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OFFICE OF THE AUDITOR GENERAL
WILLIAM G. HOLLAND

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 2004

REPORT DIGEST

PROGRAM AUDIT OF

THE DEPARTMENT OF HUMAN SERVICES

OFFICE OF THE INSPECTOR GENERAL

Released: December 2004

State of Illinois
Office of the Auditor General

WILLIAM G. HOLLAND
AUDITOR GENERAL

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SYNOPSIS

This is our eighth audit of the Department of Human Services' Office of the Inspector General's (OIG's) effectiveness in investigating allegations of abuse or neglect. In Fiscal Year 2004, the Department of Human Services operated 17 State facilities and licensed, certified, or funded approximately 400 community agencies. The OIG has revised requirements in both its administrative rules and Investigative Directives that have had a significant impact on its operations. These include:

- Revised guidance on what constitutes abuse or neglect, resulting in a decrease in the number of abuse and neglect allegations reported to the OIG for investigation;
- No longer requiring serious injuries to residents not involving an abuse or neglect allegation to be reported to the OIG;
- A relaxing of the number of days to complete investigations from 60 calendar days to 60 working days;
- Less specific requirements and guidance in its Investigative Directives for investigators to follow; and
- Elimination of a minimum number of hours of training investigators are required to receive annually.

In this audit we also reported that:

- Timeliness of investigations has been an issue in all of the seven previous OIG audits. The OIG continued to have problems completing investigations timely. In Fiscal Year 2003, only 30 percent and in Fiscal Year 2004, only 39 percent were completed in 60 calendar days. In Fiscal Year 2002, 46 percent of investigations were completed in 60 calendar days.
- The OIG does not have an effective case management system in place to adequately monitor the timeliness of case completions. The OIG's case management system is not an electronic system, but is a series of manually prepared reports.
- OIG case reports generally were thorough, comprehensive, and addressed the allegation. Progress notes were obtained in cases where they were pertinent. However, photographs were not taken in 40 of 52 (77%) cases sampled where there was an allegation of an injury sustained.
- OIG investigators were not conducting their interviews with alleged victims in a timely manner. During our case file review, an average of 37 days elapsed from the date the OIG was notified of the incident to when the alleged victim was interviewed.
- The Quality Care Board (Board) did not meet statutory requirements regarding quarterly meetings, and in September 2004, all of the Board members' terms expired, leaving the Board without any current members.

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 2004, DHS operated 17 State facilities and licensed, certified, or funded approximately 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 eighth audit conducted of the OIG since 1990.

The OIG has revised requirements in both its administrative rules and Investigative Directives that have had a significant impact on its operations. These include:

- Revised guidance on what constitutes abuse or neglect, resulting in a decrease in the number of abuse and neglect allegations reported to the OIG for investigation;
- No longer requiring serious injuries to residents not involving an abuse or neglect allegation to be reported to the OIG;
- A relaxing of the number of days to complete investigations from 60 calendar days to 60 working days;
- Less specific requirements and guidance in its Investigative Directives for investigators to follow; and
- Elimination of a minimum number of hours of training investigators are required to receive annually.

The OIG has made three important changes affecting the allegation reporting process. As a result of these changes, the number of allegations of abuse and neglect and other reportable incidents has decreased significantly during the audit period. First, the OIG now requires that all allegations be reported to the OIG Hotline where intake staff conduct an assessment. If intake staff conclude that the incident does not constitute a reportable abuse or neglect allegation, the case is not investigated. Second, the OIG no longer requires reporting of serious injuries of residents, unless it involves an allegation of staff abuse or neglect. Third, the OIG's working definition of neglect has been narrowed.

In our 2002 audit of the OIG, we recommended that the OIG assure that investigators have clear and consistent guidance. Specifically,

the OIG operated under three versions of its administrative rules, and had memos, Directives, and Guidelines that were all in effect during portions of the last audit period. During this audit period, the OIG operated under one version of its administrative rules and Directives. However, during our review of the current OIG Directives, we found that vague investigative guidance may continue to leave investigative staff, especially new investigators, unclear on appropriate investigative requirements. The current OIG Directives in comparison to the former Guidelines have omitted important details in the areas of photographing and the collection and handling of physical evidence. These elements of an investigation are now left to the judgment of the investigator and if not completed properly might impede the investigation.

The OIG and the Illinois State Police signed an interagency agreement in January 2003. The agreement does not meet the statutory requirement established by the Act. The agreement provides guidance related to allegations involving State employees but not other allegations against non-State employees where evidence indicates a possible criminal act. This recommendation was also reported in our 2002 audit.

The OIG does not have the necessary monitoring in place to ensure that allegations are reported timely to the State Police as required by State law. The Act requires that the OIG notify State Police for all allegations where a possible criminal act has been committed or where special expertise is required in the investigation. In our testing of Fiscal Year 2004 cases, we found five cases which were referred to State Police. The OIG refers these cases to the State Police by telephone and OIG does not maintain documentation of these calls in the case files. We determined that 1 of the 5 (20%) cases was not referred to the State Police within 24 hours as required by the Act. The case was not reported for nine days.

Timeliness of investigations has been an issue in all of the seven previous OIG audits. During this audit period, the OIG continued to have problems completing investigations timely. In Fiscal Year 2003, only 30 percent and in Fiscal Year 2004, only 39 percent were completed in 60 calendar days. In Fiscal Year 2002, 46 percent of investigations were completed in 60 calendar days. The OIG changed its timeliness requirements from calendar days to working days in its administrative rules in January 2002. If working days are used, the OIG is still not completing its cases within the required 60-day time period. Using working days, only 46 percent of cases in Fiscal Year 2003 and 51 percent of cases in Fiscal Year 2004 were completed within 60 working days.

During our case file review, we found that the OIG investigators were not conducting their interviews with the alleged victims in a timely manner. In our sample, an average of 37 days elapsed from the date the

OIG was notified of the incident to when the alleged victim was interviewed. In addition, in 27 of 89 (30%) cases where OIG conducted an interview with the victim, the victim either recanted the allegation (19), did not remember the incident (5), or refused to cooperate (3). The average time taken by OIG investigators to interview victims in these 27 cases was 43 days. Timely interviews of the victims are imperative to ensure an effective and thorough investigation.

Data from the OIG database shows that none of the four investigative bureaus are reviewing substantiated cases within the timelines delineated in OIG Directive. The data shows that the review for substantiated cases is using a large percent of the 60-day time requirement that OIG has to complete its investigations. However, the review time may be overstated because the OIG's database does not capture the necessary dates to determine if any additional investigation is conducted once the case is submitted for review. The OIG should assure that substantiated cases of abuse and neglect are reviewed timely and that it captures the necessary data to allow for the monitoring of case review timeliness.

The OIG does not have an effective case management system in place to adequately monitor the timeliness of case completions. The OIG's case management system is not an electronic system, but is a series of manually prepared reports. We recommended that the Inspector General develop an electronic case management system to help manage investigation and case file review timeliness.

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 rules. Although there was improvement since our last audit in 2002, we found that in Fiscal Year 2004, 10 percent of facility incidents and 42 percent of community agency incidents were not reported within the required four-hour time frame.

OIG case reports generally were thorough, comprehensive, and addressed the allegation. All case files in our sample contained a Case Tracking Form, Case Routing/Approval Form, and Case Report. Additionally, progress notes were obtained in cases where they were pertinent. We did find that photographs were not taken in 40 of 52 (77%) cases sampled from Fiscal Year 2004 where there was an allegation of an injury sustained.

Due to recent policy changes made by the OIG, community agencies no longer conduct a significant number of investigations for the OIG. These changes include: requiring community agencies to accept the community agency protocol and be properly trained, as well as a change in administrative rule that only allows community agencies to investigate

cases that allege mental injury. In Fiscal Year 2004, 63 investigations were conducted by 40 community agencies. In Fiscal Year 2002, community agency investigators investigated 304 cases for the OIG.

In addition, community agencies are not being properly trained in basic investigative skills. Without proper training, investigative steps may not be completed properly and may hinder the investigation. Community agencies may take initial statements and collect evidence. In addition, the community agencies may not correctly assess an incident of abuse and neglect and may fail to report it to the OIG as required by law. The OIG should send all community agencies copies of the investigative protocol and training manuals and require the community agencies to adhere to the contents to help ensure that the community agency conducts the initial steps of an investigation properly for the OIG investigators.

The OIG has not established a comprehensive program to ensure that every person employed or newly hired to conduct investigations receives training on an on-going basis as required by the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6.5). As in our last OIG audit, issues regarding training were again noted in this audit period. We recommended that the Inspector General ensure that statutory requirements are met by developing and implementing a comprehensive and ongoing training program.

The Quality Care Board (Board) did not meet statutory requirements regarding quarterly meetings. This is the second OIG audit where the Board has not met quarterly as required by statute. Although the Board had three vacancies for most of Fiscal Year 2003 and all of Fiscal Year 2004, the Board met quarterly in all of Fiscal Year 2003 and all but the first quarter of Fiscal Year 2004. However, even though the Board met, it failed to have a quorum at 7 of the 8 meetings during Fiscal Years 2003 and 2004. In September 2004, the remaining three Board members' terms expired, leaving the Board without any current members.

The Office of the Inspector General did not timely submit its Fiscal Year 2003 Annual Report to the General Assembly and to the Governor in accordance with State law. The report, which is required to be submitted no later than January 1st of each year, was not printed until February 2004 and was not delivered until March 2004.

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 30/1 *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 was expanded to include the authority to investigate reports of abuse or neglect at facilities or programs not only operated by the Department of Human Services (facilities), but also those licensed, certified, or funded by DHS (community agencies).

As of May 2004, the OIG had 61 staff that included three on leave. This represents a decrease of seven positions from staffing levels reported in our 2002 OIG audit. Investigative staff for abuse or neglect investigations decreased from 39 in Fiscal Year 2000 to 27 in Fiscal Year 2002, and decreased to 22 (including two investigators on leave) in Fiscal Year 2004. The largest organizational unit within the OIG is the Bureau of Investigations. The Bureau of Investigations is responsible for conducting investigations of allegations of abuse or neglect. The OIG has established four regions or bureaus within the Bureau of Investigations.

In Fiscal Year 2004, the Department of Human Services operated 17 facilities Statewide that served 12,167 individuals. Eight facilities served the developmentally disabled, eight facilities served the mentally ill, and one facility served both. In addition, DHS licenses, certifies, or provides funding for approximately 400 community agency programs that provided services to approximately 24,500 individuals with developmental disabilities and approximately 168,000 individuals with mental illness in Fiscal Year 2004.

In the past, the Office of the Auditor General has conducted seven audits of the OIG to assess the effectiveness of its 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, 2000, and 2002. (pages 4-8, 20)

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

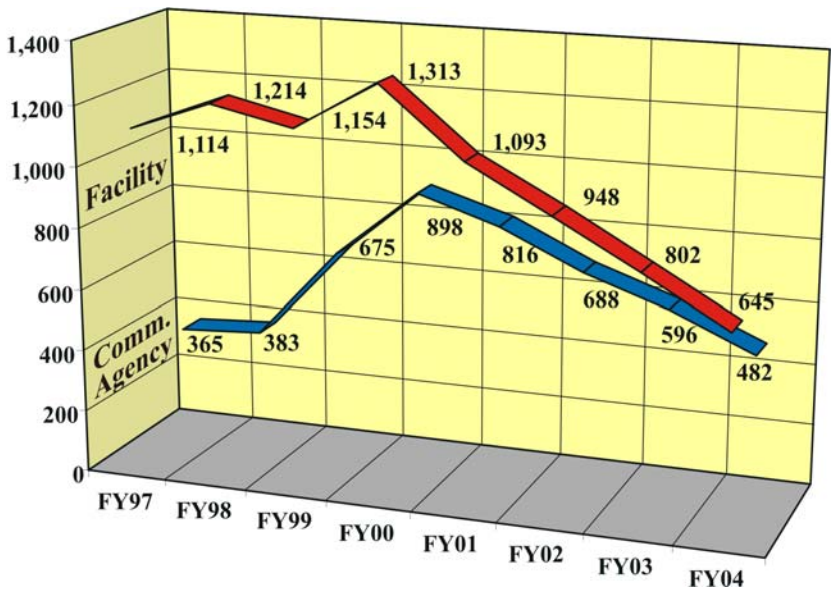
REPORTING OF ALLEGATIONS

Allegations of abuse and neglect reported to the OIG have been steadily decreasing over the last several years.

Allegations of abuse and neglect reported to the OIG have been steadily decreasing over the last several years. In Fiscal Year 2004, a total of 1,127 allegations of abuse or neglect were reported to the OIG (645 from State facilities and 482 from community agencies). Digest Exhibit 1 summarizes abuse or neglect allegations reported to the OIG from the two sources for Fiscal Years 1997 to 2004.

The OIG has made three important changes affecting the allegation reporting process. As a result of these changes, the number of allegations reported to the OIG has decreased significantly during this audit period. The three changes are: the OIG now requires direct reporting of allegations to the OIG Hotline; serious injury allegations are no longer reportable conditions; and the definition of neglect has been narrowed.

Digest Exhibit 1
TOTAL ABUSE OR NEGLECT ALLEGATIONS REPORTED TO OIG



Note: State facilities served 3,042 individuals with developmental disabilities and 9,125 individuals with mental illness in FY 2004. Community agencies served approximately 24,500 individuals with developmental disabilities and approximately 168,000 individuals with mental illness in FY 2004.

Source: OAG analysis of OIG data.

As a result of these changes:

- If Intake staff determine it is not a reportable allegation, the allegation is not entered into the database, thus reducing the number of inappropriate cases from being investigated.
- The OIG now considers serious injuries without an allegation of abuse or neglect to be not reportable.
- The OIG's position that harm is required to substantiate mental injury or neglect is eliminating cases that the OIG believed to be substantiated allegations of abuse and neglect in the past. (pages 8, 9, 14-16)

OIG INVESTIGATIONS

During our review of the OIG's Directives, we found that vague investigative guidance may continue to leave investigative staff, especially new investigators, unclear on appropriate investigative requirements. The current OIG Directives in comparison to the former Guidelines have omitted important detail in the areas of photographing and the collection and handling of physical evidence. These elements of an investigation are now left to the judgment of the investigator and if not followed properly might impede the investigation.

In addition, the OIG does not mandate the use of the investigative checklist by the investigators to ensure that all elements of an investigation are completed. Use of the checklist would serve as a review aid for Bureau Chiefs who could ensure that all elements of the investigation have been satisfied before a review is conducted, thereby aiding in the thoroughness and timeliness of their reviews. (pages 9-12)

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 OIG and the Illinois State Police signed an interagency agreement in January 2003. The agreement, however, does not meet the statutory requirement established by the Act. The agreement provides guidance related to allegations involving State employees but not allegations against non-State employees (such as employees at community agencies) where evidence indicates a possible criminal act. (pages 17-19)

INVESTIGATION TIMELINESS

During this audit period, the OIG continued to have problems completing investigations timely.

