the clearest indicators of this improvement is that in Fiscal Year 2002, 46 percent of investigations were completed in 60 days while in Fiscal Year 2000 only 25 percent were completed within 60 days. Although improvement is still needed, significant progress was made. We recommended that the Inspector General continue to work to improve the timeliness in investigations of abuse and neglect.

Alleged incidents of abuse or neglect are not being reported to the OIG by facilities and community agencies in the time frames required by OIG administrative rule. We recommended that the Inspector General work with State facilities and community agencies to ensure that allegations of abuse or neglect are reported within the time frame specified in State law and OIG administrative rules.

INVESTIGATION TIMELINESS

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

The OIG changed the definition of days in administrative rules in January 2002 to be working rather than calendar days. Sixty working days generally works out to over 80 calendar days. Although we will consider working days in some of our discussions the bulk of our analysis will still use 60 calendar days so that comparisons can be made over time.

While overall timeliness of investigations has been an issue in the previous six OIG audits, there has been noteworthy improvement in FY 2001 and FY 2002. One of the clearest indicators of this improvement is that in FY 2002, 46 percent of investigations were completed in 60 calendar days, while in FY 2000 only 25 percent were completed in 60 calendar days. Although improvement is still needed, significant progress was made.

Exhibit 2-1
CALENDAR DAYS TO COMPLETE ABUSE OR NEGLECT INVESTIGATIONS
Fiscal Years 1997-2002

Days to Complete Cases	FY 1997 % of Cases	FY 1998 % of Cases	FY 1999 % of Cases	FY 2000 % of Cases	FY 2001 % of Cases	FY 2002 % of Cases
0-60	**41%**	**14%**	**21%**	**25%**	**49%**	**46%**
61-90	27%	19%	10%	18%	18%	31%
91-120	17%	16%	11%	14%	11%	13%
121-180	12%	29%	23%	16%	10%	6%
181-200	2%	6%	6%	4%	2%	1%
>200	1%	16%	30%	23%	10%	3%
Total > 60 days	**59%**	**86%**	**79%**	**75%**	**51%**	**54%**
Total Cases by FY	964	1,308	1,507	2,341	1,883	1,442

Note: Analysis excludes cases investigated by the Illinois State Police. "Completed cases" shown in this Exhibit are cases where the OIG issued a Preliminary Report to the State facility or community agency in the fiscal year. "Closed cases," referred to later in this report, are cases where the OIG sent the final report to the Secretary of DHS in the fiscal year.

Source: OAG analysis of OIG data.

Overall it took an average of 152 days and a median of 121 days to complete an investigation of abuse or neglect in FY 1999 and FY 2000. In FY 2001 the average was 90 days and the median was 62 days. In FY 2002 the average decreased to 76 days and the median was 64 days.

In FY 2002, the OIG completed 46 percent of its investigations within 60 calendar days. This was a slight decrease from FY 2001 when 49 percent were completed within 60 calendar days, but a significant improvement compared to prior years. Exhibit 2-1 shows the percentage of cases completed in terms of ranges of the number of days to completion for Fiscal Years 1997 to 2002. Case completion is measured from the date the allegation of abuse or neglect is reported to 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.

Cases Over 200 Days

The number of cases taking more than 200 days to complete has also decreased significantly from FY 2000. In FY 2000, 547 cases took longer than 200 days to complete. By FY 2002, the cases taking longer than 200 days to complete decreased to 41. Exhibit 2-2 shows the types of allegations taking more than 200 days to complete in FY 2000 and FY 2002. Investigations at State facilities completed during FY 2002 accounted for 46 percent (19 of 41)

of the cases that took longer than 200 days to complete and community agency investigations accounted for 54 percent (22 of 41).

In FY 2000, of the four OIG Investigation Bureaus, the North Bureau accounted for the majority of cases taking longer than 200 days to complete (59 percent). By FY 2002, the four bureaus were more similar with the North Bureau still having the largest with 44 percent taking longer than 200 days. The other three bureaus had: Metro 15 percent; Central 20 percent, and South 22 percent.

Exhibit 2-2
TYPES OF ALLEGATIONS FOR CASES OVER 200 DAYS TO COMPLETE
Fiscal Years 2000 and 2002

Type of Allegation	FY00	FY02
Neglect	192	7
Physical Abuse	154	7
Verbal Abuse	84	0
Death	59	22
Psychological Abuse	0	3
Sexual Abuse	28	2
Other	30	0
TOTAL	547	41

Source: OAG analysis of OIG data.

In FY 2000, Elgin Mental Health Center accounted for a large proportion of the State facility cases over 200 days old, followed by Kiley Developmental Center and Chicago-Read Mental Health Center. This pattern is now more widely distributed among all the State facilities. In FY 2002 three facilities were tied for the highest percentage of cases taking more than 200 days, each with 7 percent of the cases. The three were Choate Mental Health and Developmental Center, Elgin Mental Health Center, and Jacksonville Developmental Center.

DELAYS IN CASE COMPLETION

There are aspects of some investigations that are outside the direct control of OIG, for example, cases that were referred to Illinois State Police or to Clinical Services at the Department of Human Services. For these types of cases the average case completion time is greater than for others. Since our last audit, the OIG made a process change that has improved timeliness for cases with clinical issues.

Illinois State Police

Statutes require that the OIG notify State Police within twenty-four hours in all reports where a possible criminal act has been committed, or where special expertise is required in the investigation. State Police must then investigate any report indicating a possible murder, rape, or other felony. In our testing of FY 2002 cases, we had six cases which were referred to State Police and all but one case was referred the same day or the next day after the incident.

State Police either conducts an investigation or refers the case back to OIG for investigation. In some instances, the OIG will conduct an investigation in a case even if State Police conducted an investigation. The State Police investigation is a criminal investigation and the OIG investigation is administrative. According to OIG's investigative guidance, OIG conducts no further investigative activity when State Police accepts a case unless requested to do so by State Police. Exhibit 2-3 shows the number of cases referred to State Police and the disposition of those cases.

Exhibit 2-3
DISPOSITION OF CASES REFERRED TO STATE POLICE
Fiscal Year 2002

Disposition	Number of Cases FY00	FY02
Referred back to OIG without investigation	139	85
Investigated by State Police and:		
Declined by Prosecutor	12	9
Not Sustained	3	12
Conviction	2	0
Other	3	6
TOTAL	159	112

Source: OAG analysis of Illinois State Police data.

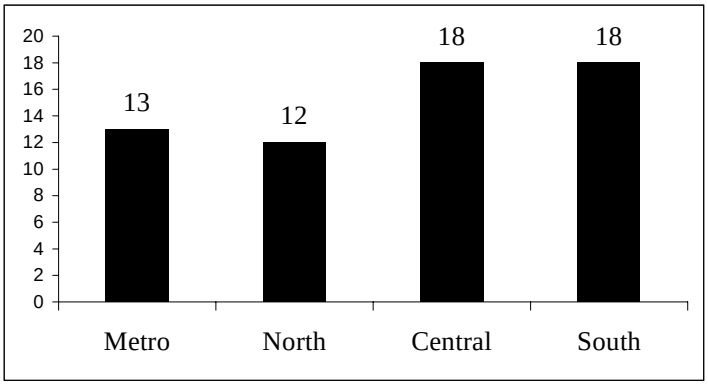
Clinical Services Cases

In our last OIG audit, cases with medical issues were referred to Clinical Services at the Department of Human Services. These referrals may have an impact on the timeliness of investigations. In the current audit period, a Clinical Coordinator within the OIG handles cases with medical issues. The Coordinator works and consults with Clinical Services at DHS and refers questions but does not refer cases. In our prior OIG audit we reported that the average completion time for cases referred to Clinical Services was 302 days compared to 138 days for those not referred. Although cases with clinical issues still took longer in FY 2002, the average days were 217, which is a significant improvement over the prior OIG audit.

Investigator Caseloads

Investigator caseloads do not appear to be a factor in untimely investigations. In our 2000 OIG audit, investigative staff cited caseloads as a reason for not completing investigations in a timely manner. Our review of the number of cases assigned per investigator found the average caseload per investigator to be 12 to 18 cases in the investigative Bureaus as of August 14, 2002.

Exhibit 2-4
AVERAGE ACTIVE INVESTIGATOR CASELOADS
By Bureau as of August 14, 2002



Source: OIG Data Summarized by the OAG.

Exhibit 2-4 shows the average active caseload per investigator by investigative bureau as of August 14, 2002. The Central and South Bureaus averaged 18 cases per investigator while the Metro and North Bureaus averaged 13 and 12 respectively. The South Bureau did have a significant number of cases (18) assigned to the Investigative Team Leader and not to an investigator.

Time to Initiate the Investigation

Timely initiation of an investigation is important because memories may fade or witnesses may become unavailable for follow-up interviews. Therefore, one possible way to help determine the effectiveness of an investigation, is to measure the length of time it took to initiate the investigation. Delays in getting accounts from those involved, especially from the alleged victim, increases the risk of losing information and weakening the evidence obtained.

OIG procedures allow an investigator to authorize facility or community agency staff to take initial statements from victims or perpetrators. The decision to allow facility or community agency staff to take initial statements is based on factors which include the seriousness of the allegation and where the assigned investigator is located within the State. The facility or community agency staff must be trained as statement takers to allow the OIG to assign the duty of taking initial statements. According to OIG officials, all facilities operated by the State have at least one person on staff trained as statement takers. The use of a trained statement taker allows OIG to gather initial statements from victims and alleged perpetrators in a timely fashion.

In the OIG investigations that we sampled, the average time until an initial interview with a victim was 3 days and the average time until initial interviews with perpetrators was 8 days. These statistics are for cases where the interview was conducted by a statement taker or an OIG investigator and was for cases where interviews were feasible (i.e. resident is capable of verbal communication, case is not a death case).

Timeliness of Case File Reviews

Guidelines during the current audit period included a three level supervisory review with no mention of a timeline. The only specific time requirement concerned the amount of time the OIG had to send the report to the DHS facility or community agency after all reviews were complete. OIG has issued a new Directive effective July 1, 2002 that now allows Investigative Team Leaders and Bureau Chiefs each five working days to review substantiated and priority cases and 10 working days to review unsubstantiated and unfounded cases. However, since this new Directive was not effective until FY 2003, compliance with it was not tested in this audit.

Once the investigator completes the investigation and writes the Preliminary Report, the report is submitted for review. During the audit period, Guidelines stated that the investigative case file (including the Preliminary Report) is reviewed by the Investigative Team Leader, Bureau Chief, and if necessary (substantiated cases), the Deputy Inspector General.