Timeliness of investigations has been an issue in all of the seven previous OIG audits. During this audit period, the OIG continued to have problems completing investigations timely. One of the clearest indicators of its continued problems is that in Fiscal Year 2002, 46 percent of investigations were completed in 60 calendar days, while in Fiscal Year 2003 only 30 percent and in Fiscal Year 2004 only 39 percent were completed in 60 calendar days. Digest Exhibit 2 shows timeliness data for OIG investigations for the last six fiscal years.

Since the OIG changed the definition of days from calendar to a more lenient working days in its administrative rules in January 2002, we also looked at the percent of cases completed within 60 working days. Even with the more lenient standard, the OIG only completed 46 percent of its Fiscal Year 2003 cases and 51 percent of its Fiscal Year 2004 cases within 60 working days.

The number of cases taking more than 200 days to complete increased from 41 in FY 2002 to 258 in FY 2004.

The number of cases taking more than 200 calendar days to complete has also increased significantly from Fiscal Year 2002. In Fiscal Year 2002, 41 cases took longer than 200 days to complete. By Fiscal Year 2004, the cases taking longer than 200 days to complete increased to 258. Investigations at State facilities completed during Fiscal Year 2004 accounted for 53 percent (136 of 258) of the cases that took longer than 200 days to complete and community agency investigations accounted for 47 percent (122 of 258). (pages 23-26)

Digest Exhibit 2
CALENDAR DAYS TO COMPLETE ABUSE OR NEGLECT INVESTIGATIONS
Fiscal Years 1999 to 2004

Days to Complete Cases	FY 1999 % of Cases	FY 2000 % of Cases	FY 2001 % of Cases	FY 2002 % of Cases	FY 2003 % of Cases	FY 2004 % of Cases
0-60	**21%**	**25%**	**49%**	**46%**	**30%**	**39%**
61-90	10%	18%	18%	31%	16%	11%
91-120	11%	14%	11%	13%	17%	10%
121-180	23%	16%	10%	6%	23%	20%
181-200	6%	4%	2%	1%	5%	5%
>200	30%	23%	10%	3%	9%	14%
Total > 60 days	**79%**	**75%**	**51%**	**54%**	**70%**	**61%**
Total Cases by FY	1,507	2,341	1,883	1,442	1,248	1,472

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

Source: OAG analysis of OIG data.

Illinois State Police

The OIG does not maintain documentation to record when cases are referred to the Illinois State Police. Statutes require that the OIG notify State Police within 24 hours of all allegations 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.

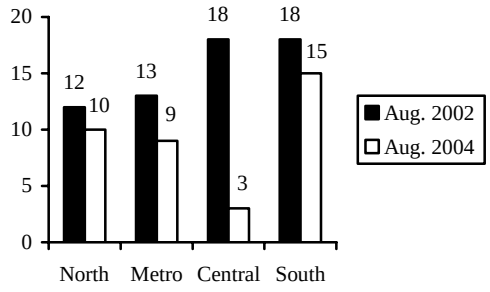
In our testing of Fiscal Year 2004 cases, we had five cases which were referred to State Police. The OIG refers these cases to the State Police by telephone and does not keep a record of these calls in the case files. However, the OIG was able to provide us with dates of the referrals for the five cases. One of the five (20%) was not referred to the State Police in 24 hours as required by statute. The case was not reported for nine days. (pages 28, 29)

Investigator Caseloads

Investigator caseloads do not appear to be a factor in untimely investigations. Digest Exhibit 3 shows that in all four investigative bureaus, investigator caseloads decreased from Fiscal Year 2002 to Fiscal Year 2004. The greatest decrease was in the Central Bureau where average caseloads decreased by 83 percent from 18 in Fiscal Year 2002 to 3 in Fiscal Year 2004. (pages 30, 31)

Investigator caseloads do not appear to be a factor in untimely investigations.

Digest Exhibit 3
INVESTIGATOR CASELOADS
By Bureau as of August 14, 2002 and 2004



Source: OIG data summarized by the OAG.

Timeliness of Investigative Interviews

During our case file review, we found that the OIG investigators were not conducting their interviews with the alleged victims in a timely manner. Timely interviews of alleged victims and perpetrators are important because as time passes memories may fade or witnesses may become unavailable for follow-up interviews. Even though initial statements are often taken at the time of the incident, delays in getting detailed interviews from those involved, especially from the alleged victim, increase the risk of losing information and weakening the evidence

obtained. Current OIG Directives do not specifically designate a required timeline for conducting interviews with those involved.

The average time to interview the victims from our sample was 37 days.

The average time to interview the victims from our sample was 37 days. In addition, in 27 of 89 (30%) cases the victim either recanted the allegation (19), did not remember the incident (5), or refused to cooperate (3). The average time it took OIG investigators to interview victims in these 27 cases was 43 days. Timely interviews of the victims are imperative to ensure an effective and thorough investigation. (pages 31, 32)

Timeliness of Case File Reviews

Data from the OIG database shows that none of the four Investigative Bureaus are reviewing substantiated cases within the timelines delineated in OIG Directive. OIG Directives allow the Investigative Team Leader and Bureau Chief each 5 working days to review substantiated and priority cases and 10 working days to review unsubstantiated and unfounded cases.

OIG's database does not track cases that were sent back for additional investigation. Therefore, our analysis only shows the total calendar days from date submitted for review until the Bureau Chief signs the case as reviewed. Without tracking cases sent back for additional investigations, OIG management cannot effectively monitor how long it takes for cases to be reviewed.

Case Management System for Timeliness

The OIG does not have an effective case management system in place to adequately monitor the timeliness of case completions.

The OIG does not have an effective case management system in place to adequately monitor the timeliness of case completions. The OIG's case management system is not an electronic system but is a series of manually prepared reports. The OIG has a Directive relating to its case management system; however, the reports produced do not provide adequate management control. (pages 33, 34)

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 rules. The current administrative rules require that

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

	FY03	FY04
Facilities	15%	10%
Community Agencies	42%	42%

Source: OAG analysis of OIG data.

allegations of abuse or neglect be reported to the OIG within four hours of discovery. In January 2002, the OIG increased the required reporting time from one hour to four hours. There have been improvements in the timely reporting of incidents since the last audit in 2002.

Community agencies continue to have untimely reports in comparison to facilities. Digest Exhibit 4 shows the time to report incidents for facilities and community agencies for Fiscal Year 2003 and Fiscal Year 2004. (pages 35, 36)

INVESTIGATION THOROUGHNESS

OIG case reports generally were thorough, comprehensive, and addressed the allegation. All case files in our sample contained a Case Tracking Form, Case Routing/Approval Form, and Case Report. Additionally, progress notes were obtained in cases where they were pertinent. We did find that photographs were not taken in 40 of 52 (77%) cases sampled where there was an allegation of an injury sustained.

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

Community Agency Investigations

Due to recent policy changes made by the OIG, community agencies no longer conduct a significant number of investigations for the OIG. In Fiscal Year 2004, 63 investigations were conducted by 40 community agencies. All 40 community agencies had accepted the community agency protocols required by the OIG. In Fiscal Year 2002, community agency investigators investigated 304 cases for the OIG. The decrease is due to two policy changes by the OIG 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.

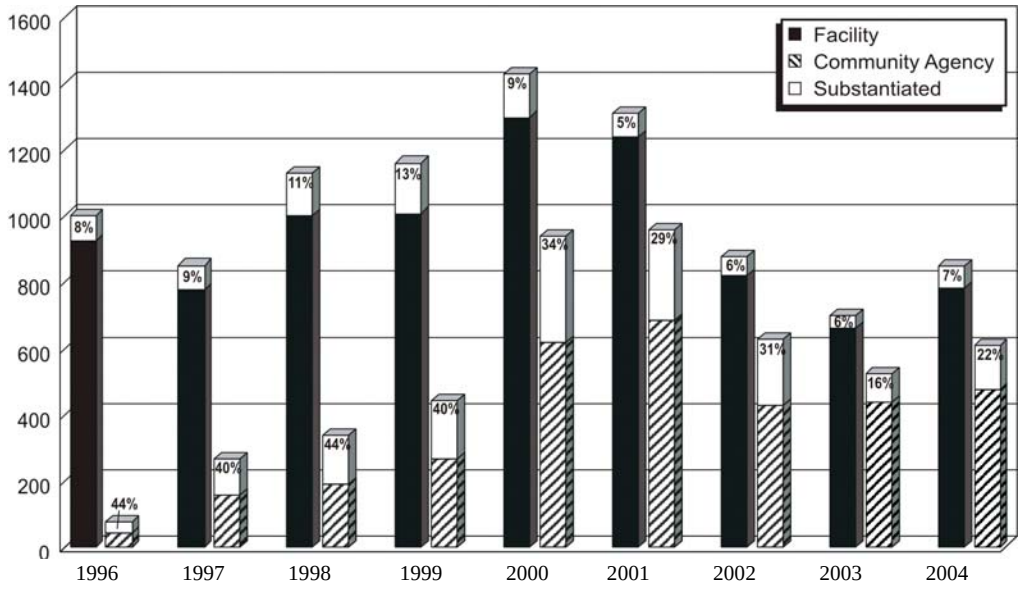
Community agencies are not being properly trained in basic investigative skills. Without proper training, investigative steps may not be completed properly and may hinder the investigation. Community agencies may take initial statements and collect evidence. In addition, the community agencies may not correctly assess an incident of abuse and neglect and may fail to report it to the OIG as required by law. The OIG should send all community agencies copies of the investigative protocol and training manuals and require the community agencies to adhere to the

contents to help ensure that the community agency conducts the initial steps of an investigation properly for the OIG investigators. (pages 37-41)

SUBSTANTIATED ABUSE AND NEGLECT CASES

In Fiscal Year 2004, the OIG closed a total of 1,455 investigations of allegations of abuse or neglect. The OIG substantiated 197 of the abuse or neglect allegations, resulting in a 14 percent substantiation rate. Digest Exhibit 5 shows the past nine 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. These numbers and percentages include substantiated cases that were classified as abuse or neglect at intake. (pages 43, 44)

Digest Exhibit 5
ABUSE AND NEGLECT CASES CLOSED AND SUBSTANTIATED FOR FACILITIES AND COMMUNITY AGENCIES
(Allegations Categorized as Abuse or Neglect at Intake)
Fiscal Years 1996 to 2004



Note: State facilities served 3,042 individuals with developmental disabilities and 9,125 individuals with mental illness in FY 2004. Community agencies served approximately 24,500 individuals with developmental disabilities and approximately 168,000 individuals with mental illness in FY 2004.

Source: OAG analysis of OIG data.

OIG INVESTIGATOR TRAINING

The OIG did not comply with the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6.5) to provide continuing education to its investigators.

The OIG did not comply with the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6.5) to provide continuing education to its investigators. The 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.

During the prior audit, the Directive on training stated that OIG investigators were required to have 10 hours of continuing education annually in the following areas: Investigations; Report Writing; Systems Improvement; or Provision of Service to persons with developmental disabilities or mental illness. The current Directive states that continuing OIG training requirements for investigators, that are necessary, will be determined by the Inspector General, and the annual requirement for 10 hours of continuing education was removed. The OIG did provide all orientation and initial training for the two investigators hired in Fiscal Year 2003. (pages 53-55)

QUALITY CARE BOARD

The Quality Care Board (Board) did not meet statutory requirements regarding quarterly meetings. This is the second OIG audit where the Board has not met quarterly as required by statute. The Board met quarterly in all of Fiscal Year 2003 and all but the first quarter of Fiscal Year 2004. However, even though the Board met, it failed to have a quorum at 7 of the 8 meetings during Fiscal Years 2003 and 2004. The November 2003 meeting was the only meeting that had a quorum.

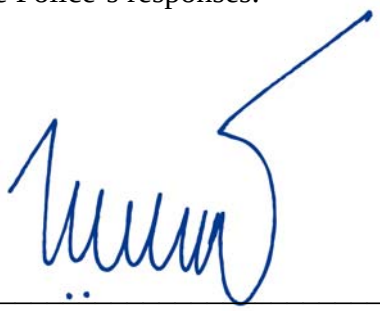
The Board minutes indicated that it had difficulty maintaining membership during this audit period. According to a Board official, the Board has not received the needed appointments for successors to fill vacant positions, nor has it received reappointments for members whose terms have expired. In June 2004, one of the remaining Board members resigned, leaving the Board unable to have a quorum. In September 2004, the remaining three Board members' terms expired, leaving the Board without any current members. (pages 55, 56)

ANNUAL REPORT

The Office of the Inspector General did not submit its Fiscal Year 2003 Annual Report to the General Assembly and to the Governor in accordance with 210 ILCS 30/6.7. Section 6.7 of the Abused and Neglected Long Term Care Facility Residents Reporting Act requires the OIG to submit the Annual Report to the General Assembly and to the Governor no later than January 1st of each year. Although the transmittal letter accompanying the Annual Report addressed to the members of the General Assembly and to the Governor was dated December 2003, the report was not printed until February 2004 and was not delivered until March 2004. (pages 56, 57)

RECOMMENDATIONS

The audit report contains 12 total recommendations, 10 related to the Office of the Inspector General, one recommendation to both the Office of the Inspector General and the Illinois State Police, and one to the Office of the Inspector General and the Department of Human Services. While the Inspector General's response noted that the OIG intends to implement most of the recommendations, the response did raise some concerns with conclusions reached in the audit report. The State Police agreed with its recommendation. Appendix E to the audit report contains the Inspector General's and the State Police's responses.



WILLIAM G. HOLLAND
Auditor General

WGH\EKW

December 2004

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Chapter One

INTRODUCTION AND BACKGROUND

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 2004, DHS operated 17 State facilities and licensed, certified, or funded approximately 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 eighth audit conducted of the OIG since 1990.

The OIG has revised requirements in both its administrative rules and Investigative Directives that have had a significant impact on its operations. These include:

- Revised guidance on what constitutes abuse or neglect, resulting in a decrease in the number of abuse and neglect allegations reported to the OIG for investigation;
- No longer requiring serious injuries to residents not involving an abuse or neglect allegation to be reported to the OIG;
- A relaxing of the number of days to complete investigations from 60 calendar days to 60 working days;
- Less specific requirements and guidance in its Investigative Directives for investigators to follow; and
- Elimination of a minimum number of hours of training investigators are required to receive annually.

The OIG has made three important changes affecting the allegation reporting process. As a result of these changes, the number of allegations of abuse and neglect and other reportable incidents has decreased significantly during the audit period. First, the OIG now requires that all allegations be reported to the OIG Hotline where intake staff conducts an assessment. If intake staff conclude that the incident does not constitute a reportable abuse or neglect allegation, the case is not investigated. Second, the OIG no longer requires reporting of serious injuries of residents, unless it involves an allegation of staff abuse or neglect. Third, the OIG's working definition of neglect has been narrowed.

In our 2002 audit of the OIG, we recommended that the OIG assure that investigators have clear and consistent guidance. Specifically, the OIG operated under three versions of its

administrative rules, and had memos, Directives, and Guidelines that were all in effect during portions of the last audit period. During this audit period, the OIG operated under one version of its administrative rules and Directives. However, during our review of the current OIG Directives, we found that vague investigative guidance may continue to leave investigative staff, especially new investigators, unclear on appropriate investigative requirements. The current OIG Directives in comparison to the former Guidelines have omitted important details in the areas of photographing and the collection and handling of physical evidence. These elements of an investigation are now left to the judgment of the investigator and if not completed properly might impede the investigation.

The OIG and the Illinois State Police signed an interagency agreement in January 2003. The agreement does not meet the statutory requirement established by the Act. The agreement provides guidance related to allegations involving State employees but not other allegations against non-State employees where evidence indicates a possible criminal act. This recommendation was also reported in our 2002 audit.

The OIG does not have the necessary monitoring in place to ensure that allegations are reported timely to the State Police as required by State law. The Act requires that the OIG notify State Police for all allegations where a possible criminal act has been committed or where special expertise is required in the investigation. In our testing of Fiscal Year 2004 cases, we found five cases which were referred to State Police. The OIG refers these cases to the State Police by telephone and OIG does not maintain documentation of these calls in the case files. We determined that 1 of the 5 (20%) cases was not referred to the State Police within 24 hours as required by the Act. The case was not reported for nine days.

Timeliness of investigations has been an issue in all of the seven previous OIG audits. During this audit period, the OIG continued to have problems completing investigations timely. In Fiscal Year 2003, only 30 percent and in Fiscal Year 2004, only 39 percent were completed in 60 calendar days. In Fiscal Year 2002, 46 percent of investigations were completed in 60 calendar days. The OIG changed its timeliness requirements from calendar days to working days in its administrative rules in January 2002. If working days are used, the OIG is still not completing its cases within the required 60-day time period. Using working days, only 46 percent of cases in Fiscal Year 2003 and 51 percent of cases in Fiscal Year 2004 were completed within 60 working days.

During our case file review, we found that the OIG investigators were not conducting their interviews with the alleged victims in a timely manner. In our sample, an average of 37 days elapsed from the date the OIG was notified of the incident to when the alleged victim was interviewed. In addition, in 27 of 89 (30%) cases where OIG conducted an interview with the victim, the victim either recanted the allegation (19), did not remember the incident (5), or refused to cooperate (3). The average time taken by OIG investigators to interview victims in these 27 cases was 43 days. Timely interviews of the victims are imperative to ensure an effective and thorough investigation.

Data from the OIG database shows that none of the four investigative bureaus are reviewing substantiated cases within the timelines delineated in OIG Directive. The data shows that the review for substantiated cases is using a large percent of the 60-day time requirement

that OIG has to complete its investigations. However, the review time may be overstated because the OIG's database does not capture the necessary dates to determine if any additional investigation is conducted once the case is submitted for review. The OIG should assure that substantiated cases of abuse and neglect are reviewed timely and that they capture the necessary data to allow for the monitoring of case review timeliness.

The OIG does not have an effective case management system in place to adequately monitor the timeliness of case completions. The OIG's case management system is not an electronic system, but is a series of manually prepared reports. We recommended that the Inspector General develop an electronic case management system to help manage investigation and case file review timeliness.

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 rules. Although there was improvement since our last audit in 2002, we found that in Fiscal Year 2004, 10 percent of facility incidents and 42 percent of community agency incidents were not reported within the required four-hour time frame.

OIG case reports generally were thorough, comprehensive, and addressed the allegation. All case files in our sample contained a Case Tracking Form, Case Routing/Approval Form, and Case Report. Additionally, progress notes were obtained in cases where they were pertinent. We did find that photographs were not taken in 40 of 52 (77%) cases sampled from Fiscal Year 2004 where there was an allegation of an injury sustained.

Due to recent policy changes made by the OIG, community agencies no longer conduct a significant number of investigations for the OIG. These changes include: requiring community agencies to accept the community agency protocol and be properly trained, as well as a change in administrative rule that only allows community agencies to investigate cases that allege mental injury. In Fiscal Year 2004, 63 investigations were conducted by 40 community agencies. In Fiscal Year 2002, community agency investigators investigated 304 cases for the OIG.

In addition, community agencies are not being properly trained in basic investigative skills. Without proper training, investigative steps may not be completed properly and may hinder the investigation. Community agencies may take initial statements and collect evidence. In addition, the community agencies may not correctly assess an incident of abuse and neglect and may fail to report it to the OIG as required by law. The OIG should send all community agencies copies of the Protocol and training manuals and require the community agencies to adhere to the contents to help ensure that the community agency conducts the initial steps of an investigation properly for the OIG investigators.

The OIG has not established a comprehensive program to ensure that every person employed or newly hired to conduct investigations receives training on an on-going basis as required by the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6.5). As in our last OIG audit, issues regarding training were again noted in this audit period. We recommended that the Inspector General ensure that statutory requirements are met by developing and implementing a comprehensive and ongoing training program.

The Quality Care Board (Board) did not meet statutory requirements regarding quarterly meetings. This is the second OIG audit where the Board has not met quarterly as required by statute. Although the Board had three vacancies for most of Fiscal Year 2003 and all of Fiscal Year 2004, the Board met quarterly in all of Fiscal Year 2003 and all but the first quarter of Fiscal Year 2004. However, even though the Board met, they failed to have a quorum at 7 of the 8 meetings during Fiscal Years 2003 and 2004. In September 2004, the remaining three Board members' terms expired, leaving the Board without any current members.

The Office of the Inspector General did not timely submit its Fiscal Year 2003 Annual Report to the General Assembly and to the Governor in accordance with State law. The report, which is required to be submitted no later than January 1 of each year, was not printed until February 2004 and was not delivered until March 2004.

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 30/1 *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 was expanded to include the authority to investigate reports of abuse or neglect at facilities or programs not only operated by the Department of Human Services (facilities), but also those licensed, certified, or funded by DHS (community agencies).

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 amended administrative rules (59 Ill. Adm. Code 50) were adopted October 19, 1998. The rules require that facilities and community agencies report incidents of alleged abuse or neglect to the OIG. During our last OIG audit, these administrative rules were revised with an emergency rule and then a final rule effective May 24, 2002.

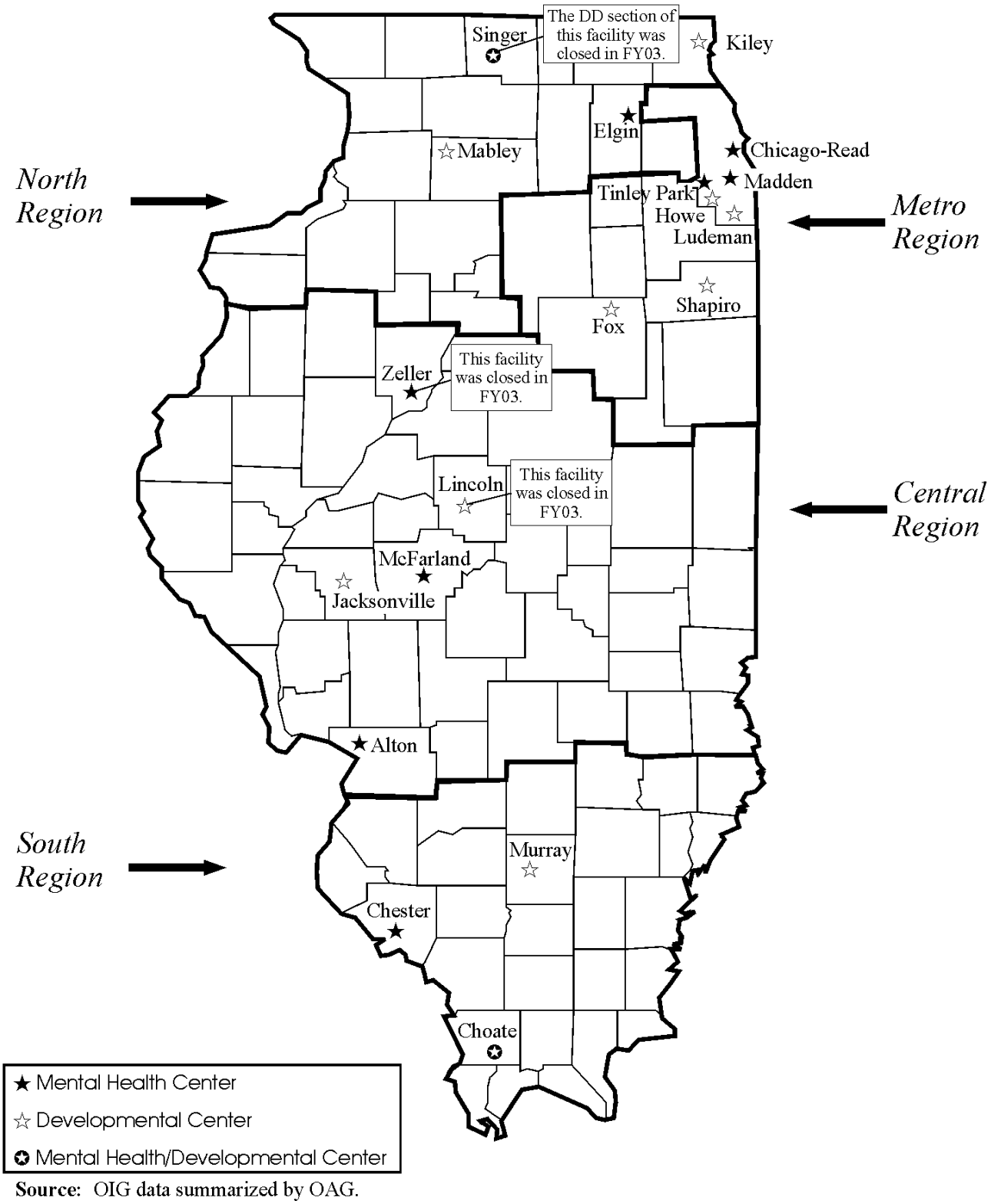
The Inspector General is located within the Department of Human Services and is appointed by the Governor and confirmed by the Senate for a four-year term. The current Inspector General was appointed in May 2003.

The Abused and Neglected Long Term Care Facility Residents Reporting Act (Act) directs the Auditor General to conduct a biennial program audit of the Department of Human Services, Office of the Inspector General. The Act specifically requires the audit to include the Inspector General's effectiveness in investigating reports of alleged neglect or abuse of residents in any facility operated by the Department of Human Services and in making any recommendations for sanctions to DHS and to the Department of Public Health. The Act requires that the audit be released no later than January 1 of each odd-numbered year. In the past, the Act contained a sunset clause that required authorization by the General Assembly before each audit began. Public Act 93-636, effective December 31, 2003, eliminated the sunset clause.

In Fiscal Year 2004, the Department of Human Services operated 17 facilities Statewide that served 12,167 individuals. Eight facilities served the developmentally disabled, eight facilities served the mentally ill, and one facility served both. In Fiscal Year 2003, two facilities and half of a third were closed. Exhibit 1-1 shows the location of the DHS operated facilities, and indicates whether the facilities are part of the OIG's North, Metro, Central, or South region or bureau.

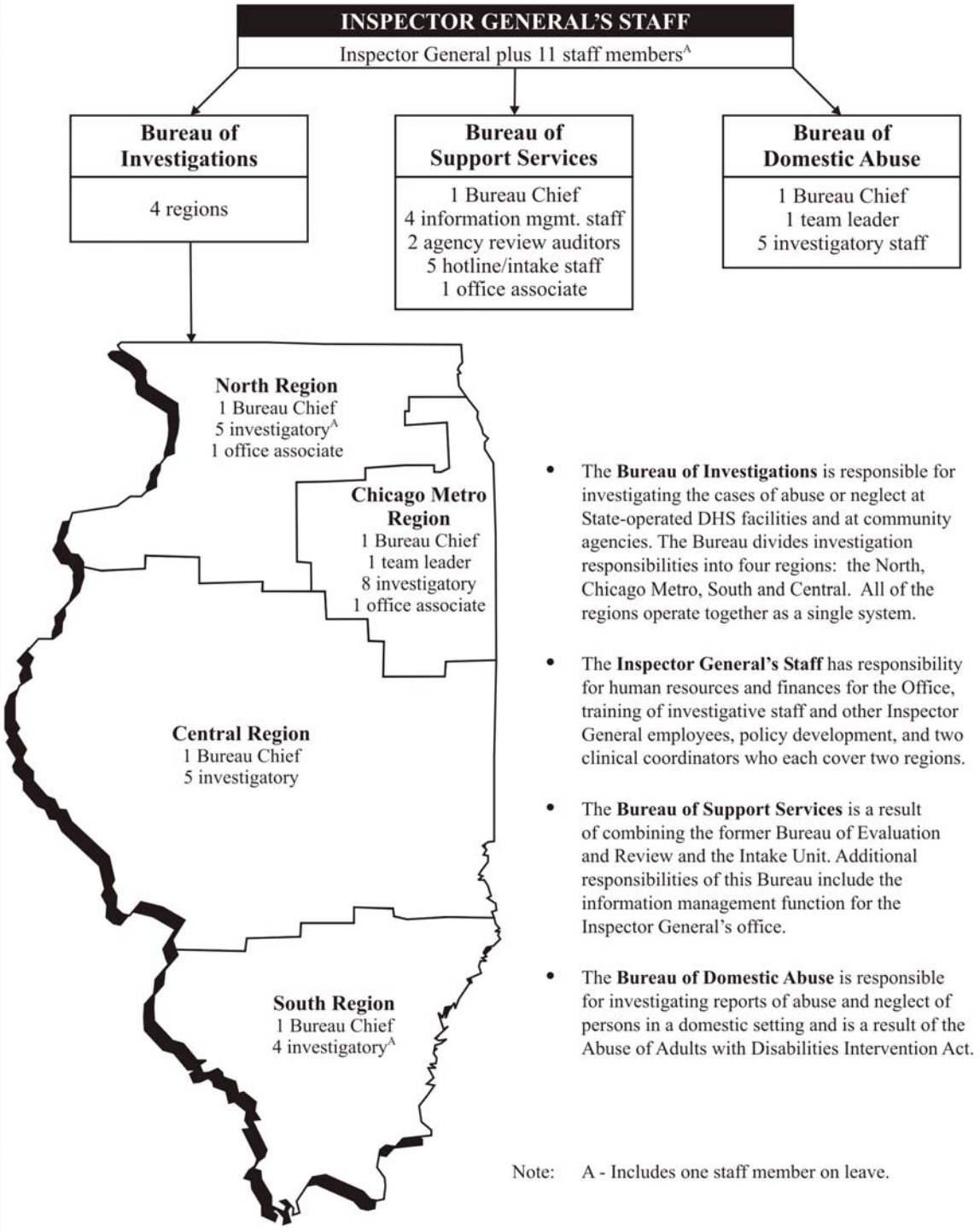
In addition, DHS licenses, certifies, or provides funding for approximately 400 community agency programs that provide services to the developmentally disabled and the mentally ill in community settings within Illinois. These community agency programs provide transportation services, workshops, or community living arrangements. In Fiscal Year 2004, approximately 24,500 individuals with developmental disabilities and approximately 168,000 individuals with mental illness were served in community agencies required to report to the OIG.