The timeliness of case file review by OIG management improved from the last OIG audit. In FY 1999 and FY 2000 the median number of days in review were 21 days and 19 days

respectively. In FY 2001 and 2002 the median number of days in review were 13 and 14 respectively. Although the median number improved from our last audit, the average days to review a case in FY 2001 was 20.7 and in FY 2002 was 20.6. This is one-third of the 60-day requirement that the OIG has to complete a case. Improvements in the time it takes to review cases could have a substantial effect on the overall timeliness of case completions at the OIG.

CASE MANAGEMENT SYSTEM FOR TIMELINESS

Although timeliness has improved since our last audit, the OIG does not have a good method to document for all cases what is preventing completion of cases that go over the 60-day completion requirement and to assure that cases continue to have investigative progress. In January 2001, the Inspector General issued a memo saying that a case management system would be implemented February 1, 2001. In February 2002, an OIG Directive was issued that established the policy for the case management system along with the authority, responsibilities and related procedures. The system is not electronic but a paper based system where each investigator submits one form for each case if it is not completed within 30 days and within 45 days of assignment. Team leaders review the investigator's reports, sign off on them and submit a monthly report on them to their supervisor, the Bureau Chief. Bureau Chiefs then submit a monthly report to the Deputy Inspector General which shows all cases more than 45 days old. This report should include the reason for the delay, the actions needed to complete the investigation, and the expected date of completion.

Our analysis showed that February 2002 reports that Bureau Chiefs prepared did not contain all of the cases over 45 days old. Less than 30 percent of cases over 45 days old were included on the case management reports. When the reports are incomplete, Bureau Chiefs cannot rely on them to adequately monitor timeliness.

In our prior audit, the OIG required case files that take over 60 days to complete to include a note which identified a "barrier to completion." Of cases we reviewed which required a notation, 67 percent did not include the required documentation. The new Case Management System is the substitute documentation of why cases are not being completed and is not successful in doing that.

POTENTIAL FOR CONTINUED TIMELINESS PROBLEMS

The OIG may continue to have problems completing cases in the required 60 days. Although timeliness had improved in recent years, Exhibit 2-5 shows that as of September 13, 2002, each bureau has over 50 percent of open cases that had already exceeded the 60-day requirement. These cases are already worse than the timeliness rates that the OIG achieved for FY 2001 and FY 2002, and none of these cases are completed.

Increased investigation responsibilities is a contributing factor that may continue to prevent the OIG from completing investigations in 60 days. Since our last audit the OIG has lost 4 investigators, and additional positions may be lost due to budget restrictions and early retirements. In both the emergency rule approved on January 1, 2002 and the adopted rule effective on May 24, 2002, the OIG has limited community agencies' ability to conduct

investigations to include only mental injury cases. In addition, the OIG now has responsibilities for the Adults with Disabilities Abuse Project. These changes will increase OIG responsibilities and caseloads for alleged abuse and neglect cases. Declining staff and increasing caseload has already affected how long it takes for an investigation to be completed.

TIMELINESS OF CASE COMPLETION	
RECOMMENDATION 3	***The Inspector General should continue to work to improve the timeliness in investigations of abuse and neglect.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	We acknowledge the improvement in the timeliness of our investigations. The Office of the Inspector General will continue to work to improve the timeliness of investigations.

Exhibit 2-5
CASES OVER THE 60-DAY REQUIREMENT
as of September 13, 2002

OIG Bureaus	Number of Cases Open Over 60 Days	Percent of Cases Over 60 Days	Total Open Cases
Central	45	58%	78
Metro	83	54%	155
North	76	72%	106
South	55	54%	102
Total	259	59%	441

Source: OIG data summarized by OAG.

FACILITY NOTIFICATION AND RESPONSE

After the investigative report review process is completed and the report has been accepted by the Inspector General, the facility or community agency needs to be 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. The OIG Directives and administrative rules establish a detailed reconsideration or clarification process that allows the notified parties 15 days to submit a reconsideration request. If the facility or community agency disagrees with the outcome of the investigation, they may request that the Inspector General further explain the findings, or request the Inspector General to reconsider the findings based on additional information submitted by the community agency or facility. After a community agency or facility request for

reconsideration or clarification is received, the Inspector General has 15 working days to notify the community agency or facility of a decision to either accept or deny their request.

For cases closed in FY 2001, the OIG received 43 requests for reconsideration and clarification and in FY 2002 they received 19 requests. We could not determine if the community agencies and facilities were timely in requesting reconsideration because the OIG's data was incomplete. After the investigative report is sent and no response for reconsideration or clarification is submitted to the OIG, the case is closed after 30 days and the case is considered final.

In substantiated cases, the facility or community agency must provide a written response. It must be sent to the OIG within 30 days and include steps to protect individual(s) from abuse or neglect, including implementation dates. The OIG requires community agencies and facilities to submit a written response for substantiated cases, however, 30 days after the investigative report is sent out, the OIG closes the case regardless if they have the required written responses or not. Substantiated cases of abuse or neglect also must be reported to the Secretary of the Department of Human Services. The Secretary has the authority to accept or reject the written response and determine if the facility or program followed the approved response.

TIMELY REPORTING OF ALLEGATIONS

Alleged incidents of abuse and neglect are not being reported to the OIG by facilities and community agencies in the time frames required by OIG administrative rule. Improvement in time to report incidents was not realized until the second half of FY 2002 when the OIG revised the reporting requirement from one to four hours after discovery of the incident. In the first half of FY 2002, the reporting times by facilities and community agencies were almost identical to the times from the 2000 OIG audit.

- **Facility** -33 percent of facility incidents were not reported within the one-hour time frame in FY 2000 compared to 30 percent in the first half of FY 2002.
- **Community Agency** -65

Exhibit 2-6
ALLEGATIONS OF ABUSE OR NEGLECT REPORTED BY FACILITIES/COMMUNITY AGENCIES

All Fiscal Year 2002	**Facility**	**Agency**
Allegations in this Analysis*	868	619
July 1, 2001 – December 31, 2001 (One Hour Reporting Requirement)		
Total Allegations	476	350
Number of allegations not reported timely	140	220
Percent of allegations not reported timely	**30%**	**63%**
January 1, 2002 – June 30, 2002 (Four Hour Reporting Requirement)		
Total Allegations	392	269
Number of allegations not reported timely	64	135
Percent of allegations not reported timely	**16%**	**50%**

***** This does not include 80 facility and 49 community agency cases where data did not allow us to do the analysis. For example, some cases had a date but not the time reported.

Source: OAG analysis of OIG data.

percent of community agency incidents were not reported within the one-hour time frame in FY 2000 compared to 63 percent in the first half of FY 2002.

In January 2002, the OIG increased the required reporting time from one hour to four hours. This increase in the time requirement improved the timeliness substantially. Facility incidents not reported timely decreased from 30 percent to 16 percent, and community agency incidents not reported timely decreased from 63 percent to 50 percent. Exhibit 2-6 shows the time to report incidents for facilities and community agencies before and after the time required was increased by the OIG in January 2002.

REPORTING	
RECOMMENDATION 4	***The Inspector General should work with State facilities and community agencies to ensure that allegations of abuse or neglect are reported within the time frame specified in State law and OIG administrative rules.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	As the audit notes there has been a substantial improvement in the reporting time of allegations of abuse and neglect. The Office of the Inspector General will continue to monitor and ensure that allegations of abuse and neglect are reported within the time frame required.

Chapter Three

THOROUGHNESS OF ABUSE OR NEGLECT INVESTIGATIONS

CHAPTER CONCLUSIONS

OIG case reports generally were thorough, comprehensive, and addressed the allegation. All case files in our sample contained a case report and a library sheet. Additionally, progress notes were obtained in cases where they were pertinent. We did find that photographs were not taken in 5 of 11 cases where an injury report indicated that an injury was sustained.

The Deputy Inspector General did not review all substantiated cases of abuse or neglect as required by OIG's investigative guidance. Our fieldwork sample contained 18 substantiated cases of abuse or neglect. Twelve of the 18 substantiated investigations were completed by community agencies. None of these 12 cases were reviewed by the Inspector General, the Deputy Inspector General, or a designee. We recommended that the Inspector General assure that all cases requiring review by the Inspector General, the Deputy Inspector General, or a designee receive that review.

INVESTIGATION THOROUGHNESS

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

Collection of Evidence

Although the OIG has reduced the amount of required documentation in the investigative case files, cases that we sampled from FY 2002 were generally thorough, comprehensive, and well documented. Current OIG investigative guidance gives the investigator the authority to determine what evidence needs to be collected. Before changes in the current audit period, Investigative Guidelines required that certain evidence be collected for specific types of cases. However, as discussed earlier in this report, the Guidelines related to these types of evidence have been rescinded, and as of the end of our testing period, virtually all elements are to be collected only if the investigator believes that they should be.

The evidence that was required for part of our testing period included: photographs, progress notes, documentation concerning injuries (including documentation that no injury occurred), and restraint/seclusion records. In spite of changes in investigative guidance, we continue to consider these elements important documentary evidence for an investigation and

considered whether individual elements were warranted for us to consider an investigation thorough. In our testing related to these elements we found:

- **Photographs:** Photographs were missing in 5 of 11 cases where an injury report indicated that there was an injury sustained from our sample from FY 2002. Past OIG Investigative Guidelines state that photographs were required in all instances where an injury had been sustained as a result of an incident. Additionally, current OIG administrative rules state that an investigation shall consist of pertinent documents which could include photographs. Photographs of injuries serve as demonstrative evidence to document the size, location and severity of the injury and can indicate when the injury may have been inflicted.

- **Progress Notes:** During the review of our 126 sample cases, we did not find any instances where an investigation failed to obtain pertinent progress notes. However, we did discover discrepancies on the collection of progress notes among the four OIG Investigative Bureaus. We discovered that the North Bureau and Chicago Metro Bureau require progress notes for all cases and that the Central and Southern Bureaus only collect progress notes when they appeared to be pertinent.

- **Restraint/Seclusion Records:** All three cases sampled which met the criteria requiring that a restraint/seclusion record be included contained the appropriate documentation.

CASE MONITORING AND SUPERVISORY REVIEW

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

According to OIG investigative guidance, each OIG investigation is to be thoroughly reviewed, and the reviewer is to complete a standardized case review form indicating questions, comments or instructions for the investigator that were noted during the review. A typical case will move through two and possibly three levels of review (for substantiated cases) before being sent to the facility or community agency.

Documentation of Case Monitoring and Review

In the past, the OIG required that all files contain a Library Sheet, Case File Review Action Slip, Barrier to Completion Notation, Review Sheet and any correspondence received from the facility, community agency, or the entity that is relevant to the case. Recently, OIG Directives have rescinded some of these requirements. For example, barriers to completion and review sheets are no longer requirements of the case file. The OIG does require that case file review be documented on the Case File Review Action Slip or the newly created Case Routing/Approval Form which replaces the Case File Review Action Slip.