Exhibit 1-1
DHS OPERATED RESIDENT FACILITIES AND OIG REGIONS



Source: OIG data summarized by OAG.

Exhibit 1-2
OIG ORGANIZATIONAL CHART
As of May 1, 2004



- 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 regions: the North, Chicago Metro, South and Central. All of the regions 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, policy development, and two clinical coordinators who each cover two regions.
- 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: A - Includes one staff member on leave.

Source: OIG data summarized by OAG.

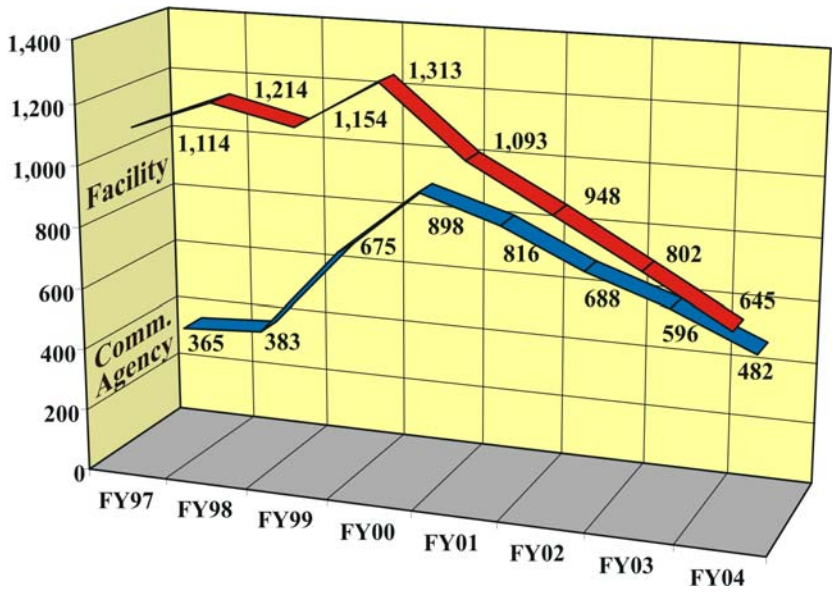
OIG Organization

As of May 2004, the OIG had 61 staff that included three on leave. This represents a decrease of seven positions from staffing levels reported in our 2002 OIG audit. Investigative staff for abuse or neglect investigations decreased from 39 in Fiscal Year 2000 to 27 in Fiscal Year 2002, and decreased to 22 (including two on leave) in Fiscal Year 2004. The largest organizational unit within the OIG is the Bureau of Investigations. The Bureau of Investigations is responsible for conducting investigations of allegations of abuse or neglect. As shown in Exhibit 1-2, the OIG has established four regions or bureaus within the Bureau of Investigations. Each region has a Bureau Chief and investigative staff. The Metro Bureau has an Investigative Team Leader who is responsible primarily for case file review. The other three do not have Investigative Team Leaders. Exhibit 1-2 shows the organizational structure of the OIG and the number of staff in each of the regions. In our last audit, the OIG had an appropriation of $6 million for Fiscal Year 2002. In Fiscal Year 2003, the appropriation was $6.2 million and for Fiscal Year 2004 the appropriation was $5.8 million.

Trends in Allegations of Abuse or Neglect

Allegations of abuse and neglect reported to the OIG have been steadily decreasing over the last several years. In Fiscal Year 2004, a total of 1,127 allegations of abuse or neglect were reported to the OIG (645 from State facilities and 482 from community agencies). Exhibit 1-3 summarizes abuse or neglect allegations reported to the OIG from the two sources for Fiscal Years 1997 to 2004. State facilities served 3,042 individuals with developmental disabilities and 9,125 individuals with mental illness in Fiscal Year 2004. Community agencies served 24,500 individuals with developmental disabilities and 168,000 individuals with mental illness in Fiscal Year 2004.

Exhibit 1-3
TOTAL ABUSE OR NEGLECT ALLEGATIONS REPORTED TO OIG



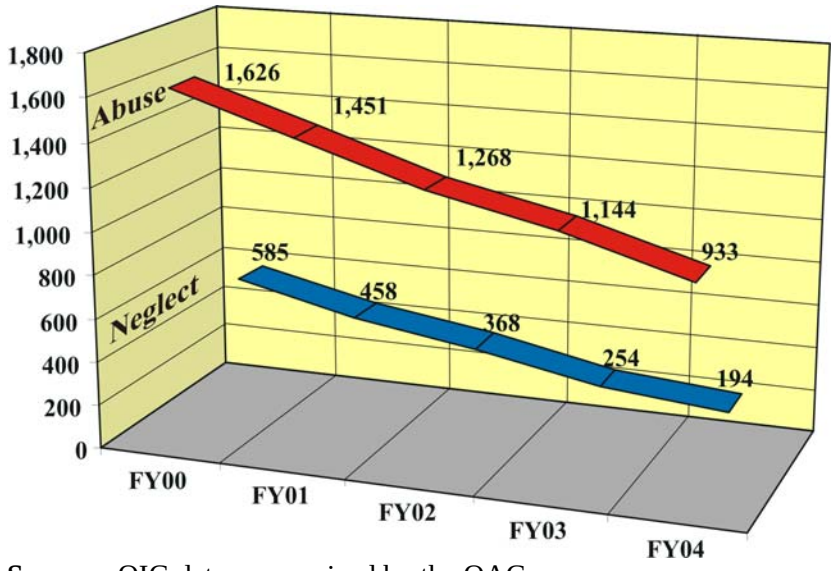
Note: State facilities served 3,042 individuals with developmental disabilities and 9,125 individuals with mental illness in FY 2004. Community agencies served approximately 24,500 individuals with developmental disabilities and approximately 168,000 individuals with mental illness in FY 2004.

Source: OAG analysis of OIG data.

Allegations of abuse reported to the OIG have decreased 43 percent since Fiscal Year 2000. In Fiscal Year 2000, there were 1,626 abuse allegations reported to the OIG. This compares to 933 in Fiscal Year 2004.

Allegations of neglect have declined 67 percent since Fiscal Year 2000. In Fiscal Year 2000, there were 585 neglect allegations reported to the OIG. This compares to 194 in Fiscal Year 2004. Exhibit 1-4 shows the trends in reporting of abuse and neglect to the OIG. Reasons for the decrease in allegations of abuse and neglect are discussed in the following sections.

Exhibit 1-4
TRENDS IN REPORTING ABUSE & NEGLECT
Fiscal Years 2000 to 2004



Source: OIG data summarized by the OAG.

OIG INVESTIGATIONS

On May 24, 2002, the Office of the Inspector General amended its administrative rules, changing how the OIG interprets what is required to be reported as abuse and neglect. As a result, in Fiscal Year 2002, 1,636 allegations of abuse and neglect were reported to the OIG compared to only 1,127 in Fiscal Year 2004. The number of abuse and neglect allegations reported has steadily been declining since Fiscal Year 2000 when 2,211 were reported.

Abuse

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

Neglect

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.

In addition, the number of investigations conducted by the OIG significantly decreased. The change in rule primarily shortened explanations and definitions leaving room for more interpretation. The changes include:

- The definition of abuse no longer specifically includes abuse inflicted on an individual by another person who is not an employee.
- The definition of mental injury no longer specifically includes verbal or psychological abuse or exploitation by an employee.
- Neglect, under the new definition must now result in physical or mental injury to an individual or in the deterioration of an individual’s physical or mental condition.

- Deaths of individuals receiving mental health outpatient services are no longer reportable unless there is a specific allegation or suspicion of abuse or neglect by the agency.
- Serious injury cases are no longer specifically reportable to the OIG.
- Community Agencies with an approved protocol are only allowed to investigate allegations of mental injury.

Investigative Process

During our audit period, the investigation process began when an allegation was reported to the OIG Hotline. The case was then assigned to the Investigative Bureau 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.

When the Investigator conducts an investigation, an investigative plan of action will be developed in accordance with OIG Directives and submitted to the Inspector General within 60 working days of the assignment unless there are extenuating circumstances. The investigation will end with an Investigative Report outlining the investigative activities including a determination of findings. This report will be forwarded via e-mail to the Investigative Team Leader (if applicable) and the Bureau Chief for initial review and approval. According to OIG Directive, the case is required to be reviewed within the following time frames: substantiated and priority cases will be reviewed within 5 working days of receipt; unsubstantiated and unfounded cases will be reviewed within 10 working days of receipt. Once the Bureau Chief reviews and approves a substantiated case of physical abuse, sexual abuse, or egregious neglect, it will then be sent to the Inspector General or his/her designee for review.

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

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

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

The OIG sends notice of the outcome of the investigation to the complainant, the individual who was allegedly abused or neglected or his or her legal guardian, and the person

alleged to have committed the offense. If any of these parties disagree with the findings or wants more information, they may submit in writing a request for reconsideration or clarification. Requests for clarification or reconsideration must be submitted within 15 working days after the receipt of the report or notification of the finding(s). All requests must include new information that could change the finding.

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

Investigative Guidance

In our 2002 audit of the OIG, we recommended that the OIG assure that investigators have clear and consistent guidance. We found that various changes in investigative guidance may have left investigative staff unclear on appropriate definitions and investigative requirements. Specifically, the OIG operated under three versions of its administrative rules, and had memos, Directives, and Guidelines that were all in effect during portions of the last audit period. The OIG addressed this recommendation and during this audit period operated under one version of its administrative rules. The OIG also rescinded all Investigative Guidelines and replaced them with a complete set of Investigative Directives.

During our review of the OIG's Directives, we found that vague investigative guidance may continue to leave investigative staff, especially new investigators, unclear on appropriate investigative requirements. The current OIG Directives in comparison to the Guidelines have omitted important detail in the areas of photographing and the collection and handling of physical evidence. These elements of an investigation are now left to the judgment of the investigator and if not followed properly might impede the investigation.

Photographs

In the former OIG Guidelines, photographs were required in all instances where an injury had been sustained as a result of an incident. Also, the Guidelines provided detailed instructions on how and what to photograph during an investigation. This vital investigative step provides evidence of the location and severity of an injury and may be useful in proving or disproving an allegation or extent of an injury. It also provides documentation of the location of evidence and spatial relationship. The OIG Directives list photographing as a step on a checklist; however, this checklist is not required to be used by investigators. The use of photographs is now left to the judgment of the investigator. There is no additional guidance in the Directives concerning the detailed instructions that was contained in the former Guidelines. We found that photographs were not taken in 40 of 52 cases we sampled in Fiscal Year 2004 where there was an allegation of an injury sustained.

Evidence Collection and Handling

Another crucial investigative area that has been left to the judgment of investigators is the proper handling and collection of evidence from an investigative scene. The former Guidelines provided detailed steps on how to collect and preserve evidence. For example, clothing which contains blood-borne pathogens or is stained with fluid should be allowed to dry before packaging in plain wrapping paper or paper bags. The paper, unlike plastic bags, allows for the flow of air and therefore does not precipitate rotting or bacterial growth. This type of guidance is absent from the Directives, which could lead to the mishandling of evidence by investigators, and could hinder the reliability of an investigation.

Investigative Checklist

The Directives manual contains a checklist that lists the steps an investigator may perform while conducting an investigation. This checklist includes taking photographs and collecting physical evidence. The checklist only lists the steps, and does not detail specific instances where photographs should be taken or how evidence is to be collected. Use of the checklist by the investigators is not required unless mandated by the Bureau Chief. During file testing we found that 25 of 125 case files contained an investigative checklist.

The OIG should amend the current Directives to include detailed guidance relating to photographs and evidence handling and collection to ensure investigations are consistent, complete, and reliable. In addition, the OIG should mandate the use of the investigative checklist by the investigators to ensure that all elements of an investigation are completed. The checklist would serve as a review aid for Bureau Chiefs who could ensure that all elements of the investigation have been satisfied before a review is conducted, thereby aiding in the thoroughness and timeliness of their reviews.