Library Sheet – Case Tracking Form

All case files in our sample contained a Library Sheet as required by investigative guidance. The Library Sheet identifies the case, investigator, Investigative Team Leader, and investigating agency. This form's main purpose is to document the case finding, recommendation for action, and action taken in the case. It also indicates the case closure date and the type of allegation that was investigated.

Barrier to Completion

The OIG no longer requires documentation of barriers to completion which were required in our last OIG audit. Instead the OIG uses a Case Management System to monitor cases that are over the 60-day requirement. The Case Management System is discussed in Chapter Two which deals with timeliness. Under Investigative Guidelines, which have since been rescinded, cases that took over 60 days to complete, the Team Leader (first level of review) was required to document on the Library Sheet in the investigation case file a "barrier to completion." The barrier to completion notation was to document the circumstances that caused the case to exceed the 60-day requirement. As has been noted earlier, the OIG administrative rule 50 changed the definition of days from 60 calendar to 60 working days.

Case File Review Action Slip – Case Routing/Approval Form

After a case is submitted for review, the review progress is documented through a Case File Review Action Slip or the newly created Case Routing/Approval Form. After each level of review, the reviewer signs and dates the form to indicate that the review has taken place and sends the case to the next level of review. On these forms, the reviewer can note when the case was sent to special review, clinical, legal, consultant, or another office. All 126 sample cases tested contained either a Case File Review Action Slip or a Case Routing/Approval Form. Generally, the 126 forms appeared to be complete.

Review Sheet

The OIG Review Sheet is used by case file reviewers at each level to document their comments on the case and to suggest further instructions for investigators. Past OIG Guidelines required reviewers to complete a Review Sheet. Almost all of the files that we reviewed, 124 of 126, included review sheets. Current OIG Directives have rescinded the review sheet requirement; however, all review activity is now documented on the Case Routing/Approval Form.

Final Case Reports

OIG case reports that we tested from Fiscal Year 2002 were generally thorough, comprehensive, and addressed the allegation. A well-written final case report is also essential to an effective investigation because it often provides a basis for management's decision on the action warranted in the case. At the OIG, the investigator's final report is reviewed by up to three levels of management who must "sign off" on the case before a recommendation is sent to the facility. Therefore, it is important that the final case report be clear and convincing to

anyone who reads it. The report should address all relevant aspects of the investigation and reveal what the investigation accomplished. All case files in our sample contained a case report.

COMMUNITY AGENCY INVESTIGATIONS

In our last audit, community agencies were required to seek approval from the OIG for their own investigative protocols. We reported problems with many community agencies investigating cases that did not have a protocol that was approved by the OIG. At that time, administrative rules allowed community agencies with approved protocols to investigate: physical or mental abuse without injury or with an injury not requiring medical treatment by a physician; neglect without injury or with an injury not requiring medical treatment by a physician; and deaths from accidents or natural causes.

In general, investigations by the community agencies were complete and thorough in our sample of cases from FY 2002. However, the Inspector General has made two policy changes related to community agency investigations.

- Community agencies now must accept the community agency protocol developed by the OIG and be properly trained or they will not be allowed to conduct any investigations for the OIG.

- As of January 1, 2002, OIG administrative rules were changed so that community agencies can investigate only abuse cases that allege mental injury.

In addition, facilities and community agencies may still investigate reportable incidents that do not meet the definition of abuse and neglect.

There were 304 cases reported in FY 2002 that were investigated by community agencies. In the first half of the fiscal year (between July 1, 2001 and December 31, 2001), 279 cases were investigated by community agencies. The second half of the fiscal year (between January 1, 2002 and June 30, 2002) only 25 cases were investigated by community agencies. The significant decrease in community agency investigations is likely due to policy changes noted above.

We reviewed the 25 cases that were investigated by community agencies from the second half of FY 2002 to see if the community agencies had adopted OIG investigative protocols. We found one community agency that investigated 3 of the 25 cases but had not adopted the OIG Investigative protocol as required by OIG administrative rule.

REVIEW OF SUBSTANTIATED CASES

The Deputy Inspector General did not review all substantiated cases of abuse or neglect as required by OIG's investigative guidance. Although these cases went through other stages of review, OIG Guidelines that dealt with review of the preliminary report required that substantiated case files be submitted to the Inspector General or designee for review and

signature. In addition, an Inspector General memo dated February 1, 2001, states that: "…the Deputy Inspector General shall review all substantiated cases prior to submission to the Inspector General." Third, an OIG Directive which was last revised July 1, 2002, also requires the Deputy Inspector General to review all substantiated cases. Our fieldwork sample contained 18 substantiated cases. Twelve of those investigations were done by community agencies and 6 were done by the OIG. None of the community agency investigations were reviewed by the Inspector General, Deputy Inspector General, or a designee.

REVIEW OF SUBSTANTIATED CASES	
RECOMMENDATION 5	***The Inspector General should assure that all cases that require review by the Inspector General, Deputy Inspector General, or a designee receive that review.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Prior to January 1, 2002, the designee for the review of substantiated cases investigated by community agencies was the Investigation Bureau Chief. This review procedure was in accordance with the OIG Guidelines in effect at that time. As a result of a statutory change that became effective, January 1, 2002, all substantiated cases are to be reviewed by the Inspector General, Deputy Inspector General or a designee. This change was memorialized in an Investigative Directive that was issued April 17, 2002.
	AUDITOR COMMENT: Although the OIG indicates that the Bureau Chief was the designee, they provided no documentation of that designation. In addition, the Bureau Chief reviewed <u>all</u> cases and the Guidelines in effect prior to the Directive state that "When the Bureau Chief approves a substantiated case file, he/she will submit the investigative case file to the Inspector General/designee for review and signature." The Guideline did not differentiate between Facility and Community Agency investigations.

Chapter Four

ACTIONS, SANCTIONS, AND RECOMMENDATIONS

CHAPTER CONCLUSIONS

Although the Office of the Inspector General is statutorily responsible for requiring facilities and community agencies to submit written responses for substantiated cases, they have not established a process to insure that all written responses are completed and received. In our 2000 OIG audit and in this audit, we recommended that OIG establish a process to track and follow-up on cases that did not provide a written response.

Over the past nine fiscal years (1994 to 2002) the Inspector General has not used sanctions against facilities. The Act (210 ILCS 30/6.2) gives the Inspector General broad authority to recommend sanctions. In our 2000 OIG audit the OIG's Guidelines included criteria for sanctions. At the close of this audit, the Inspector General was working to develop a new Directive which specifies criteria when sanctions could be recommended.

During FY 2001 and 2002, the OIG did not meet their established timelines for submitting site visit reports to facilities. During FY 2001, 16 of the 19 facilities received a final site visit report after the 90-day requirement. During FY 2002, 8 of 17 facilities received a final site visit report after the 60-day requirement.

SUBSTANTIATED ABUSE AND NEGLECT CASES

In FY 2002, the OIG closed a total of 1,503 investigations of allegations of abuse or neglect. The OIG substantiated 253 of the abuse or neglect allegations, resulting in a 17 percent substantiation rate. In the following sections and exhibits there are three subsets of substantiated cases of abuse and neglect. There are substantiated cases based on whether it was an allegation of abuse or neglect at intake (253 cases); there are substantiated cases regardless of category at intake (260 cases); and there are 12 additional cases which were investigated by Illinois State Police and local law enforcement, bringing the total of substantiated cases to 272.

Exhibits 4-1 and 4-2 both show the past seven years' closed cases and substantiation rates for allegations classified as abuse and neglect. The exhibits break out both facility and community agency allegations and substantiated cases of abuse and neglect. Exhibit 4-1 shows the data in a table and Exhibit 4-2 shows that data graphically. These numbers and percentages include substantiated cases that were classified as abuse or neglect at intake.

The exhibits show that the number of cases of substantiated abuse or neglect, for both facilities and community agencies, has generally been increasing over the years but has leveled off and was declining by FY 2002. Substantiation rates for both groups had been declining since FY 1999 but showed a slight increase for FY 2002.

Exhibits 4-3 and 4-4 in the next section show substantiated cases for FY 2002 but include 7 more substantiated cases, or a total 260 substantiated cases, because they include cases regardless of category at intake. There were an additional 12 cases investigated by Illinois State Police and local law enforcement that were substantiated bringing the total of substantiated cases to 272.

Exhibit 4-1
ABUSE AND NEGLECT CASES
CLOSED AND SUBSTANTIATED
(Allegations Categorized as Abuse or Neglect at Intake)
Fiscal Years 1996 to 2002

	Closed Cases	Substantiated	
		Cases	Percentage
FY96 Facility	1,001	76	8%
FY96 Community	75	33	44%
FY 1996 Total	**1,076**	**109**	**10%**
FY97 Facility	850	73	9%
FY97 Community	266	106	40%
FY 1997 Total	**1,116**	**179**	**16%**
FY98 Facility	1,129	128	11%
FY98 Community	337	148	44%
FY 1998 Total	**1,466**	**276**	**19%**
FY99 Facility	1,159	152	13%
FY99 Community	445	179	40%
FY 1999 Total	**1,604**	**331**	**21%**
FY00 Facility	1,426	129	9%
FY00 Community	939	321	34%
FY 2000 Total	**2,365**	**450**	**19%**
FY01 Facility	1,293	65	5%
FY01 Community	959	274	29%
FY 2001 Total	**2,252**	**339**	**15%**
FY02 Facility	874	55	6%
FY02 Community	629	198	31%
FY 2002 Total	**1,503**	**253**	**17%**

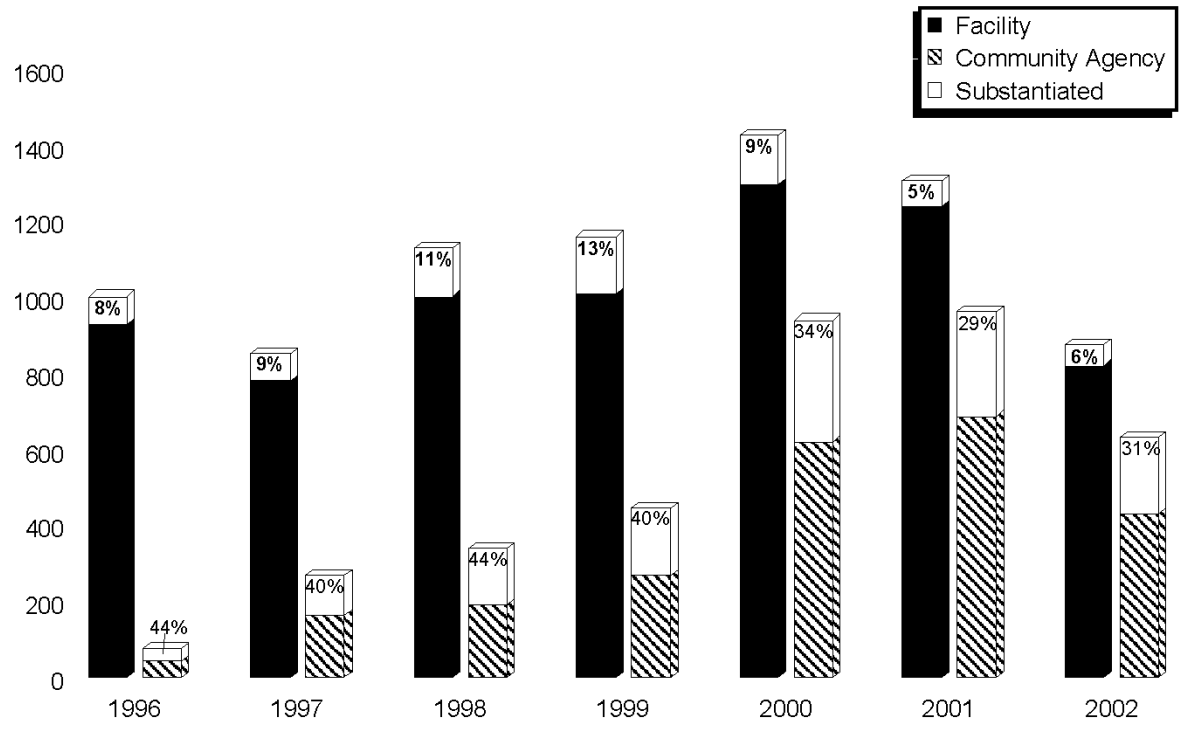
Note: State facilities served 3,388 individuals with developmental disabilities and 10,292 individuals with mental illness in FY 2002. Community agencies served 24,500 individuals with developmental disabilities and 160,000 individuals with mental illness in FY 2002.

Source: OIG information summarized by OAG.

RECOMMENDATIONS AND ACTIONS

At the conclusion of an investigation, the OIG Investigative Team Leader determines whether the evidence in the case supports the finding that the allegation of abuse or neglect is substantiated, unsubstantiated, or unfounded. The case is reviewed and a preliminary report is sent to the facility or community agency notifying them of the results of the investigation.

Exhibit 4-2
ABUSE AND NEGLECT CASES CLOSED AND SUBSTANTIATED FOR FACILITIES AND COMMUNITY AGENCIES
(Allegations Categorized as Abuse or Neglect at Intake)
Fiscal Years 1996 to 2002



Note: State facilities served 3,388 individuals with developmental disabilities and 10,292 individuals with mental illness in FY 2002. Community agencies served 24,500 individuals with developmental disabilities and 160,000 individuals with mental illness in FY 2002.

Source: OAG analysis of OIG data.

If the allegation is substantiated or the OIG had other recommendations, the letter recommends what type of action the OIG thinks should be taken. Some examples of recommendations for actions in substantiated cases include:

- Policy revision or creation;
- Medical/Clinical review;
- Legal review;
- Administrative action against staff;
- Specific retraining of employee; and
- Programmatic changes.

After the recommendation is sent, the facility or community agency generally takes some action to resolve the issues related to the case. For cases closed in Fiscal Year 2002, almost all of OIG's recommendations were taken as actions by facility or community agencies.

Exhibit 4-3 shows the 260 substantiated cases by the type of action taken and by the investigating agency. Administrative action was taken in 78 percent of the cases (202 of 260) and was the most frequently used action in both OIG and community agency investigations. Administrative actions include, but are not limited to suspension, termination, reprimand, and retraining. The exhibit shows 26 cases that were categorized as none.

Exhibit 4-3
ACTIONS TAKEN ON SUBSTANTIATED CASES
(All Allegations Regardless of Category at Intake)
FY 2002

Action	Investigated by		Total
	OIG	Community Agency	
Administrative Action	66	136	202
General Retraining	4	3	7
Policy Creation/Revision	2	4	6
Procedural Clarification	1	0	1
Specific Staff Retraining	8	9	17
Facility Structural Change	0	0	0
Program Changes	0	1	1
Legal Review	0	0	0
None	24	2	26
Total Substantiated	**105**	**155**	**260**

Source: OAG analysis of OIG data.

Exhibit 4-4 shows the type of allegation, who investigated the allegation, and the actions taken in the 260 substantiated cases closed in FY 2002. Appropriate administrative actions to be taken are left to the discretion of the facility or community agency management. Appendix C shows the number of cases closed and a substantiation rate by facility in FY 2001 and FY 2002.

Exhibit 4-4
SUBSTANTIATED CASES BY TYPE OF ALLEGATION AND ACTIONS TAKEN
(All Allegations Regardless of Category at Intake)
FY 2002

TYPE OF ALLEGATION	INVESTIGATED BY			ACTIONS TAKEN
	OIG	Community Agency	TOTAL	
A-2—Physical Abuse w/ Serious Injury	2	0	2	None
A-3—Other Physical Abuse	24	52	76	Administrative Action, Retraining, None
A-4—Sexual Abuse	6	2	8	Administrative Action, None
A-5—Verbal Abuse	8	36	44	Administrative Action, Retraining
A-6—Psychological Abuse	5	11	16	Administrative Action, Retraining, None
A-7—Exploitation	0	2	2	Administrative Action
Total Abuse Cases	**45**	**103**	**148**	
N-1—Neglect w/ Imminent Danger	3	0	3	Administrative Action, Retraining
N-2—Neglect in Serious Injury Cases	17	4	21	Administrative Action, Retraining, Policy Revision, None
N-3—Neglect in Non-serious Injury Cases	16	8	24	Administrative Action, Retraining, Policy Revision, Procedural Clarification, Program Changes, None
N-4—Neglect in an Individual's Absence	6	1	7	Administrative Action, Policy Revision, None
N-6—Exploitation	1	0	1	Administrative Action
N-7—Neglect w/ No Harm / Injury	14	35	49	Administrative Action, Retraining, Policy Revision, None
Total Neglect Cases	**57**	**48**	**105**	
D-2 —Death Due to Suicide Within 14 Days of Discharge	1	0	1	Administrative Action
D-3—All Other Suicides	1	0	1	None
D-6—Death Due to Natural Causes	1	0	1	Retraining
Total Death Cases	**3**	**0**	**3**	
S-4—Serious Injury from Accidental or Unknown Causes	0	4	4	Administrative Action
Total Serious and Other Injuries	**0**	**4**	**4**	
TOTAL SUBSTANTIATED	**105**	**155**	**260**	

Note: Does not include investigations conducted by State Police or Local Law Enforcement, these entities had 12 additional substantiated cases in FY 2002.

Source: OAG analysis of OIG data.

OIG SUBSTANTIATED CASE WRITTEN RESPONSES

The Office of the Inspector General has not established a process to insure that all written responses for substantiated cases from facilities and community agencies are completed and received as required by statute. In our 2000 audit report, we recommended that OIG establish a process to track and follow-up on cases that did not provide a written response.

When the OIG substantiates a case, they must require the facility or community agency to provide a written response. The statute states:

> For cases where the allegation of abuse or neglect is substantiated, the **Inspector General shall require the facility or agency to submit a written response**. The written response from a facility or agency shall address in a concise and reasoned manner the actions that the agency or facility will take or has taken to protect the resident or patient from abuse or neglect, prevent reoccurrence, and eliminate problems identified and shall include implementation and completion dates for all such action. (210 ILCS 30/6.2 b-5) [Emphasis added.]

Under OIG policy the facility or community agency has 30 days after receiving the investigative report to provide a written response. After 30 days, OIG considers the case to be complete and the case is closed with or without the response. The statute also requires that within 10 days of completing the case, the OIG provide a complete report on the case to the Secretary of DHS including the written response from the facility or community agency. The Secretary has the authority to accept or reject the written response and determine if the facility or program followed the approved response.

The written response should include the action that has been taken by the facility or community agency to correct and address the substantiated issues, lists the persons responsible to carry out the action and notes the date the action should be implemented.

While the OIG did have written responses for most of their substantiated cases in FY 2002, they did not have them for five substantiated cases. Additionally, OIG's database did not document all data relating to written responses. The database showed that there was no written response for 76 substantiated cases. Of these, the database indicated no in the field for 19 cases and the field was blank for 57 cases. OIG officials indicated that the written response had been received for all but five cases, however, the data was not entered into OIG's database.

The OIG does not believe that they have the authority to enforce or provide penalties if a facility or community agency does not respond. This seems to conflict with the requirement quoted earlier. Without the required written response or complete and accurate data, the OIG has no way to determine whether action has been taken to protect individuals from future harm.

WRITTEN RESPONSES	
RECOMMENDATION 6	***The Inspector General should establish a process to accurately track and follow-up on cases for which no response to a substantiated case of abuse or neglect has been received from a State facility or community agency. If the community agency or facility fails to provide a written response OIG should consider recommending appropriate sanctions.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	The Office of the Inspector General tracks written responses through the database records and the investigative case file. State Operated Facilities and Community Agencies are notified by letter of their requirement to submit a written response. The Office of the Inspector General will outline a procedure for ensuring that copies of written responses are in all substantiated case files. This procedure will be outlined in a Case Closure Directive. The Office of the Inspector General will recommend sanctions on a case by case basis.
	AUDITOR COMMENT: OIG's database did not adequately track all cases where there was no written response received. The database had blanks for 76 substantiated cases. OIG officials indicated that the written response had been received for all but five cases, however, the data was not entered into OIG's database.

Statutes provide authority to the Secretary of the Department of Human Services to accept or reject the response from the facility or community agency. The Secretary may require Department personnel to visit the facility or community agency for training, technical assistance, programmatic, licensure, or certification purposes in order to correct the problem.

APPEALS PROCESS IN SUBSTANTIATED CASES

A requirement of the Abused and Neglected Long Term Care Facility Residents Reporting Act (Act) (210 ILCS 30/6.2) is that there shall be an appeals process for any person or agency that is subject to any action based on a recommendation. In FY 2001 and FY 2002, there were 14 community agency cases that requested an appeal of OIG recommendations. Of those, three had filed requests for reconsideration and in all three cases the reconsideration request was made prior to filing the appeal.

SANCTIONS

Over the past nine fiscal years (1994 to 2002) the Inspector General has not used sanctions against facilities. The Act (210 ILCS 30/6.2) gives the Inspector General broad authority to recommend sanctions. Sanctions are intended to ensure the protection of residents such as closing a facility, transferring or relocating residents, or appointing on-site monitors. In our 1996 OIG audit and again in our 1998 audit, we recommended that the Inspector General establish criteria for when sanctions would be used. When we did our work for our 2000 audit the Inspector General's Investigative Guidelines did include criteria to define conditions that would warrant a sanction and the procedures the OIG is to follow when recommending sanctions to the Department of Public Health or the Department of Human Services. At the close of this audit, the Inspector General was working to develop a new Directive which specifies criteria when sanctions could be recommended.