INVESTIGATIVE GUIDANCE	
RECOMMENDATION 1	***The Inspector General should assure that clear and consistent investigative guidance is available for investigators by amending the Directive to include specific guidance in the areas of photographing and the handling and collection of evidence. The Inspector General should also require that photographs are taken in all instances where physical injury is alleged. In addition, the Inspector General should mandate the use of the Investigative checklist. This would aid both investigators and Bureau Chiefs in conducting and reviewing an investigation.***

OFFICE OF THE INSPECTOR GENERAL RESPONSE [A] Due to the length of the exhibit that the OIG references in its response, the exhibit has not been included in this report, but can be viewed on-line with the report at www.state.il.us/auditor or at the Auditor General's Springfield or Chicago Offices.	The Office of Inspector General ("OIG") agrees that each investigation should have a written plan of action prior to the commencement of any investigation to ensure that all investigations proceed in a timely manner. However, OIG contends that staff are provided with clear and consistent investigative direction; in fact, we note that in but two instances did the audit find OIG's directives to be vague. First, newly hired investigators must complete an extensive 3 month training program which clearly and explicitly explains the entire investigative process, covering such topics as investigative planning, the collection of evidence and when and how to take photographs *(see exhibit 1)*.[A] Moreover, all OIG staff receive the OIG training manual which clearly outlines exactly how to collect different types of evidence as well as how and when to take photographs. Thus, while the Directives Manual does not cover all investigative techniques, the Training Manual does provide this level of detail and serves as a "How To" guide. Secondly, this information is reiterated at bureau meetings, in net-learning modules, and in-service training classes. OIG urges the Auditor General to recognize that certain critical investigative decisions must be left to the discretion of investigators and their supervisors to ensure that we devote our resources where most beneficial to the investigation. We specifically take issue with any recommendation that OIG formulate a directive requiring investigators to take photographs in all physical abuse cases. Where the taking of a photograph will not reveal evidence nor disprove evidence of an injury, photographs are of no evidentiary value, are not fiscally prudent, and are not an efficient use of investigative time. In fact, photographs that do not show an apparent injury can undermine a substantiated finding of physical abuse.
	AUDITOR COMMENT: As noted by the Inspector General, evidence handling is addressed in training manuals and net-learning modules, and reiterated at bureau meetings and in-service training classes. The auditors concluded that evidence handling also should be included in the Directives that are intended to provide guidance to investigators (as prior OIG Investigations Guidelines have done). Specifically regarding photographs, the auditors stand by the recommendation that photographs should be taken in all abuse and neglect cases where injuries are alleged. Furthermore, the Inspector General's position in response to this audit report appears to contradict both the OIG's community agency protocol and OIG training materials. The protocol still requires photographs to be taken "when injuries are the result of an alleged incident of abuse or neglect . . . even if the injury is not evident at the time of report/discovery." (see OIG Exhibit III, p. 11 on-line at www.state.il.us/auditor)[A] Training material provided by the OIG also states that "Photographs document the existence of injuries or the lack thereof." (see OIG Exhibit I Photographs section on-line at www.state.il.us/auditor)[A]

REPORTING OF ALLEGATIONS

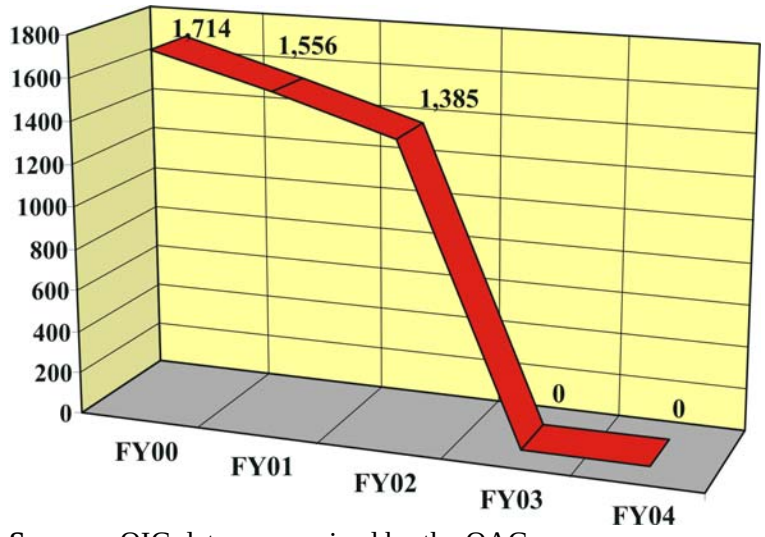
Total incidents of alleged abuse and neglect and serious injuries reported to the OIG have decreased significantly since Fiscal Year 2000. In Fiscal Year 2000, 3,925 incidents were reported (1,626 abuse, 585 neglect, and 1,714 serious injury). In Fiscal Year 2004, only 1,127 incidents were reported (933 abuse, 194 neglect, and 0 serious injury). The OIG has made three important changes affecting the allegation reporting process. As a result of these changes, the number of allegations reported to the OIG has decreased significantly during this audit period (see Exhibits 1-3 and 1-4). The three changes are: the OIG now requires direct reporting of allegations to the OIG Hotline; serious injury allegations are no longer reportable conditions; and the definition of neglect has been narrowed.

Direct Reporting to the OIG Hotline

All facilities and community agencies are now reporting allegations of abuse and neglect by calling into the OIG Hotline. This allows OIG Intake staff to make an assessment as to whether the allegation is abuse or neglect, thus reducing the number of inappropriate cases from being investigated. Intake personnel directly enter the information into a database and the case is then e-mailed to the bureaus to begin the investigation. According to OIG officials, non-reportable allegations that are reported to the OIG Hotline are not entered into the database; however a manual record is created.

If Intake staff determines it is not a reportable allegation, the allegation is not entered into the database. If all incidents were captured, it would allow for quality assurance by a supervisor to ensure that all reportable cases are being investigated. In addition, the data would be present to allow investigators to look for patterns which may be indicative of abuse or neglect. For example, if a patient is continuously being injured, even though it may not be an allegation of abuse or neglect, the OIG may want to follow up to determine the cause. It would also allow the investigators to look for patterns of abuse or neglect at individual facilities or agencies and by individual employees at the facilities or agencies.

Exhibit 1-5
TRENDS IN SERIOUS INJURIES REPORTED
Fiscal Years 2000 to 2004



Source: OIG data summarized by the OAG.

Serious Injuries

The OIG now considers serious injuries without an allegation of abuse or neglect to be not reportable. In the past, these cases were reported and were investigated by the OIG

even though there was no allegation of abuse or neglect. The OIG has made the interpretation that it is not required to investigate these serious injury cases and has taken the necessary steps to ensure that these cases are no longer reported or investigated. Exhibit 1-5 shows that serious injury cases reported have decreased from 1,714 in Fiscal Year 2000 to 0 in Fiscal Years 2003 and 2004. However, as noted above, capturing the information for these cases in its database would enable investigators to look for patterns. In addition, it should be up to the OIG to determine if an injury was caused by abuse or neglect, not the facility or community agency that may have an interest to not report.

Serious injuries caused by neglect may not have a direct allegation associated with them, such as incidents involving resident on resident injuries. Resident on resident incidents may be a result of neglect by staff and the OIG should consider requiring that these types of cases be reported for review and/or investigation. In addition, an Illinois Department of Public Health official noted IDPH looks into all allegations of abuse or neglect including resident on resident incidents.

Definition of Neglect and Mental Injury

The OIG's interpretation of the definitions for neglect and mental injury appear to have reduced the number of cases reported and the number of cases substantiated in two categories of abuse and neglect allegations. In a memorandum provided by the OIG, the Inspector General states that neglect "now requires harm or deterioration in the individual's condition" and, therefore, the OIG is no longer substantiating cases unless neglect results in harm. However, this seems to conflict with OIG's reporting category of "Neglect with Risk of Harm or Injury." As Exhibit 1-6 shows, the number of cases reported in this category has declined.

Exhibit 1- 6
DECREASED ALLEGATIONS AND SUBSTANTIATIONS FOR MENTAL INJURY (VERBAL) AND NEGLECT WITH RISK OF HARM OR INJURY CASES
Fiscal Years 2002 and 2004

Fiscal Year	Mental Injury (Verbal) Alleged		Neglect with Risk of Harm or Injury	
	Allegations Reported	Substantiated Cases	Allegations Reported	Substantiated Cases
FY 2002	266	44	142	49
FY 2004	57	21	51	8
Percent of Change	(79%)	(52%)	(64%)	(84%)

Source: OIG data summarized by the OAG.

Decreases in allegations reported and cases substantiated in two of the OIG's codes used to categorize allegations of abuse and neglect appear to be related to OIG's determination that harm is now required. These two category codes are for "mental injury (verbal) alleged" and "neglect with risk of harm or injury." In Fiscal Year 2002, these two category codes combined for 408 allegations and 93 substantiated cases. In Fiscal Year 2004, the two combined for 108 allegations and 29 substantiated cases. Therefore, substantiated cases

decreased 69 percent in these two categories. The OIG's position that harm is required to substantiate mental injury or neglect is eliminating cases that the OIG believed to be substantiated allegations of abuse and neglect in the past. Exhibit 1-6 shows the decline in both allegations and substantiations from Fiscal Year 2002 to Fiscal Year 2004.

REPORTING OF ALLEGATIONS	
RECOMMENDATION 2	***The Inspector General should take the following actions:*** • ***capture data for all allegations of serious injuries in its database;*** • ***require all resident on resident incidents be reported;*** • ***ensure that all injuries which meet the statutory definition of abuse or neglect are reported and adequately investigated; and*** • ***clarify its definitions of neglect and mental injury to ensure that all cases of abuse and neglect are reported. In addition, training should be provided to ensure that all necessary individuals understand these definitions.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE [A] Due to the length of the exhibit that the OIG references in its response, the exhibit has not been included in this report, but can be viewed on-line with the report at www.state.il.us/auditor or at the Auditor General's Springfield or Chicago Offices.	OIG's current operating procedures do ensure that all allegations of abuse and neglect as defined by 59 Ill. Admin. Code 50, (Rule 50), are reported and thoroughly investigated. Moreover, although the language of the audit report suggests otherwise, the report fails to demonstrate that allegations are not being reported or thoroughly investigated in accordance with both the statute and Rule 50. While an argument can be made that capturing data on serious injuries may reveal evidence of abuse or neglect, OIG's years of research and analysis of data revealed that most often serious injuries were the result of an accident or the individual engaging in self-injurious behaviors. Such injuries, though a matter of concern, are not covered by 210 ILCS 30/6.2 et. seq nor Rule 50 and fall outside our purview. Additionally, this information as well as resident on resident incidents are captured and analyzed by the DHS Division of Mental Health and the Division of Developmental Disabilities, state operated facilities and community agencies. These are quality assurance issues, not an issue of abuse and neglect. Where abuse or neglect are suspected, the division will contact OIG and an investigation will commence. To ensure the most efficient use of our resources, Rule 50 was amended in 2002 and no longer requires the reporting of serious injuries absent an allegation of abuse or neglect. Lastly, we encourage the Auditor General to review the amended definition of mental injury as it subsumes both the old definitions of verbal and psychological abuse (*see exhibit II*).[A]

	*AUDITOR COMMENT: The Inspector General notes that serious injuries are a matter of concern but are not covered by 210 ILCS 30/6.2. In fact, the Abused and Neglected Long Term Care Facility Residents Reporting Act defines "abuse" as "**any physical injury, sexual abuse or mental injury inflicted on a resident other than by accidental means".** This broad statutory definition seems to include injuries to residents, unless they are clearly accidental. Regarding neglect and mental injury, the auditors noted a 79 percent decrease in mental injury (verbal) allegations from fiscal year 2002 to 2004, and a 64 percent decrease in neglect with risk of harm or injury allegations over the same time period. Because of this large decrease in incidents, it does not appear that the old definition has been fully "subsumed" into the new one.*

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. Again as was noted in our 2002 audit, 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 the Illinois 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 the Illinois State Police signed an interagency agreement in January 2003. The agreement, however, does not meet the statutory requirement established by the Act. The

agreement provides guidance related to allegations involving State employees but not allegations against non-State employees (such as employees at community agencies) where evidence indicates a possible criminal act. During our last audit, an OIG official reported that State Police did not want non-State employee reports. However, the Act also covers abuse and neglect allegations from community agencies as well as State facilities 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 the 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, the OIG may conduct a separate investigation after the State Police investigation is completed. In the last audit, 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 the OIG's administrative rules does not require the OIG to report all possible criminal acts to State Police as required by statutes. The 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. The 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 3	***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 Ill. Adm. Code 50.50 h).***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	The OIG provided the Auditor General with OIG's legislative proposal**,** which was not enacted, to give OIG the authority to contact the local law enforcement authority upon a report of a possible felony. OIG intends to again submit the proposal during the 95th Legislative Session. Although it is not the practice of the Illinois State Police to investigate such matters that occur in non-state facilities and involve non-state employees, OIG will contact ISP pending passage of the legislative proposal. However, to ensure that crimes against the disabled in non-state facilities are thoroughly investigated, OIG will continue to contact

	the local police department.
STATE POLICE RESPONSE	Concur. The ISP is collaborating with the DHS to re-draft an interagency agreement to comply with the statutory requirements set forth under the Abused and Neglected Long Term Care Facility Residents Reporting Act. Additionally, while past efforts have met with little success, both agencies will continue to work toward ensuring current administrative rules are consistent with the Act.

Department of Public Health

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

Department of Children and Family Services

The Abused and Neglected Child Reporting Act (325 ILCS 5/1 *et seq*.) mandates that many persons, including State employees, immediately report incidents of suspected abuse or neglect of all persons under the age of 18 to the Department of Children and Family Services (DCFS). DCFS then has 14 days to determine whether there is a "good faith" indication of potential child abuse or neglect. DCFS has 60 days to complete the investigation and make a final disposition. According to documentation provided to us by the OIG, an interagency agreement was executed by DCFS and 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 the 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.

The objective of this audit was to evaluate the Inspector General's effectiveness in investigating reports of alleged abuse or neglect of residents in any facility operated, licensed, certified, or funded by the Department of Human Services and in making any recommendations

for sanctions to DHS and the Department of Public Health. Detailed audit objectives are outlined in Appendix B of this report.

Initial work began on this audit in February 2004 and fieldwork was concluded in September 2004. We interviewed representatives from the Inspector General's Office and spoke with individuals from the Department of Public Health, State Police, and the Department of Children and Family Services. We reviewed documents from the Inspector General's Office and the State Police. We examined the current OIG organizational structure, policies and procedures, investigations process, case review process, and documentation requirements. We also reviewed internal controls over the investigation process. We reviewed backgrounds for investigators hired since our last OIG audit and reviewed investigator training records. We tested a sample of cases from Fiscal Year 2004 and analyzed electronic data from Fiscal Years 2003 and 2004. A more complete description of our testing and analyses is 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 seven previous OIG audits, OIG internal documents, policies and procedures, management controls, and the OIG administrative rules. We reviewed management controls relating to the audit objectives that 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 that 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 seven prior OIG audits to assess the effectiveness of its investigations into allegations of abuse and neglect, as required by statute (210 ILCS 30/6.8). These audits were released in 1990, 1993, 1994, 1996, 1998, 2000, and 2002. Exhibit 1-7 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 also appeared as findings and recommendations in many of our OIG audits.

Exhibit 1-7
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	December 2002
Allegation Reporting						X (1)	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)		
Guidance							X (1)
Interagency Agreements						X (1)	X (1)
Investigations				X (1)		X (1)	
Mission and Goals						X (1)	
Monitoring	X (1)			X (1)	X (1)		
Quality Care Board							X (1)
Reporting to DPR					X (1)		
Review		X (1)	X (1)	X (1)	X (1)	X (1)	X (1)
Follow-up/Sanctions				X (1)	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)	X (1)
Training	X (1)	X (1)		X (3)	X (2)		X (1)
Year 2000 Compliance					X (1)		
Matter for Consideration			X (1)				
Total Recommendations	**7**	**5**	**9**	**15**	**11**	**8**	**8**

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

Source: 1993, 1994, 1996, 1998, 2000, 2002 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, the Quality Care Board, and the annual report.

Chapter Two

TIMELINESS OF ABUSE OR NEGLECT INVESTIGATIONS

CHAPTER CONCLUSIONS

Timeliness of investigations has been an issue in all of the seven previous OIG audits. During this audit period, the OIG continued to have problems completing investigations timely. One of the clearest indicators of OIG's continued problems is that in Fiscal Year 2002, 46 percent of investigations were completed within 60 calendar days, while in Fiscal Year 2003 only 30 percent and in Fiscal Year 2004 only 39 percent were completed within 60 calendar days. In January 2002, the OIG amended its administrative rules to require investigations be completed within 60 *working* days. Only 46 percent of cases in Fiscal Year 2003 and 51 percent of cases in Fiscal Year 2004 were completed within 60 working days.