SITE VISITS

During FY 2001 and 2002, the OIG conducted annual unannounced site visits of all State-operated facilities as required by 210 ILCS 30/6.2. However, the OIG site visitors did not meet the OIG established timelines for submitting site visit reports to facilities. The OIG does not conduct site visits at community agencies because they do not have the specific statutory authority to do them.

Since the last OIG audit, the OIG developed a new protocol for FY 2002 unannounced site visits and specific procedures for site visitors. The new protocol and procedures were implemented in July 2001. The new site visit protocol was developed with input from the Inspector General and other OIG officials. In FY 2001, the OIG conducted unannounced site visits at all of the facilities using a site visit protocol adopted in January 1997 and revised in October 1999. That protocol was developed with input from advocacy groups, network administrators, consumers, facility personnel, and OIG investigators.

The OIG provided us with site visit reports and other documentation for the FY 2001 and 2002 unannounced site visits. The site visit protocols appeared to have been applied effectively and site visit reports appeared to provide useful information to the facilities and focus on pertinent issues.

During FY 2001, the site visitors reviewed all closed cases with approved written responses before conducting site visits. They also reviewed implementation plans for each written response. The written responses revealed steps that the facility had taken or may need to take to prevent abuse and neglect. In order to determine if all aspects of the written responses were implemented, the site visitor conducted interviews, read relevant policies and procedures, and reviewed training records and personnel files where appropriate. Site visits usually lasted between 2-4 days.

For FY 2002 site visits, some of the site visit procedures remained the same, however, site visits were more focussed on investigations of abuse and neglect, and site visits generally lasted no longer than 2 days. Before conducting site visits, site visitors reviewed all closed cases

and incident reports received by the OIG. They also reviewed all substantiated cases and cases with written responses. The goal of the new site visit process was to identify ways in which abuse or neglect can be prevented based on OIG investigations conducted since the previous site visit.

Time Guidelines

During FY 2001 and 2002, OIG site visitors did not meet their established timelines for submitting site visit reports to facilities. At the conclusion of the FY 2001 site visits, the OIG had a 90-day timeline to send a site visit report to the Facility Director and to officials at the DHS Office of Mental Health and/or Office of Developmental Disabilities. However, the 90-day timeline was changed for FY 2002. Final site visit reports for FY 2002 are to be written and sent to the facility and other DHS officials within 60 days.

During FY 2001, 16 of the 19 facilities received a final site visit report after the 90-day timeline. According to an official, during FY 2001, the OIG assessed its role in conducting unannounced site visits and thought through how the unannounced site visit reports should be completed. In order to decide on the final report format for FY 2001, a review of draft reports went through several critiques before a final decision on the format was given. All of these factors contributed to the lateness of the final reports.

During FY 2002, the established timelines were again not met but timeliness had improved. Eight of 17 facilities received a final site visit report after the 60-day timeline. According to OIG officials, report format issues and other assignments again contributed to the lateness of the reports.

Chapter Five

OTHER ISSUES

CHAPTER CONCLUSIONS

Although training of OIG investigators had improved in our last OIG audit, there were again issues noted in this audit period. In our previous OIG audits, we have had seven recommendations on training in four of the audits. We again recommended that the Inspector General should ensure that all OIG investigators meet training requirements as set forth by OIG investigative guidance.

During Fiscal Years 2001 and 2002, the Quality Care Board did not meet statutory requirements for meeting quarterly. In Fiscal Year 2001, the Board only met twice and in Fiscal Year 2002, the Board met three times. This is the first OIG audit where the Board has not met as required by statute. We recommended that the Inspector General work with the Quality Care Board to assure that the Board meets quarterly as required by statute.

OIG INVESTIGATOR TRAINING

Although training of OIG investigators had improved in our last OIG audit, there were again issues noted in this audit period. In our previous OIG audits, we have had seven recommendations on training in four of the audits. In our 2000 OIG audit there was not a recommendation, however, three employees were lacking a required course and one investigator did not receive a required course within the first year of employment. In Fiscal Year 2000, all investigators received required continuing education. In this audit that covered Fiscal Years 2001 and 2002 we noted that four OIG investigators had not obtained one of the required investigation related courses and two of the four employees did not receive courses within the first year of employment as required by OIG Investigative Guidelines. In addition, three OIG investigators had not obtained the required 10 hours of continuing education.

The Abused and Neglected Long Term Care Facility Residents Reporting Act requires the OIG to establish a comprehensive program to ensure that every person employed or newly hired to conduct investigations shall receive training on an on-going basis. This training should be in the areas of investigative techniques, communication skills, and the appropriate means of contact with persons admitted or committed to the mental health or developmental disabilities facilities under the jurisdiction of DHS.

To conduct an effective investigation, OIG investigators must be adequately trained. The criteria for OIG investigator training are clearly defined in OIG's Investigative Guidelines. All investigators were required by OIG investigative guidance to receive the 13 courses listed in

Exhibit 5-1 during their first year of employment. "The Employee Assistance Program" and "The Challenge of Inclusion" courses are required only for supervisors.

Some of these required courses are not conducted by OIG staff. Instead, an OIG investigator may receive these courses at a facility or other location. Fifty-five training events were offered at State-operated facilities throughout the State during FY 2001 and 2002.

Our last OIG audit noted that 3 employees were lacking one of the required courses. Two of the employees with training deficiencies in our 2000 OIG audit have received the required training. One of the employees is no longer employed at the OIG.

Four employees hired during this audit period have not attended the "Orientation to the Department" course. However, the OIG has provided a letter from the DHS Bureau of Training and Development that states that the New Employee Orientation has been suspended since July of 2001. In addition, two of the four employees did not receive all courses that are required by the OIG within the first year of employment.

Exhibit 5-1
REQUIRED TRAINING FOR OIG INVESTIGATORS

ORIENTATION
- Prevention and Identification of Abuse and Neglect
- AIDS/HIV in the Workplace
- Orientation to the Department
- Sexual Harassment
- Employee Assistance Program*
- The Challenge of Inclusion*

OTHER REQUIRED COURSES
- Basic Investigations Course
- Advanced Investigations Course
- Aggression Management
- Communications
- Hearing Impairment
- Introduction to Developmental Disabilities
- Introduction to Mental Illness
- Legal Issues
- Restraints

CONTINUING EDUCATION
- 10 Hours per Year related to Investigations; Report writing; Systems Improvement; or Provision of Services.

* Course is required only for supervisors.

Source: OIG investigative guidance.

Continuing Education

Three OIG investigators had not obtained the required 10 hours of continuing education. In addition to the specific courses required in OIG policy, each investigator is required to obtain at least 10 hours per year of continuing training related to:

- Investigations;
- Report writing;
- Systems improvement; or
- Provision of services to those with mental illness or developmental disabilities.

Two investigators did not have the required 10 hours of continuing education. The third investigator had ten hours of training, but had attended Sexual Harassment training, which does not fit into one of the four categories.

OIG INVESTIGATOR TRAINING	
RECOMMENDATION 7	***The Inspector General should ensure that all OIG investigators meet training requirements as set forth by OIG investigative guidance.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	The Office of the Inspector General is reviewing the current training requirements for investigators. The Inspector General will make every effort to ensure that future training requirements are met.

QUALITY CARE BOARD

Statutes establish a Quality Care Board within the Department of Human Services' Office of the Inspector General. One of the requirements of the Quality Care Board is to meet quarterly. During FY 2001 and 2002, the Board did not meet statutory requirements regarding quarterly meetings. The Board only met twice during FY 2001 and only met three times during FY 2002. This is the first OIG audit where the Board has not met as required by statute. However, it appears that the Board is following other requirements established by the statutes.

Fulfillment of Statutory Requirements

The statutes establish a Quality Care Board within the OIG to be comprised of 7 members appointed by the Governor with the advice and consent of the Senate. The Board is required to meet quarterly, and may hold other meetings on the call of the chairman. Four Board members constitute a quorum.

During FY 2001, the Board did not meet statutory requirements regarding quarterly meetings. The Board only met twice during FY 2001: November 2000 and February 2001. A Board meeting was scheduled for September 2000, but was cancelled because a quorum could not be met. According to an OIG official, scheduled meetings are sometimes cancelled due to a lack of a quorum. The official stated that Board members come from different areas in the State of Illinois and sometimes have difficulty attending scheduled meetings. The official also stated that Board members have other responsibilities.

During FY 2002, the Board again was not able to hold meetings during the months of August and September 2001, due to a lack of a quorum. As a result, because of quorum difficulties, from the time of the February 2001 meeting, the Board did not meet again until October 2001. However, the Board did meet 3 times during FY 2002: October 2001, February 2002, and March 2002. The March 2002 meeting was a special meeting regarding rule 50. The Board tried to meet in May 2002, but did not have a quorum.

In an effort to meet statutory requirements regarding quarterly meetings, Board members established a set day and time for meetings. The implementation of these quarterly meetings

began with the Board's February 2002 meeting, but the Board tried to meet at the next scheduled time but they did not have a quorum.

The statutes also require the Quality Care Board to monitor and oversee the operations, policies, and procedures of the Inspector General and to assure the prompt and thorough investigation of allegations of abuse or neglect. Based on our review of Board meeting minutes for FY 2001 and 2002, and a discussion of the role of the Board with OIG officials, it appears that the Quality Care Board is meeting other statutory requirements.

QUALITY CARE BOARD	
RECOMMENDATION 8	***The Inspector General should work with the Quality Care Board to assure that the Board meets quarterly as required by statute (210 ILCS 30/6.3).***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	A member of the Inspector General's staff contacts all board members to determine their availability for the scheduled board meeting and reports that information to the chairman. The chairman of the Quality Care Board determines if a meeting will be held.

APPENDICES

APPENDIX A
(210 ILCS 30/6.8)

Illinois Compiled Statutes -- 210 ILCS 30/6.8

from the

Abused and Neglected Long Term Care Facility Residents Reporting Act

Sec. 6.8. Program audit. The Auditor General shall conduct a biennial program audit of the office of the Inspector General in relation to the Inspector General's compliance with this Act. The audit shall specifically include the Inspector General's effectiveness in investigating reports of alleged neglect or abuse of residents in any facility operated by the Department and in making recommendations for sanctions to the Departments of Human Services and Public Health. The Auditor General shall conduct the program audit according to the provisions of the Illinois State Auditing Act and shall report its findings to the General Assembly no later than January 1 of each odd-numbered year.

This Section is repealed on January 1, 2004.

(Source: P.A. 91-169, eff. 7-16-99; 92-358, eff. 8-15-01.)

APPENDIX B
Sampling & Analytical Methodology

Appendix B

SAMPLING & ANALYTICAL METHODOLOGY

We interviewed representatives and obtained information and documentation from the Inspector General's Office, the Department of Human Services, the Department of Public Health, Department of State Police, and the Department of Children and Family Services. We analyzed OIG's electronic database from Fiscal Years 2001 and 2002. We examined the current OIG organizational structure, policies and procedures, investigations process, case review process, documentation requirements and current changes to administrative rules and new Directives. We reviewed backgrounds for investigators hired since our last OIG audit and reviewed investigator's training records.

As a part of our audit work we included follow-up on previous OIG audit recommendations. We assessed risk by reviewing recommendations from all six previous OIG audits released in 1990, 1993, 1994, 1996, 1998, and 2000. We reviewed management controls relating to the audit objectives which were identified in section 6.8 of the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6.8 see Appendix A). This audit identified some weaknesses in those controls, which are included as recommendations in this report.

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

TESTING AND ANALYTICAL PROCEDURES

Initial work began on this audit in March 2002 and fieldwork was concluded in October 2002. In order to test case files for thoroughness of investigation methods, we selected a sample of cases closed in Fiscal Year 2002. Using a data collection instrument, we gathered certain information from case files and develop a database of sample information to analyze. That information included verification of data from the OIG electronic system. Our sample was chosen from the universe of cases closed (1,944) in Fiscal Year 2002. We took a systematic random sample of 126 cases with a confidence level of at least 90 percent and an acceptable error rate of 10 percent. Our random sample was stratified into the two following case classifications:

1. Cases investigated by OIG at State Operated Facilities (including death cases investigated by OIG),

2. Cases investigated by OIG or the community agency occurring at the community agencies.

We also performed analyses of timeliness and thoroughness based on an electronic database of OIG reported cases from Fiscal Years 2001 and 2002 and did comparisons of similar

data from prior OIG audits. The validity of electronic data was verified as part of our case file testing described above.

APPENDIX C

Rates of Substantiated Abuse or Neglect Cases by Facility

FY 2001 and FY 2002

Appendix C

RATE OF SUBSTANTIATED ABUSE OR NEGLECT CASES BY FACILITY

(Based on all Allegations Regardless of Category at Intake)

FY 2001 and FY 2002

	FISCAL YEAR 2001			FISCAL YEAR 2002		
Facility	**Number Closed**	**Number Substantiated by OIG**	**Substantiation Rate**	**Number Closed**	**Number Substantiated by OIG**	**Substantiation Rate**
Alton	152	3	2%	86	2	2%
Chester	292	3	1%	147	1	1%
Chicago-Read	63	2	3%	41	1	2%
Choate	275	11	4%	281	2	1%
Elgin	307	7	2%	250	13	5%
Fox	15	1	7%	12	1	8%
Howe	279	8	3%	214	2	1%
Jacksonville	191	3	2%	173	3	2%
Kiley	153	7	5%	97	4	4%
Lincoln	150	4	3%	112	7	6%
Ludeman	185	4	2%	187	1	1%
Mabley	60	1	2%	55	3	5%
Madden	50	4	8%	37	3	8%
McFarland	38	0	0%	25	1	4%
Murray	62	4	6%	99	2	2%
Shapiro	108	3	3%	151	6	4%
Singer	99	5	5%	67	8	12%
Tinley Park	50	1	2%	60	2	3%
Zeller	37	2	5%	21	0	0%
Community Agencies*	1,839	289	16%	1,374	210	15%
Special Cases	6	3	50%	0	0	0%
Totals	**4,411**	**365**	**8%**	**3,489**	**272**	**8%**

***** Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

APPENDIX D

Allegations of Abuse or Neglect by Facility

FY 2000 through FY 2002

SECTION A-1

CATEGORIES FOR ALLEGATIONS AND OTHER INCIDENTS

(This is not a listing of allegations to report, it merely lists categories for coding them. For complete definitions of terms and reportable allegations, please refer to Rule 50.)

A. Allegations of **Abuse**

A1 -- Allegation of **physical abuse** where it appears a recipient may be in **imminent danger**.

A2 -- Allegation of **physical abuse** with a **serious injury**.

A3 -- Allegation of **physical abuse** other than in A1 or A2 above.

A4 -- Allegation of **sexual abuse**, including sexual exploitation.

A5 -- Allegation of **verbal abuse**.

A6 -- Allegation of **psychological abuse**.

A7 -- Allegation of **exploitation** by an employee, including financial exploitation, but not including sexual exploitation (see A4 above).

B. Allegations of **Neglect**

N1 -- Allegation of **neglect** where a recipient(s) may be in **imminent danger**.

N2 -- Allegation of **neglect** where a recipient(s) has a **serious injury**.

N3 -- Allegation or suspicion of **neglect** in a non-serious injury.

N4 -- Allegation or suspicion of **neglect** in a individual's **absence**.

N5 -- Allegation or suspicion of **neglect** in recipient **sexual activity**.

N6 -- Allegation or suspicion of **neglect** in allowing other **exploitation** of a recipient by another recipient.

N7 -- Any other allegation of **neglect**, without documented harm or injury.

C. Recipient **Deaths**

D1 -- Death of an individual due to **suicide** that occurs **within** a residential program or after emergency transfer of the individual to a local hospital.

D2 -- Death due to suicide within 14 days of discharge, deflection, transfer, or temporary absence from a residential setting.

D3 -- All other reportable deaths due to suicide, including but not limited to outpatient mental health patients.

D4 -- Death of an individual that occurs **within** a residential program by any cause *other* than suicide and *other* than apparent natural causes (e.g.. accident, homicide).

D5 -- Death of an individual **not** occurring within a residential program by any cause *other* than suicide and *other* than apparent natural causes (e.g.. accident, homicide).

D6 -- Death of an individual apparently due to natural causes within a residential program or after emergency transfer to a local hospital.

D7 -- **Any other** reportable death.

D. **Serious** and Other Injuries

S1 -- Any **serious** injury inflicted by a non-staff person by other than accidental means (if by staff, see A2).

S2 -- **Suicide** attempts with serious or non-serious injury and without any allegation of neglect by staff.

S3 -- Other serious **self-inflicted** injuries.

S4 -- Serious injuries from an **accidental** or unknown cause.

S5 -- **Repeated** injuries.

S6 -- Injuries involving multiple recipients **victims**.

S7 -- Injuries involving multiple recipient **aggressors**.

E. Other **Reportable** Incidents

R1 -- Allegation of **domestic abuse**.

R2 -- Allegation of **domestic neglect**.

R3 -- Allegation of **domestic exploitation**.

R4 -- Allegation of **criminal conduct** by a state employee and reportable to the Illinois State Police.

R5 -- Allegation of **theft of State property** over $100.00.

R6 -- Allegation of **theft of recipient property** over $100.00.

R7 -- **Any other occurrence** deemed by the authorized representative to be serious enough to be reportable to OIG.

Appendix D
ALLEGATIONS BY FACILITY
FY 2000 through FY 2002

Location	Abuse Allegations								
	A1 physical abuse - imminent danger			A2 physical abuse - serious injury			A3 other physical abuse		
	FY 00	FY 01	FY 02	FY 00	FY 01	FY 02	FY 00	FY 01	FY 02
DD Facilities									
Fox	0	0	0	0	0	0	0	1	0
Howe	1	0	0	0	0	3	44	29	33
Jacksonville	0	0	0	3	0	1	25	41	41
Kiley	0	0	0	0	1	1	30	19	21
Lincoln	0	0	1	2	0	0	17	17	15
Ludeman	0	0	0	1	0	0	27	32	17
Mabley	0	0	0	0	0	0	3	11	9
Murray	0	0	0	0	0	1	3	3	4
Shapiro	0	0	0	0	0	2	33	39	40
MH Facilities									
Alton	0	0	0	1	0	1	78	40	43
Chester	0	0	0	1	0	0	144	103	79
Chicago-Read	0	0	0	0	0	1	19	8	9
Elgin	0	0	0	1	1	2	55	46	38
Madden	0	0	0	0	1	0	16	11	9
McFarland	0	0	0	1	0	1	20	11	11
Tinley Park	0	0	0	1	0	0	11	9	7
Zeller	0	0	0	0	0	0	9	5	6
Dual Facilities									
Choate	0	0	0	0	0	0	135	112	95
Singer	0	0	0	0	1	0	42	25	18
Community Agencies *	2	2	0	4	12	5	316	295	259
Special Cases	0	0	0	0	0	0	1	0	
Totals	**3**	**2**	**1**	**15**	**16**	**18**	**1,028**	**857**	**754**

***** Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

Appendix D
ALLEGATIONS BY FACILITY
FY 2000 through FY 2002

Abuse Allegations											
A4 sexual abuse - sexual exploitation			**A5 verbal abuse**			**A6 psychological abuse**			**A7 exploitation by an employee**		
FY 00	**FY 01**	**FY 02**	**FY 00**	**FY 01**	**FY 02**	**FY 00**	**FY 01**	**FY 02**	**FY 00**	**FY 01**	**FY 02**
1	0	0	0	1	0	0	0	0	0	0	0
2	0	2	16	8	3	2	8	7	0	0	0
1	0	0	0	3	3	3	1	3	0	0	0
0	1	0	8	2	3	8	1	0	0	0	0
0	2	0	1	4	3	0	4	1	1	0	1
1	1	0	1	0	1	3	0	3	0	0	0
0	0	0	1	6	1	1	0	0	0	0	0
1	0	1	1	0	1	0	0	2	0	0	0
0	2	0	3	0	7	0	0	2	0	0	0
7	8	19	15	17	9	7	12	8	0	0	0
7	5	3	54	38	16	8	32	13	0	0	0
2	0	0	4	8	2	6	3	3	0	1	0
14	19	8	29	41	49	27	36	17	4	0	0
3	2	0	8	8	8	0	3	0	0	0	0
0	1	1	6	4	4	2	0	3	0	0	0
4	1	0	9	9	14	2	3	3	0	0	0
0	1	2	2	1	5	0	0	1	0	0	0
10	11	4	17	12	17	8	12	9	0	0	0
10	5	6	9	5	1	10	6	2	0	0	0
51	46	39	120	90	119	67	92	59	9	0	7
2	1	0	1	0	0	0	0	0	0	0	0
116	**106**	**85**	**305**	**257**	**266**	**154**	**213**	**136**	**14**	**1**	**8**