The OIG does not have the necessary monitoring in place to ensure that allegations are reported to the State Police timely as required by the Abused and Neglected Long Term Care Facility Residents Reporting Act (Act). The Act requires that the OIG notify State Police within 24 hours of all allegations where a possible criminal act has been committed or where special expertise is required in the investigation. In our testing of Fiscal Year 2004 cases, we found five cases which were referred to State Police. The OIG refers these cases to the State Police by telephone and does not maintain documentation of these calls in the case files. We determined that 1 of the 5 (20%) cases was not referred to the State Police in 24 hours as required by the Act. The case was not reported for nine days.

During our case file review, we found that the OIG was not conducting interviews with the alleged victims in a timely manner. The average time to interview the victims from our sample was 37 days. In addition, in 27 of 89 (30%) cases where data was relevant, the victim either recanted the allegation (19), did not remember the incident (5), or refused to cooperate (3). The average time it took OIG investigators to interview victims in these 27 cases was 43 days. Timely initiation of an investigation is important because as time passes memories may fade or witnesses may become unavailable for follow-up interviews.

Data from the OIG database shows that none of the four investigative bureaus are reviewing substantiated cases within the timelines delineated in OIG Directive. The data shows that the review for substantiated cases is using a large percent of the 60-day time requirement that OIG has to complete its investigations. However, the review time may be overstated because the OIG's database does not capture the necessary dates to determine if any additional investigation is conducted once the case is submitted for review. The OIG should assure that substantiated cases of abuse and neglect are reviewed timely and that it captures the necessary data to allow for the monitoring of case review times.

The OIG does not have an effective case management system in place to adequately monitor the timeliness of case completions. The OIG's case management system is not an electronic system but is a series of manually prepared reports. We recommended that the Inspector General develop an electronic case management system to help manage investigation and case file review timeliness.

Although there has been improvement since our 2002 audit, 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 rules. 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, we will continue to use calendar days in our analyses so that comparisons can be made over time to our prior audits.

Timeliness of investigations has been an issue in all of the seven previous OIG audits. During this audit period, the OIG continued to have problems completing investigations timely. One of the clearest indicators of its continued problems is that in Fiscal Year 2002, 46 percent of investigations were completed in 60 calendar days, while in Fiscal Year 2003 only 30 percent and in Fiscal Year 2004 only 39 percent were completed in 60 calendar days.

In Fiscal Year 2001, the average calendar days to complete an investigation was 90 and the median was 62. In Fiscal Year 2002, the average decreased to 76 days and the median was 64 days. During Fiscal Year 2003 and Fiscal Year 2004, the average and median days to complete an investigation of abuse or neglect increased significantly from Fiscal Year 2002. In Fiscal Year 2003, the average was 106 and the median was 97. In Fiscal Year 2004, the average increased to 109 days but the median decreased to 87 days.

Exhibit 2-1
CALENDAR DAYS TO COMPLETE ABUSE OR NEGLECT INVESTIGATIONS
Fiscal Years 1999 to 2004

Days to Complete Cases	FY 1999 % of Cases	FY 2000 % of Cases	FY 2001 % of Cases	FY 2002 % of Cases	FY 2003 % of Cases	FY 2004 % of Cases
0-60	**21%**	**25%**	**49%**	**46%**	**30%**	**39%**
61-90	10%	18%	18%	31%	16%	11%
91-120	11%	14%	11%	13%	17%	10%
121-180	23%	16%	10%	6%	23%	20%
181-200	6%	4%	2%	1%	5%	5%
>200	30%	23%	10%	3%	9%	14%
Total > 60 days	**79%**	**75%**	**51%**	**54%**	**70%**	**61%**
Total Cases by FY	1,507	2,341	1,883	1,442	1,248	1,472

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

Source: OAG analysis of OIG data.

In Fiscal Year 2004, the OIG completed 39 percent of its investigations within 60 calendar days. This was less timely than in Fiscal Year 2002 when 46 percent of its investigations were completed within 60 calendar days. However, it is an improvement from Fiscal Year 2003 when only 30 percent were completed within 60 calendar days. Exhibit 2-1 shows the percentage of cases completed in terms of ranges of the number of days to completion for Fiscal Years 1999 to 2004. Case completion is measured from the date the allegation of abuse or neglect is reported to the OIG to the date the investigative report is sent to the facility or community agency notifying them of the investigation outcome. Data analysis was conducted on the entire population of cases closed in each of the fiscal years.

Since the OIG changed the definition of days from calendar to a more lenient working days in its administrative rules in January 2002, we also looked at the percent of cases completed within 60 working days. Even with the more lenient standard, the OIG only completed 46 percent of its Fiscal Year 2003 cases and 51 percent of its Fiscal Year 2004 cases within 60 working days.

Timeliness of cases taking longer than 60 working days to complete was a problem for all four investigative bureaus for cases closed during Fiscal Year 2004. Exhibit 2-2 shows that the Central Bureau had the smallest percentage of cases taking longer than 60 working days with 33 percent. The percentages for the North, Metro, and South Bureaus were much greater. The percent of cases taking longer than 60 working days was 50 percent for the South Bureau, 53 percent for the Metro Bureau, and 64 percent for the North Bureau.

Exhibit 2-2
CASES WITH INVESTIGATIONS GREATER THAN 60 WORKING DAYS
Cases Closed During Fiscal Year 2004

OIG Bureaus	Number of Cases Greater Than 60 Days	Total Cases Closed	Percent Greater Than 60 Days
North	111	173	64%
Metro	254	479	53%
Central	138	415	33%
South	157	311	50%
Other [A]	68	94	72%
Total	728	1,472	49%

[A] Other includes cases assigned to Domestic Abuse, Intake, and Inspector General staff.

Source: OIG data summarized by OAG.

Cases Over 200 Days

The number of cases taking more than 200 calendar days to complete has also increased significantly from Fiscal Year 2002. In Fiscal Year 2002, 41 cases took longer than 200 days to complete. By Fiscal Year 2004, the cases taking longer than 200 days to complete increased to 258. Exhibit 2-3 shows the types of allegations taking more than 200 calendar days to complete from Fiscal Year 2002 through Fiscal Year 2004. Investigations at State facilities completed during Fiscal Year 2004 accounted for 53 percent (136 of 258) of the cases that took longer than 200 days to complete and community agency investigations accounted for 47 percent (122 of 258).

Exhibit 2-3
TYPES OF ALLEGATIONS FOR CASES OVER 200 CALENDAR DAYS TO COMPLETE
Fiscal Years 2002 to 2004

Type of Allegation	FY02	FY03	FY04
Physical Abuse	7	50	109
Neglect	7	46	90
Verbal Abuse	0	12	17
Death	22	21	17
Sexual Abuse	2	5	15
Psychological Abuse	3	9	9
Other	0	1	1
TOTAL	41	144	258

Source: OAG analysis of OIG data.

In Fiscal Year 2002, of the four OIG Investigation Bureaus, the North Bureau accounted for the majority of cases taking longer than 200 days to complete (44 percent). By Fiscal Year 2004, the Metro Bureau had the largest with 41 percent taking longer than 200 days. The other three bureaus had: (North) 28 percent; (Central) 10 percent, and (South) 10 percent. The other

11 percent of cases taking longer than 200 days were not assigned to a specific investigative bureau. These cases were either assigned to a Domestic Abuse investigator or to Inspector General staff.

In Fiscal Year 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 facilities were Choate Mental Health and Developmental Center, Elgin Mental Health Center, and Jacksonville Developmental Center. In Fiscal Year 2004, Howe Developmental Center (12%) accounted for the largest portion of the State facility cases over 200 days old, followed by Kiley Developmental Center (6%) and Singer Mental Health Center (6%).

TIMELINESS OF CASE COMPLETION	
RECOMMENDATION 4	***The Inspector General should continue to work to improve the timeliness of investigations of abuse and neglect.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	OIG will continue to work to improve the timeliness of investigations. At the end of the first quarter of Fiscal Year 2005, the average number of days required to complete investigations was shortened to 47.6 days. However, OIG takes issues with the reference that OIG has a more lenient time requirement for completing cases. Under the old Rule 50, investigators had 60 calendar days to complete an investigation. Because OIG investigators do not work holidays or weekends, this interpretation did not provide the investigator with 60 days but rather considerably less, particularly during a month in which there was a holiday. Converting to working days is a much fairer, not lenient, interpretation of the 60 day requirement.
	AUDITOR COMMENT: The audit continues to report timeliness on a calendar basis for comparison purposes over time. Additionally, using working days ***is*** *a more lenient time requirement. Using working days, the OIG has over 80 calendar days to complete an investigation compared to the 60 calendar day requirement.*

OTHER TIMELINESS ISSUES

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

Illinois State Police

The OIG does not maintain documentation to record when cases are referred to the Illinois State Police. Statutes require that the OIG notify State Police for all allegations 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. The Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6.2 (b)) states:

> *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.*

In our testing of Fiscal Year 2004 cases, we had five cases which were referred to State Police. The OIG refers these cases to the State Police by telephone and does not keep a record of these calls in the case files. However, the OIG was able to provide us with dates of the referrals for the five cases. One of the five (20%) was not referred to the State Police in 24 hours as required by statute. The case was not reported for nine days.

The 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 the State Police conducted an investigation. The State Police investigation is a criminal investigation and the OIG investigation is administrative. According to OIG's investigative guidance, OIG conducts no further investigative activity when the State Police accepts a case unless requested to do so by State Police. Exhibit 2-4 shows the number of cases referred to State Police and the disposition of those cases.

Exhibit 2-4
DISPOSITION OF CASES REFERRED TO STATE POLICE
Fiscal Years 2001 to 2004

	Number of Cases			
Disposition	**FY01**	**FY02** [A]	**FY03**	**FY04**
Referred back to OIG without investigation	78	85	83	44
Investigated by State Police and:				
Declined by Prosecutor	11	13	10	1
Not Sustained	13	21	26	7
Conviction	2	5	5	2
Other	9	10	8	1
Total	**113**	**134**	**132**	**55**

[A] FY02 numbers updated since 2002 audit.

Source: OAG analysis of Illinois State Police data.

REPORTING TO THE STATE POLICE	
RECOMMENDATION 5	***The Inspector General should maintain the necessary documentation to monitor referrals to the Illinois State Police. Monitoring should be in place to ensure that the referrals are timely as required by State law.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	The Auditor General noted in numerous places throughout the report that OIG does not keep a record in our case file of when we refer cases to the Illinois State Police. However in their 5 case sampling OIG referred to the case file and was in fact able to provide them with the dates of referrals. Thus, their contention that OIG does not maintain this data is not supported by their own narrative. OIG reminds the Auditor General that our investigators may not uncover evidence of a crime for some time after initiating an investigation, which is only fitting to avoid burdening law enforcement with non-criminal matters. In the one case mentioned by the Auditor General, it was not clear upon review of the intake that this case was appropriate for referral. Only after the investigator completed several investigative steps did he uncover evidence of possible criminal conduct. Thus, once OIG obtained the requisite evidence**,** the referral was made immediately, consistent with the other cases involving police referrals reviewed in this audit. OIG is currently developing an electronic case management system which will include a component for capturing cases referred to the Illinois State Police.
	AUDITOR COMMENT: To test compliance with the reporting requirement to State Police, we requested documentation from the OIG for the five cases in our sample referred to the State Police. We were told by OIG staff that no documentation was maintained. On August 26, 2004, auditors sent an e-mail to the Inspector General to verify that documentation was not kept. We subsequently received referral dates to the State Police from the OIG, but the OIG did not provide documentation, such as fax referral sheets. We noted that one of the referral dates differed from the date in OIG's computer system. Since the OIG provided two different dates for the same case, we requested and received the documentation for the one case from the State Police. The date in OIG's computer system was incorrect. The case was not investigated by the OIG for five days and was not reported to the State Police for nine days.

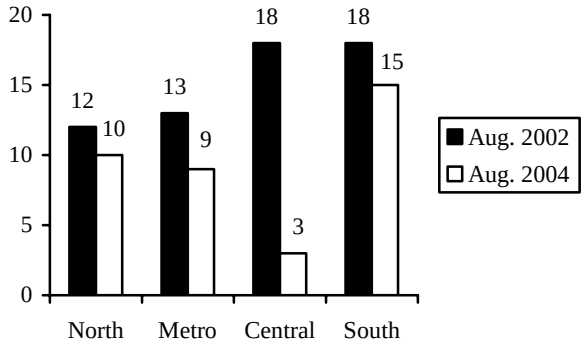
Clinical Services Cases

In the previous and current audit periods, OIG's Clinical Coordinators handle cases that involve medical issues as well as death cases that are not attributable to abuse or neglect. The Coordinators work and consult with Clinical Services at DHS and refer questions but do not refer cases. In our 2002 OIG audit, we reported that the average completion time for cases referred to the Clinical Coordinator was 138 days. In Fiscal Year 2004, the average days were 72, a significant improvement over the 2002 audit.

Investigator Caseloads

Investigator caseloads do not appear to be a factor in untimely investigations. Exhibit 2-5 shows that in all four investigative bureaus, investigator caseloads decreased from Fiscal Year 2002 to Fiscal Year 2004. The greatest decrease was in the Central Bureau where average caseloads decreased by 83 percent from 18 in Fiscal Year 2002 to 3 in Fiscal Year 2004.

Exhibit 2-5
INVESTIGATOR CASELOADS
By Bureau as of August 14, 2002 and 2004



Source: OIG data summarized by the OAG.

In Fiscal Year 2004, the highest average cases completed per month by investigator by Bureau was 7.6 in the Central Bureau. The lowest average cases completed monthly per investigator was 3.8 in the North Bureau. The average days to complete a case in Fiscal Year 2004 ranged from 68 in the Central Bureau to 185 days in the North Bureau. In addition, the Metro Bureau took an average of 126 days and the South Bureau took an average of 87 days to complete investigations.

Exhibit 2-6 shows that due to the high number of average calendar days to complete investigations, the investigations being completed by the North and Metro Bureaus are not the current allegations that are being reported. In addition, the North, Metro, and South Bureaus average cases completed per month by investigators are much lower than in the Central Bureau. The OIG should work to increase the average number of investigations completed per month for the North, Metro, and South Bureaus to help reduce its backlog of cases in order for them to conduct more timely and adequate investigations.

Exhibit 2-6
INVESTIGATIONS COMPLETED AND INVESTIGATION TIMELINESS BY BUREAU
Fiscal Year 2004

	Cases Reported	Investigations Completed	Investigations Open as of 6/30/04	Monthly Completed Per Investigator	Avg. Calendar Days to Complete
North	172	210	50	3.8	185
Metro	374	447	84	5.6	126
Central	310	366	18	7.6	68
South	271	300	50	5.5	87
Total	**1,127**	**1,323**	**202**	**5.6**	**113**

Source: OIG Data Summarized by the OAG.

Timeliness of Investigative Interviews

Timely interviews of alleged victims and perpetrators are important because as time passes memories may fade or witnesses may become unavailable for follow-up interviews. Even though initial statements are often taken at the time of the incident, delays in getting detailed interviews from those involved, especially from the alleged victim, increase the risk of losing information and weakening the evidence obtained. Current OIG Directives do not specifically designate a required timeline for conducting interviews with those involved.

During our case file review, we found that the OIG investigators were not conducting their interviews with the alleged victims in a timely manner. The average time to interview the victims from our sample was 37 days. In addition, in 27 of 89 (30%) cases where data was relevant, the victim either recanted the allegation (19), did not remember the incident (5), or refused to cooperate (3). The average time it took OIG investigators to interview victims in these 27 cases was 43 days. Timely interviews of the victims are imperative to ensure an effective and thorough investigation.

Since there was a high percentage of individuals who recanted the allegation, said that they did not remember, or refused to cooperate from our sample, we looked for reasons that may contribute to the result. In addition to the timeliness of the interview, we found several instances where the accused staff member was interviewed before the victim. In several cases it was months or weeks earlier. This could potentially lead to harassment or intimidation of the victim. Case Example 1 is an example where alleged perpetrators were interviewed more than three months before the alleged victim was interviewed. When the alleged victim was interviewed the allegation was recanted. The OIG should consider requiring interviews to be conducted with the victim prior to interviewing the accused.

Case Example 1

It was alleged that the victim was choked by one staff member, slapped by another, and hit with an ink pen by a third staff member. The alleged perpetrators were interviewed in **December 2003**. The alleged victim was not interviewed until **April 2004** at which time he indicated that he made up the allegation.

TIMELINESS OF INVESTIGATIVE INTERVIEWS	
RECOMMENDATION 6	***The Inspector General should develop specific time requirements for conducting interviews of the alleged perpetrator, victim, and any witnesses. Consideration should be given to interviewing the accused after the alleged victim has been interviewed.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Although we agree with this Recommendation's aim of completing case reviews faster, we believe that instituting a case management system (Recommendation 7) will achieve this goal more effectively. As noted, this office already directs investigators to interview certain individuals within specific time frames. Establishing additional interim deadlines may expose otherwise thorough and timely investigations to meaningless criticism. Each investigation is unique, so effective case management depends upon giving investigators the appropriate flexibility and discretion to conduct interviews and compile evidence in a manner that leads to a thorough and efficient conclusion. For example, although this office instructs investigators to interview the victim before the alleged perpetrator, factors present in individual cases may not allow such an orderly progression. Unforeseen unavailability of witnesses and efficiency may sometimes require an investigator to interview other available witnesses after traveling several hours to the location. Forcing investigators to follow an excessively formulaic approach will hamper their ability to react to specific situations and exercise good judgment appropriately. We urge the Auditor General to maintain focus on the goal of completing cases within sixty days, and the case management system as the best tool for achieving that goal, rather than upon interim deadlines.
	AUDITOR COMMENT: The audit is not proposing a formulaic approach to investigations, but rather, recommending a control mechanism to help ensure that interviews are conducted in a timely manner. An average timeframe of 43 days, based on our sample, to interview victims for facility and community agency cases, is too long. If the OIG has other methods or controls to help ensure that interviews are completed more timely, we suggest that they implement them.

Timeliness of Case File Reviews

Data from the OIG database shows that none of the four investigative bureaus are reviewing substantiated cases within the timelines delineated in OIG Directive. OIG Directives allow the Investigative Team Leader (ITL) and Bureau Chief each 5 working days to review substantiated and priority cases and 10 working days to review unsubstantiated and unfounded cases. Investigative Guidelines in place during our 2002 audit included a three level supervisory review with no mention of a timeline. Currently, only the Metro Bureau has an ITL.

Once the investigator completes the investigation and writes the Preliminary Report, the report is submitted for review. The investigative case file (including the Preliminary Report) is reviewed by the Investigative Team Leader (Metro Bureau only), Bureau Chief, and if necessary (substantiated cases), the Inspector General or Deputy Inspector General.

Exhibit 2-7
AVERAGE CALENDAR DAYS FROM DATE SUBMITTED FOR REVIEW UNTIL FINAL REVIEW BY BUREAU CHIEF
Fiscal Year 2004

	Substantiated Cases [A]	**Unsubstantiated Cases** [A]
North	54	7
Metro	83	22
Central	44	5
South	61	10
Total Avg.	**61**	**11**

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

Source: OAG analysis of OIG data.

The ITL or the Bureau Chief may send the case back to the investigator for further investigation. OIG's database does not track cases that were sent back for additional investigation. Therefore, our analysis only shows the total calendar days from date submitted for review until the Bureau Chief signs the case as reviewed. Without tracking cases sent back for additional investigations, OIG management cannot effectively monitor how long it takes for cases to be reviewed.

Exhibit 2-7 shows that none of the bureaus are reviewing substantiated cases within the timelines delineated in OIG Directive. The Metro Bureau takes much longer to review unsubstantiated cases than the other three bureaus, which may be due to the fact that it have an additional review from the ITL. The review for substantiated cases is using a large percent of the 60-day time requirement that OIG has to complete its investigations. Improvements in the time it takes to review substantiated cases could have a substantial effect on the overall timeliness of case completions at the OIG.

Case Management System for Timeliness

The OIG does not have an effective case management system in place to adequately monitor the timeliness of case completions. The OIG's case management system is not an electronic system but is a series of manually prepared reports. The OIG has a Directive relating

to its case management system; however the reports produced do not provide adequate management control. The directive indicates:

> *It is the policy of the Office of the Inspector General to have a case management system which monitors the caseloads of each investigator and ensures the timely completion of investigations as well as the equitable distribution of cases within Investigation Bureaus and across Bureaus statewide.*

The directive specifically requires investigators to complete Case Status Reports to submit to their supervisor for all cases not completed within 30 and 45 working days of assignment. The directive also requires the Bureau Chiefs to submit monthly reports to the Inspector General or his/her designee by the 15th day of each month identifying all cases more than 45 days old. This is referred to as the 45-Day Status Report. The report must include the reason for the delay, actions to complete the investigation, and the expected date for completion.

The monthly 45-Day Status Reports submitted by the Bureau Chiefs did not include all the information required by the Investigative Directive. The reports did not have a standard format and varied by investigative bureau. The reports do not appear to be an effective case management tool. It is difficult for OIG management to determine if the reports contain all cases greater than 45 days old since these reports are not generated from a database. The Bureau of Support Services can run a 45-Day Status Report as of a particular day, which would only contain cases open in excess of 45 days. This report contains the case number, the number of days open, and the investigator name. However, it does not include any information as to why the case is not complete or what steps are being taken to complete the case. Bureau Chiefs take these reports and manually add information relating to the cases. The information capturing the reason for delay, actions to complete the investigation, and the expected date of completion are not entered into OIG's database. None of the manual reports submitted by the bureaus were submitted for the same time period making it difficult for the Inspector General to compare them to any single report run by the Bureau of Support Services.

CASE MANAGEMENT SYSTEM	
RECOMMENDATION 7	***The Inspector General should develop an electronic case management system to help manage investigation and case file review timeliness.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	OIG is currently developing an electronic case management system to improve upon our timeliness and enhance the management of our cases. However, it cannot be stressed enough that Exhibit 2-7 is not a true reflection of the actual number of days a completed case is in review for final approval. As noted by the Auditor General, the information in our existing database does not accurately account for cases initially submitted for review that are returned to the investigator for additional investigative work. Our review of the Auditor General's sample case reviews indicated that nearly all cases, once fully investigated, were reviewed within the time frames set forth within the OIG Directives Manual.

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 either request that the Inspector General further explain the findings, or request the Inspector General to reconsider the findings based on additional information submitted by the community agency or facility. After a community agency or facility request for reconsideration or clarification is received, the Inspector General will notify the community agency or facility of the decision to either accept or deny their request.

For cases closed in Fiscal Year 2003, the OIG received 38 requests for reconsideration or clarification and in Fiscal Year 2004 it received 61 requests. In Fiscal Year 2003, 11 of 38 (29%) and in Fiscal Year 2004, 16 of 61 (26%) requests for reconsideration were granted by the OIG. 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 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 whether it has received the required written response or not. According to OIG officials, prior to submission to OIG the facility and agency are directed to submit the written response to either the Division of Mental Health or Division of Developmental Disabilities for approval. Substantiated cases as well as unsubstantiated cases are reported the Secretary of Human Services. The Secretary of DHS has the authority to accept or reject the written response and determine if the facility or agency followed the written response. The OIG received written responses for all substantiated cases closed in Fiscal Year 2004.

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 rules. The current administrative rules require that allegations of abuse or neglect be reported to the OIG within four hours of discovery. In January 2002, the OIG increased the required reporting time from one hour to four hours. There have been improvements in the timely reporting of incidents since the last audit in 2002. Community agencies continue to have untimely reports in comparison to facilities. Exhibit 2-8 shows the time to report incidents for facilities and community agencies for Fiscal Year 2003 and Fiscal Year 2004.

- **Facility** - 10 percent of facility incidents were not reported within the four-hour time frame in Fiscal Year 2004 compared to 16 percent in Fiscal Year 2002.

- **Community Agency** - 42 percent of community agency incidents were not reported within the four-hour time frame in Fiscal Year 2004 compared to 50 percent in Fiscal Year 2002.

Exhibit 2-8
ALLEGATIONS OF ABUSE OR NEGLECT NOT REPORTED WITHIN FOUR HOURS OF DISCOVERY

	FY03	FY04
Facilities	15%	10%
Community Agencies	42%	42%

Source: OAG analysis of OIG data.

ALLEGATION REPORTING	
RECOMMENDATION 8	***The Inspector General should continue to work with State facilities and community agencies to ensure that allegations of abuse or neglect are reported within the time frame specified in State law and OIG administrative rules.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	OIG is pleased that the audit documents improvements in the reporting of allegations of abuse and neglect within the four hour time frame. OIG will continue to work with providers to assure that reporting requirements are met. To assist in this process, OIG generates detailed reports of late reporters and tracks trends. In one case, OIG sent a letter threatening sanctions. Additionally, OIG seeks explanations for late reporting when the report is initially made, allowing ample time for follow up. OIG sends advisories to the provider and DHS division director responsible for monitoring that provider's performance. OIG case reports always recommend that agencies whose staff have reported allegations in a tardy fashion address that deficiency and require that the provider submit a corrective action plan to prevent further non-compliance. Finally, OIG offers on-site training and other technical assistance to those agencies experiencing difficulty with meeting required time frames.

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 Tracking Form and Case Routing/Approval Form. Additionally, progress notes were obtained in cases where they were pertinent. We did find that photographs were not taken in 40 of 52 (77%) cases sampled where there was an allegation of an injury sustained.

Due to recent policy changes made by the OIG, community agencies no longer conduct a significant number of investigations for the OIG. In Fiscal Year 2004, 63 investigations were conducted by 40 community agencies. In Fiscal Year 2002, community agency investigators investigated 304 cases for the OIG.

In addition, community agencies are not being properly trained in basic investigative skills. Without proper training, investigative steps may not be completed properly and may hinder the investigation. Community agencies may take initial statements and collect evidence. In addition, the community agencies may not correctly assess an incident of abuse and neglect and may fail to report it to the OIG as required by law. The OIG should send all community agencies copies of the protocol and training manuals and require the community agencies to adhere to the contents to help ensure that the community agency conducts the initial steps of an investigation properly for the OIG investigators.

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

Cases that we sampled from Fiscal Year 2004 were generally thorough, comprehensive, and well documented. Current OIG Investigative Directives give the investigator the authority to determine what evidence needs to be collected. The prior Investigative Guidelines required that certain evidence be collected for specific types of cases. In Chapter One, we found that vague investigative guidance may continue to leave investigative staff, especially new investigators, unclear on appropriate investigative requirements. The current OIG Directives in comparison to the prior Guidelines have omitted important detail in the areas of photographing and the collection and handling of physical evidence. These elements of an investigation as listed in the

prior OIG Guidelines are now left to the judgment of the investigator and if not followed properly might impede the investigation.

The evidence used for our testing included: interviews, 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 40 of 52 (77%) cases where there was an allegation of an injury sustained from our sample from Fiscal Year 2004. Although current OIG Directives leave the decision to take photographs to the judgment of the OIG investigator, prior OIG Investigative Guidelines stated 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 alleged injuries can provide evidence of the location and severity of an injury as well as proving or disproving an allegation or extent of an injury. Although photos were missing in 40 cases, 29 of the 40 did contain documentation that some type of medical examination was conducted.

- **Progress Notes:** During the review of our 125 sample cases, we did not find any instances where an investigation failed to obtain pertinent progress notes.

- **Restraint/Seclusion Records:** All 10 cases sampled where restraints were used 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 Directive, it is the policy of the OIG to enhance the integrity and quality of investigations by conducting case reviews in a timely and consistent manner. A typical case will move through at least one level of review, and at least two levels (for substantiated cases) before being sent to the facility or community agency.

Documentation of Case Monitoring and Review

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

- **Case Tracking Form** - All case files in our sample contained a Case Tracking Form as required by Investigative Directive. The Case Tracking Form identifies information such as the case number, investigative agency, bureau, and allegation. This form's main

purpose is to track OIG's actions throughout the investigation. Dates for when the investigative report was received, when it was reviewed, and when it was closed are all tracked on this form. It is also used to document the case finding and recommendations for action.

- **Case Routing/Approval Form** - After a case is submitted for review, the review progress is documented through the Case Routing/Approval Form. After each level of review, the reviewer signs and dates the form to indicate that the review has taken place and sends the case to the next level of review. On these forms, the reviewer can note when the case was sent to special review, clinical, legal, consultant, or another office. All 125 sample cases tested contained a Case Routing/Approval Form. Generally, the forms appeared to be complete.

Final Case Reports

OIG case reports that we tested from Fiscal Year 2004 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 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.

COMMUNITY AGENCY INVESTIGATIONS

Due to recent policy changes made by the OIG, community agencies no longer conduct a significant number of investigations for the OIG. In Fiscal Year 2004, 63 investigations were conducted by 40 community agencies. All 40 community agencies had accepted the community agency protocol required by the OIG. In Fiscal Year 2002, community agency investigators investigated 304 cases for the OIG. The decrease is due to two policy changes by the OIG 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.