Appendix D
ALLEGATIONS BY FACILITY
FY 2000 through FY 2002

Location	Neglect Allegations								
	N1 neglect- imminent danger			N2 neglect- serious injury			N3 neglect- non-serious injury		
	FY 00	FY 01	FY 02	FY 00	FY 01	FY 02	FY 00	FY 01	FY 02
DD Facilities									
Fox	0	0	1	0	0	0	0	0	0
Howe	0	1	0	5	3	2	2	5	2
Jacksonville	1	0	0	2	0	2	2	4	0
Kiley	0	0	0	10	4	1	6	1	3
Lincoln	0	0	3	2	1	13	3	4	8
Ludeman	0	0	0	2	0	3	0	0	0
Mabley	0	0	0	2	0	1	1	1	2
Murray	0	0	1	0	1	1	2	1	0
Shapiro	0	0	0	2	2	0	3	0	0
MH Facilities									
Alton	0	2	0	1	1	0	1	4	0
Chester	0	0	0	0	0	1	9	3	3
Chicago-Read	0	0	0	2	0	1	3	4	1
Elgin	0	0	0	5	13	5	27	16	20
Madden	0	0	0	1	1	0	1	1	1
McFarland	0	0	0	0	1	0	0	2	1
Tinley Park	0	0	0	1	0	3	1	4	4
Zeller	0	0	1	0	2	0	0	0	2
Dual Facilities									
Choate	0	1	1	3	1	1	3	0	1
Singer	0	0	0	1	3	0	1	3	1
Community Agencies *	21	8	3	54	63	40	48	33	49
Special Cases	0	0	0	0	0	0	0	0	0
Totals	**22**	**12**	**10**	**93**	**96**	**74**	**113**	**86**	**98**

***** Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

Appendix D
ALLEGATIONS BY FACILITY
FY 2000 through FY 2002

Neglect Allegations											
N4 neglect in individual absence			**N5 neglect in recipient sexual activity**			**N6 neglect allowing exploitation**			**N7 other neglect without harm or injury**		
FY 00	**FY 01**	**FY 02**	**FY 00**	**FY 01**	**FY 02**	**FY 00**	**FY 01**	**FY 02**	**FY 00**	**FY 01**	**FY 02**
0	0	0	0	0	0	0	0	0	0	1	0
1	1	2	0	0	0	0	0	0	6	4	1
3	0	6	0	1	0	0	0	0	4	2	2
5	2	1	1	0	0	0	0	0	11	1	4
1	3	2	0	0	0	0	0	0	1	2	10
5	0	0	1	0	0	0	0	0	2	2	2
0	6	3	0	0	0	0	0	0	0	1	3
0	0	0	0	0	0	0	0	0	5	0	4
0	3	2	0	0	0	0	0	0	2	0	0
0	0	0	3	0	0	0	0	0	7	8	3
0	0	0	0	0	0	1	0	0	8	6	3
1	1	0	1	0	0	0	0	0	7	3	2
9	8	1	2	3	1	0	1	0	20	6	5
0	1	2	1	0	0	0	0	0	3	3	1
1	0	2	0	0	0	0	0	0	3	0	1
1	1	0	0	0	0	0	0	0	7	5	2
0	1	0	1	0	0	0	0	0	1	3	0
0	0	1	1	0	0	0	0	0	9	5	8
1	1	3	0	0	0	0	0	0	15	4	1
13	13	11	5	4	7	0	2	0	192	156	90
0	0	0	0	0	0	0	0	0	0	1	0
41	**41**	**36**	**16**	**8**	**8**	**1**	**3**	**0**	**303**	**213**	**142**

Appendix D
ALLEGATIONS BY FACILITY
FY 2000 through FY 2002

Location	Deaths								
	D1 suicide in program			D2 suicide in 14 days of discharge			D3 other reportable suicides		
	FY 00	FY 01	FY 02	FY 00	FY 01	FY 02	FY 00	FY 01	FY 02
DD Facilities									
Fox	0	0	0	0	0	0	2	0	0
Howe	0	0	0	0	0	0	1	0	1
Jacksonville	0	0	0	0	0	0	2	1	0
Kiley	0	0	0	0	0	0	1	0	0
Lincoln	0	0	0	0	0	0	4	0	0
Ludeman	0	0	0	0	0	0	2	0	2
Mabley	0	0	0	0	0	0	1	0	0
Murray	0	0	0	0	0	0	1	0	0
Shapiro	0	0	0	0	0	0	1	0	0
MH Facilities									
Alton	0	0	0	0	0	0	1	1	0
Chester	0	0	0	0	0	0	3	0	0
Chicago-Read	0	0	1	1	0	0	0	0	0
Elgin	1	0	1	0	1	0	0	1	2
Madden	1	0	0	0	0	0	0	0	0
McFarland	0	0	0	0	0	0	0	1	0
Tinley Park	0	0	0	0	0	1	0	0	0
Zeller	0	0	0	0	0	0	0	0	0
Dual Facilities									
Choate	0	0	0	0	0	0	1	0	1
Singer	0	0	1	0	0	0	1	0	1
Community Agencies *	4	2	1	7	5	0	185	40	22
Special Cases	0	0	0	0	0	0	0	0	0
Totals	**6**	**2**	**4**	**8**	**6**	**1**	**206**	**44**	**29**

***** Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

Appendix D
ALLEGATIONS BY FACILITY
FY 2000 through FY 2002

Deaths

D4 other than suicide in program			**D5 other than suicide not in a program**			**D6 death due to natural causes in a program**			**D7 any other deaths**		
FY 00	**FY 01**	**FY 02**	**FY 00**	**FY 01**	**FY 02**	**FY 00**	**FY 01**	**FY 02**	**FY 00**	**FY 01**	**FY 02**
0	0	0	0	0	0	1	1	3	0	0	0
0	0	0	0	0	0	1	3	3	0	0	0
0	0	0	0	0	0	3	2	6	0	0	0
0	1	1	0	0	0	0	4	1	1	0	0
0	0	0	0	0	1	4	3	6	0	0	0
0	0	1	0	0	0	0	1	0	0	0	0
0	0	0	0	0	0	0	0	2	0	0	0
0	0	0	0	0	0	1	6	1	0	2	1
1	1	0	0	0	1	3	11	5	0	1	0
0	0	0	0	0	0	0	1	0	1	0	0
0	0	0	0	0	0	1	0	1	0	0	0
0	0	0	3	1	4	0	0	0	2	1	1
0	0	0	0	0	0	0	2	0	0	0	0
0	0	0	3	1	0	0	1	0	0	0	0
0	0	0	0	1	0	1	0	0	0	0	0
0	0	0	0	0	0	0	1	0	0	0	1
0	0	0	1	0	0	0	0	1	0	0	1
0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	3	1	0	1	0
4	6	7	15	28	12	31	55	59	134	257	124
0	0	0	0	0	0	0	0	0	0	0	0
5	**8**	**9**	**22**	**31**	**18**	**46**	**94**	**89**	**138**	**262**	**128**

Appendix D
ALLEGATIONS BY FACILITY
FY 2000 through FY 2002

Location	Serious and Other Injuries								
	S1 inflicted by a non-staff person			S2 suicide attempt			S3 self-inflicted		
	FY 00	FY 01	FY 02	FY 00	FY 01	FY 02	FY 00	FY 01	FY 02
DD Facilities									
Fox	0	0	0	0	0	0	0	0	0
Howe	29	12	20	0	0	0	37	22	21
Jacksonville	5	9	19	0	0	0	1	4	5
Kiley	7	7	5	0	0	0	22	13	14
Lincoln	6	7	6	0	0	0	17	3	10
Ludeman	5	14	11	0	0	0	9	15	17
Mabley	5	2	1	0	0	0	1	6	1
Murray	3	4	2	0	0	0	2	3	9
Shapiro	6	5	0	0	0	0	6	3	5
MH Facilities									
Alton	7	4	2	0	1	0	4	2	0
Chester	11	6	6	0	1	1	9	2	3
Chicago-Read	2	3	2	1	5	0	0	0	1
Elgin	11	9	10	1	2	4	3	7	6
Madden	1	6	1	1	1	0	2	0	1
McFarland	0	0	1	2	0	0	1	2	5
Tinley Park	7	5	7	0	0	0	0	6	3
Zeller	1	0	0	1	0	0	3	5	3
Dual Facilities									
Choate	11	10	6	0	0	1	14	8	6
Singer	2	2	1	1	0	0	8	2	1
Community Agencies *	34	23	32	4	3	2	13	15	15
Special Cases	0	0	0	0	0	0	0	0	0
Totals	**153**	**128**	**132**	**11**	**13**	**8**	**152**	**118**	**126**

***** Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

Appendix D
ALLEGATIONS BY FACILITY
FY 2000 through FY 2002

Serious and Other Injuries

S4 accidental or unknown cause			**S5 repeated injuries**			**S6 multiple recipient victims**			**S7 multiple recipient aggressors**		
FY 00	**FY 01**	**FY 02**	**FY 00**	**FY 01**	**FY 02**	**FY 00**	**FY 01**	**FY 02**	**FY 00**	**FY 01**	**FY 02**
11	10	8	0	0	0	0	0	0	0	0	0
124	132	109	6	5	6	7	3	5	1	2	1
50	57	69	12	14	10	19	23	15	0	1	0
79	67	65	2	1	1	2	6	3	1	2	0
114	91	53	4	1	1	4	5	3	0	0	0
127	101	125	8	6	0	12	5	5	2	1	0
32	29	20	15	7	3	0	1	0	0	0	0
31	38	37	16	7	11	0	0	0	0	0	0
77	60	59	0	1	0	4	4	0	2	0	0
10	10	4	3	0	1	2	0	1	5	1	0
17	12	12	4	1	3	4	5	2	0	2	1
16	8	4	9	1	0	1	0	0	0	0	0
14	20	18	4	3	2	1	3	4	4	5	1
1	6	1	0	0	0	0	0	0	0	0	0
5	9	2	0	0	0	2	0	0	0	0	0
4	2	3	0	0	0	0	0	0	0	0	0
5	6	7	0	0	0	3	3	1	0	0	0
67	53	39	10	7	1	8	9	5	4	1	0
13	23	17	1	2	1	0	5	2	1	0	0
408	403	376	7	14	1	3	3	1	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0
1,205	**1,137**	**1,028**	**101**	**70**	**41**	**72**	**75**	**47**	**20**	**15**	**3**

Appendix D
ALLEGATIONS BY FACILITY
FY 2000 through FY 2002

Location	Other Reportable Incidents								
	R1 domestic abuse			R2 domestic neglect			R3 domestic exploitation		
	FY 00	FY 01	FY 02	FY 00	FY 01	FY 02	FY 00	FY 01	FY 02
DD Facilities									
Fox	0	0	0	0	0	1	0	0	0
Howe	1	0	0	0	0	0	0	0	0
Jacksonville	0	0	0	0	0	0	0	0	0
Kiley	0	0	0	0	0	0	0	0	0
Lincoln	0	0	0	0	0	0	0	0	0
Ludeman	0	0	0	0	0	0	0	0	0
Mabley	0	0	0	0	0	0	0	0	0
Murray	0	0	0	0	0	0	0	0	0
Shapiro	0	0	0	0	0	0	0	0	0
MH Facilities									
Alton	0	0	0	0	0	0	0	0	0
Chester	0	0	0	0	0	0	0	0	0
Chicago-Read	0	0	0	0	0	0	0	0	0
Elgin	0	0	0	0	0	0	0	0	0
Madden	0	0	0	0	0	0	0	0	0
McFarland	0	0	0	0	0	0	0	0	0
Tinley Park	0	0	0	0	0	0	0	0	0
Zeller	0	0	0	0	0	0	0	0	0
Dual Facilities									
Choate	0	0	1	0	0	0	0	0	0
Singer	0	0	0	0	0	0	0	0	0
Community Agencies *	0	2	0	1	0	0	0	0	0
Special Cases	0	0	0	0	0	0	0	0	0
Totals	**1**	**2**	**1**	**1**	**0**	**1**	**0**	**0**	**0**

***** Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

Appendix D
ALLEGATIONS BY FACILITY
FY 2000 through FY 2002

Other Reportable Incidents

R4 criminal conduct			**R5 theft of State property**			**R6 theft of recipient property**			**R7 any other occurrence**		
FY 00	**FY 01**	**FY 02**	**FY 00**	**FY 01**	**FY 02**	**FY 00**	**FY 01**	**FY 02**	**FY 00**	**FY 01**	**FY 02**
0	1	0	0	0	1	0	0	0	1	0	0
6	1	2	6	3	5	0	1	0	7	6	6
0	0	1	1	0	1	2	0	1	2	4	3
2	2	1	1	0	0	0	0	1	4	0	2
1	1	0	0	0	0	1	0	0	2	0	7
1	2	2	0	0	0	0	0	0	0	1	2
0	0	0	0	0	0	0	0	1	0	2	0
0	1	1	0	0	0	0	0	0	3	5	1
0	1	3	0	0	1	1	0	0	1	0	0
0	0	0	0	0	0	3	0	0	1	0	0
0	0	0	0	0	0	1	0	0	1	1	0
0	1	1	1	0	0	1	2	0	12	8	0
3	2	0	4	1	0	3	9	2	21	28	49
1	2	0	0	0	0	1	1	0	2	6	2
0	0	0	0	0	0	0	0	0	0	0	0
1	1	0	4	0	0	1	1	0	4	11	2
0	0	0	0	0	0	0	0	0	1	0	0
0	0	0	0	1	0	0	0	1	9	12	5
0	0	1	0	1	0	1	2	0	5	4	3
0	1	0	0	0	0	6	2	0	13	3	7
0	2	0	0	0	0	0	0	0	2	0	0
15	**18**	**12**	**17**	**6**	**8**	**21**	**18**	**6**	**91**	**91**	**89**

APPENDIX E

Agency Responses

Note: This Appendix contains the complete written responses of the Office of the Inspector General and the Illinois State Police. Following the Agency Responses are three numbered Auditor Comments. The number for the comment appears in the margin of the Agency Response.

George Ryan, *Governor*

Illinois Department of Human Services

Linda Renee´ Baker, *Secretary*

Office of the Inspector General
901 Southwind Road
Springfield, Il 62703

November 25, 2002

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

Dear Auditor General Holland:

I was pleased to learn that the audit found timeliness of investigations had significantly improved and that the documentation of our case files were thorough. Again, I appreciate the opportunity to respond to the recommendations in your 2002 Program Audit Report of the Office of the Inspector General.

During the program audit period, recommendations from your 2000 Program Audit were included in the Office's Strategic Plan for FY-2001 and FY-2002. Several operational and administrative changes were also made to ensure that investigative practices and procedures were clear for all Inspector General's staff. The first change was the conversion of Investigative Guidelines into Investigative Directives. The conversion of all guidelines will be completed by December 31, 2002.

The second change was statutory and expanded the duties of the Office of the Inspector General. This change in duties was mandated at the end of FY-2001. As a result, the Administrative Rule governing the Office had to be changed. Changes to the Administrative Rule were also mandated because the previous rule was written outside of the Inspector General's statutory limits.

The audit staff found some inconsistencies as a result of the changes being made in the investigative procedures in the Office of the Inspector General. Although there were inconsistencies we found the audit staff to be open to the changes. We appreciate their efforts to understand the procedure in the Office of the Inspector General and to present an objective audit.

Your recommendations will be included in future Strategic Plans in the Office of the Inspector General.

Sincerely,

Odell Thompson, Jr.
Inspector General

OFFICE OF THE INSPECTOR GENERAL
RESPONSES TO THE FY 2001 & 2002 AUDITOR GENERAL AUDIT

Clarifying Investigative Guidance

Recommendation 1:
The Office of the Inspector General should assure that clear and consistent investigative guidance is available for investigators which allows investigative effectiveness to be judged over time.

OIG Response:
The first Inspector General with command law enforcement experience and an investigative background was appointed beginning FY-2001. During the evaluation period of the Office of the Inspector General, between July 2000 and January 2001, it was determined that the Investigative Guidelines were very vague and without consistent investigative direction. Beginning March 2001, Investigative Guidelines began to be converted into Investigative Directives. To ensure that clear and consistent investigative guidance was followed during the conversion period the following procedure was implemented. When inconsistencies in the Guidelines were discovered a memorandum outlining the changes in the investigative procedures was issued until a new directive was established. Investigative standards are and should be based on clear and definitive operational procedures and not questionable or unclear operational procedures. This change from Guidelines to Directives was done to ensure accountability and that investigative procedures were clear and consistent throughout all of the investigative bureaus.

Investigating Criminal Allegations

Recommendation 2:
The Office of the Inspector General and State Police should assure that notification and investigation requirement in the Abused and Neglected Long Term Care Facility Residents Reporting Act are satisfied (210ILCS 30/6.2 b). This should include an interagency agreement that stipulates responsibilities and should include revising the current administrative rules to be consistent with the Act (59 Illinois Administrative Coed 50.50h.)

OIG Response:

The Office of the Inspector General will work with the Illinois State Police to ensure that criminal allegations are reported to the appropriate law enforcement authority. Also, the Office of the Inspector General will further clarify its investigative role with the State Police through a signed interagency agreement to be completed by December 31, 2002. When the Act was originally adopted OIG=s authority was limited to State Operated Facilities. After 1995, the Inspector General=s responsibilities were expanded to include community agencies. As a result an Administrative Rule was created to further clarify the Act and the Inspector General=s responsibilities for reporting criminal allegations in the community agencies.

Timeliness of Case Completion

Recommendation 3:
The Inspector General should continue to work to improve the timeliness in investigations of abuse and neglect.

OIG Response:

We acknowledge the improvement in the timeliness of our investigations. The Office of the Inspector General will continue to work to improve the timeliness of investigations.

Reporting

Recommendation 4:
The Inspector General should work with State facilities and community agencies to ensure that allegations of abuse or neglect are reported within the time frame specified in State law and OIG administrative rules.

OIG Response:

As the audit notes there has been a substantial improvement in the reporting time of allegations of abuse and neglect. The Office of the Inspector General will continue to monitor and ensure that allegations of abuse and neglect are reported within the time frame required.

Review of Substantiated Cases

Recommendation 5:
The Inspector General should assure that all cases that require review by the Inspector General, Deputy Inspector General, or a designee receive that review.

OIG Response:

Prior to January 1, 2002, the designee for the review of substantiated cases investigated by community agencies was the Investigation Bureau Chief. This review procedure was in accordance with the OIG Guidelines in effect at that time. As a result of a statutory change that became effective, January 1, 2002, all substantiated cases are to be reviewed by the Inspector General, Deputy Inspector General or a designee. This change was memorialized in an Investigative Directive that was issued April 17, 2002.

1

Written Responses

Recommendation 6:
The Inspector General should establish a process to accurately track and follow-up on cases for which no response to a substantiated case of abuse or neglect has been received from a State facility or community agency. If the community agency or facility fails to provide a written response OIG should consider recommending appropriate sanctions.

OIG Response:

The Office of the Inspector General tracks written responses through the database records and the investigative case file. State Operated Facilities and Community Agencies are notified by letter of their requirement to submit a written response. The Office of the Inspector General will outline a procedure for ensuring that copies of written responses are in all substantiated case files. This procedure will be outlined in a Case Closure Directive. The Office of the Inspector General will recommend sanctions on a case by case basis. **2**

OIG Investigator Training

Recommendation 7:
The Inspector General should ensure that all OIG investigators meet training requirement as set forth by OIG investigative guidance.

OIG Response:

The Office of the Inspector General is reviewing the current training requirements for investigators. The Inspector General will make every effort to ensure that future training requirements are met.

Quality Care Board

Recommendation 8:
The Inspector General should work with the Quality Care Board to assure that the Board meets quarterly as required by statute (210 ILCS 30/6.3).

OIG Response:

A member of the Inspector General's staff contacts all board members to determine their availability for the scheduled board meeting and reports that information to the chairman. The chairman of the Quality Care Board determines if a meeting will be held.

ILLINOIS STATE POLICE
Division of Internal Investigation

George H. Ryan
Governor

Sam W. Nolen
Director

December 3, 2002

Mr. Scott Wahlbrink
Office of the Auditor General
Iles Park Plaza
740 East Ash Street
Springfield, Illinois 62703-6046

Dear Mr. Wahlbrink:

In response to correspondence from Mr. Ed Wittrock, dated November 8, 2002, the Illinois State Police (ISP) has reviewed the portions of the program audit of the Department of Human Services (DHS), Office of Inspector General, which relate to this department. In regard to the audit findings, the ISP concurs with the Findings and Recommendations #2 and #3 as identified in the report. 3

In order to resolve those areas of concern, the ISP is working with the DHS to establish an interagency agreement which stipulates responsibilities of each agency for the purpose of ensuring reporting procedures, notification protocols and investigation requirements for all matters subject to the Abused and Neglected Long Term Care Facility Residents Reporting Act. Both agencies are also cooperatively developing a system to monitor cases referred to the ISP to ensure the cases are disposed of properly and in a timely manner.

Thank you for the opportunity to review and offer comments. Please call me or Assistant Deputy Director Rick Karpawicz at (217) 782-5423 if you have any questions or need additional information.

Respectfully,

H. E. Nelson II

Harold E. Nelson, II
Deputy Director

HEN:r

124 East Adams • Room 500
P.O. Box 19461 • Springfield, IL 62794-9461
1-(800) 445-7310 (voice) • 1-(800) 255-3323 (TDD)

AUDITOR COMMENTS

1 Although the OIG indicates that the Bureau Chief was the designee, they provided no documentation of that designation. In addition, the Bureau Chief reviewed all cases and the Guidelines in effect prior to the Directive state that "When the Bureau Chief approves a substantiated case file, he/she will submit the investigative case file to the Inspector General/designee for review and signature." The Guideline did not differentiate between Facility and Community Agency investigations.

2 OIG's database did not adequately track all cases where there was no written response received. The database had blanks for 76 substantiated cases. OIG officials indicated that the written response had been received for all but five cases, however, the data was not entered into OIG's database.

3 Recommendation Number 3 that State Police refers to was in the draft report shared with them but has been eliminated based on additional information supplied by the OIG.