Investigative Protocol for Community Agencies

Establishes uniform policies and procedures for community agencies for conducting investigations of allegations of abuse, neglect or death in certain situations.

Currently, the OIG requires that all community agencies that have accepted the protocol send investigators to be trained by OIG personnel. However, according to OIG officials all community agencies are not required to send investigators to Basic Investigative Skills training.

This conflicts with a training memorandum sent by the Inspector General to facilities and community agencies dated September 9, 2003. The memorandum states that Basic Investigative Skills training *"is required for any person who conducts or assists in OIG investigations."* Basic Investigative Skills training includes necessary issues such as investigative planning, incident assessment, conducting interviews, taking statements, crime scene preservation, evidence collection, and injury assessment. The OIG does require community agencies to attend Administrative Rule 50 training that provides information on overall content of the Rule. It includes identification of abuse and neglect, current definitions, and reporting requirements.

Attending this training by community agency staff is important because, once the OIG is notified of an allegation of abuse or neglect, the OIG has 24 hours to make a determination as to who will investigate. Investigations conducted by OIG investigators at community agencies are not likely to commence for several days since OIG investigators are not stationed at the community agencies. Therefore, the community agency must begin the necessary investigative steps to ensure that all evidence is preserved. These steps may include initial statement taking and evidence gathering. Without proper training, valuable investigative steps may not be completed properly and may hinder the investigation. In addition, without proper training the community agencies may not correctly assess an incident of abuse or neglect and may fail to report it to the OIG as required by law. The OIG should send all community agencies copies of the protocol and training manuals and require the community agencies to adhere to the contents. This would help to ensure that either the investigations are completed properly by the community agency, or that the community agency conducts the initial steps of an investigation properly for the OIG investigators.

As of the end of March 2004, there were 399 community agencies that provided services to the developmentally disabled and mentally ill in Illinois. Of the 399, only 192 (48%) accepted the OIG protocol. In addition, of the 399 community agencies, only 156 sent staff to Basic Investigative Skills training and only 171 sent staff to Administrative Rule 50 training.

We reviewed the six cases that were investigated by community agencies from our sample of 125 closed cases from Fiscal Year 2004. We noted exceptions in 3 of the 6 investigations. The exceptions consisted of untimely interviews of the victim, an untimely investigation, missing photographs, and one case that was an allegation of abuse where the OIG allowed the agency to investigate. OIG administrative rules require all abuse allegations other than mental injury to be investigated by the OIG. In addition, the rules also require that all investigatory materials, including physical and documentary evidence, such as photographs, interview statements and records be submitted to the OIG. Since the number of cases investigated by community agencies is small, the OIG should consider conducting all investigations of alleged abuse and neglect at the community agencies.

COMMUNITY AGENCY INVESTIGATIONS	
RECOMMENDATION 9	***The Inspector General should send all community agencies copies of the Community Agency Protocol and training manuals and require the community agencies to adhere to the contents. This would help ensure that the community agency conducts the initial steps of an investigation properly for the OIG investigators.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	OIG investigates all community agency cases where an agency has indicated that they do not want the authority to conduct their own. Of the tens of thousands of agency employees, only staff trained in Basic Investigative Skills took investigative action in the sixty three cases handled by agencies. Moreover, any initial action requested of persons not trained in Basic Investigative Skills rarely include more than providing copies of relevant documents. Untrained staff were not asked to conduct interviews, collect sensitive evidence, take needed photographs or take any other investigative related steps. OIG takes issue with any inference that untrained agency personnel conduct investigations and maintains that, in accordance with OIG directives, they are not engaging in investigative practices, nor does the report demonstrate that they have. Additionally, OIG does provide technical support to agency investigators, along with any necessary re-training needed to address noted deficiencies within their cases. It should be noted that all agency investigations are subject to the same supervisory review approval process that applies to OIG investigations**.** Given the small number of cases, which are referred to the agencies, requiring adherence to the Protocol by agencies who do not wish to conduct investigations will unduly interfere with OIG investigations *(see exhibit III)*.[A]
[A] Due to the length of the exhibit that the OIG references in its response, the exhibit has not been included in this report, but can be viewed on-line with the report at www.state.il.us/auditor or at the Auditor General's Springfield or Chicago Offices.	*AUDITOR COMMENT: Over 190,000 individuals with mental illness or developmental disabilities were served by approximately 400 community agencies in fiscal year 2004. The audit is not questioning the training that the OIG provides to community agencies that chose to send staff to such training. Rather, the audit is noting that community agency staff who have not been trained may fail to correctly assess whether an incident of abuse or neglect has occurred which needs to be reported to the OIG. Also, since several days may pass before an OIG investigator arrives on-site at the community agency, it would seem reasonable for the OIG to take steps to help ensure that community agency staff are knowledgeable so that an investigation is not compromised by improper evidence handling before an OIG investigator arrives.* *Based on analysis of OIG investigations at community agencies from our sample cases, it took the OIG an average of 42 days to conduct interviews with victims. In 22 of the 36 investigations, the first OIG interview with the victim was conducted after a week had passed.*

Chapter Four

ACTIONS, SANCTIONS, AND RECOMMENDATIONS

CHAPTER CONCLUSIONS

Over the past 11 fiscal years (1994 to 2004) the Inspector General has not used sanctions against facilities. The Abused and Neglected Long Term Care Facility Residents Reporting Act (Act) (210 ILCS 30/6.2) gives the Inspector General broad authority to recommend sanctions. During our 2000 OIG audit period, the OIG Guidelines included criteria for recommending sanctions. During Fiscal Year 2003, the Inspector General developed a new Directive which specifies criteria on when to recommend sanctions.

During Fiscal Years 2003 and 2004, the OIG conducted annual unannounced site visits of all State-operated facilities as required by 210 ILCS 30/6.2. Overall, the OIG made substantial improvements in meeting its established timelines for submitting site visit reports to State-operated facilities. During the prior audit, the OIG did not meet its established timelines for submitting site visit reports to facilities.

SUBSTANTIATED ABUSE AND NEGLECT CASES

In Fiscal Year 2004, the OIG closed a total of 1,455 investigations of allegations of abuse or neglect. The OIG substantiated 197 of the abuse or neglect allegations, resulting in a 14 percent substantiation rate. Exhibits 4-1 and 4-2 both show the past nine years' closed cases and substantiation rates for allegations classified as abuse and neglect. The exhibits break out both facility and community agency allegations and substantiated cases of abuse and neglect. Exhibit 4-1 shows the data in a table and Exhibit 4-2 shows that data graphically. These numbers and percentages include substantiated cases that were classified as abuse or neglect at intake.

Except for an increase in Fiscal Year 2004, the exhibits show that the number of cases of substantiated abuse or neglect, for both facilities and community agencies, has generally been decreasing over the last four years since Fiscal Year 2000. The substantiation rate at facilities has stayed fairly consistent since Fiscal Year 2001. However, the substantiation rate at community agencies was significantly lower during this audit period than it was in Fiscal Year 2002. In Fiscal Year 2002 the substantiation rate was 31 percent. The rate was 16 percent in Fiscal Year 2003 and 22 percent in Fiscal Year 2004.

RECOMMENDATIONS AND ACTIONS

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

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

Exhibit 4-1
ABUSE AND NEGLECT CASES CLOSED AND SUBSTANTIATED
(Allegations categorized as Abuse or Neglect at Intake)
Fiscal Years 1996 to 2004

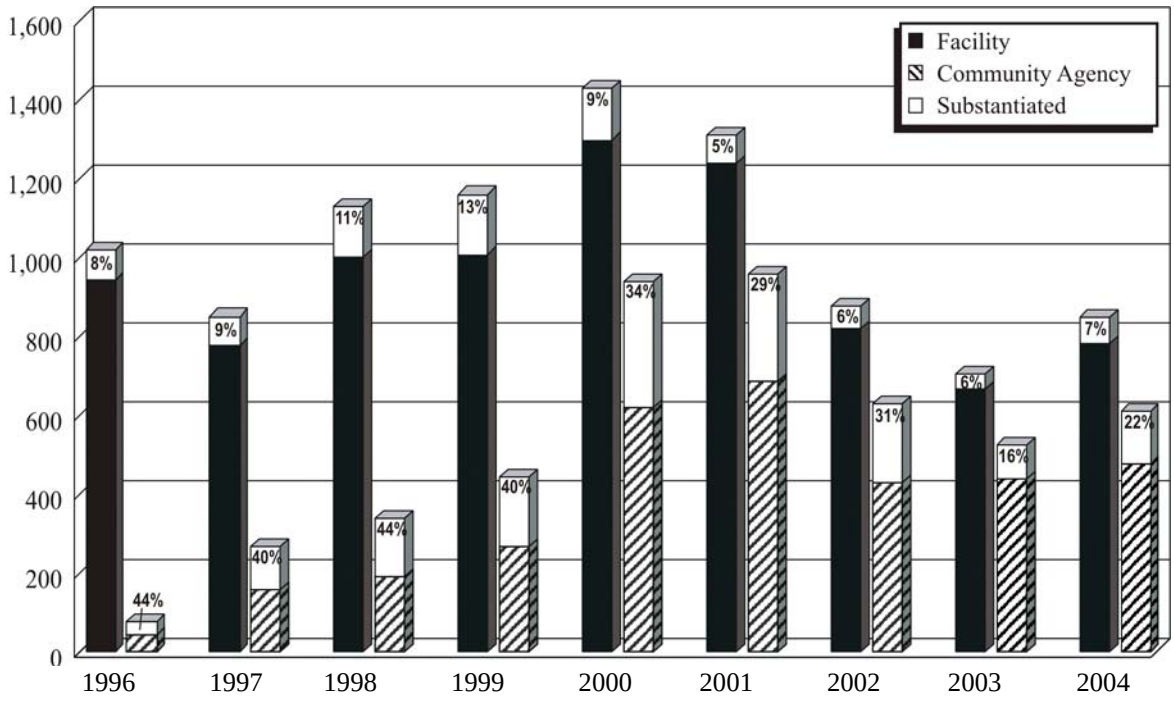
	Individuals Served[^]	Closed Cases	Substantiated Cases	Substantiated %
FY96 Facility	14,183	1,001	76	8%
FY96 Community	n/a	75	33	44%
FY 1996 Total	**n/a**	**1,076**	**109**	**10%**
FY97 Facility	13,913	850	73	9%
FY97 Community	n/a	266	106	40%
FY 1997 Total	**n/a**	**1,116**	**179**	**16%**
FY98 Facility	12,764	1,129	128	11%
FY98 Community	n/a	337	148	44%
FY 1998 Total	**n/a**	**1,466**	**276**	**19%**
FY99 Facility	12,893	1,159	152	13%
FY99 Community	n/a	445	179	40%
FY 1999 Total	**n/a**	**1,604**	**331**	**21%**
FY00 Facility	12,858	1,426	129	9%
FY00 Community	160,378	939	321	34%
FY 2000 Total	**173,236**	**2,365**	**450**	**19%**
FY01 Facility	13,048	1,293	65	5%
FY01 Community	180,026	959	274	29%
FY 2001 Total	**193,074**	**2,252**	**339**	**15%**
FY02 Facility	13,680	874	55	6%
FY02 Community	192,131	629	198	31%
FY 2002 Total	**205,811**	**1,503**	**253**	**17%**
FY03 Facility	12,285	701	40	6%
FY03 Community	194,884	522	85	16%
FY 2003 Total	**207,169**	**1,223**	**125**	**10%**
FY04 Facility	12,167	846	63	7%
FY04 Community	192,532	609	134	22%
FY 2004 Total	**204,699**	**1,455**	**197**	**14%**

n/a - Numbers were not available from the Department of Human Services.

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

Source: OIG information summarized by OAG.

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 2004



Note: State facilities served 3,042 individuals with developmental disabilities and 9,125 individuals with mental illness in FY 2004. Community agencies served approximately 24,500 individuals with developmental disabilities and approximately 168,000 individuals with mental illness in FY 2004.

Source: OAG analysis of OIG data.

After the recommendation is sent, the facility or community agency generally takes some action to resolve the issues related to the case. Exhibit 4-3 shows the 204 substantiated cases by the type of recommended action and by the investigating agency. Administrative action was recommended in 47 percent of the cases and was the most frequently used action in both OIG and community agency investigations. Administrative actions include, but are not limited to, suspension, termination, and reprimand. The exhibit shows that there were 15 cases where no action was recommended.

Exhibit 4-4 shows the type of allegation and the actions taken in the 204 substantiated cases closed in Fiscal Year 2004. Appropriate administrative actions to be taken are left to the discretion of the facility or community agency management. Appendix C shows the number of cases closed and a substantiation rate by facility from Fiscal Year 2002 through Fiscal Year 2004.

Exhibit 4-3
RECOMMENDED ACTIONS ON SUBSTANTIATED CASES
(All Allegations Regardless of Category at Intake)
Fiscal Year 2004

Recommended Action	Investigated by			Total
	OIG	Community Agency	State Police	
No Action	10	4	1	15
Retraining	13	1	0	14
Policy Creation or Revision	12	0	0	12
Other (Administrative Action)	78	17	1	96
Nurse Aide Registry	67	0	0	67
Total Substantiated	**180**	**22**	**2**	**204**

Note: Data in Exhibit 4-1 does not include death cases.

Source: OAG analysis of OIG data.

Exhibit 4-4
SUBSTANTIATED CASES BY TYPE OF ALLEGATION AND ACTIONS TAKEN
(All Allegations Regardless of Category at Intake)
Fiscal Year 2004

TYPE OF ALLEGATION	INVESTIGATED BY				ACTIONS TAKEN
	OIG	Community Agency	DII	Total	
A-2 -Physical abuse with serious harm alleged	3	0	0	3	Suspended, Discharged, Resigned, Training
A-3 -Physical abuse without serious harm alleged	75	0	1	76	Oral and Written Reprimands, Counseling, Suspended, Discharged, Resigned, Reassigned, Training, Supervision, Create/Modify Policy and Procedure, Modify Habilitation Plan
A-4 -Sexual abuse alleged	4	0	1	5	Written Reprimand, Discharged, Resigned, Reassigned, Training, Create/Modify Procedure
A-5 -Mental injury (verbal) alleged	14	7	0	21	Oral and Written Reprimands, Counseling, Suspended, Discharged, Resigned, Reassigned, Training, Performance, Create/Modify Policy, Modify Habilitation Plan
A-6 -Mental injury (psychological) alleged	17	8	0	25	Counseling, Suspended, Discharged, Resigned, Training, Supervision, Create/Modify Policy and Procedure
Total Abuse Cases	**113**	**15**	**2**	**130**	
N-1 -Neglect with imminent danger alleged	1	0	0	1	Training, Create/Modify Procedure
N-2 -Neglect in any serious injury	20	0	0	20	Suspended, Discharged, Resigned, Reassigned, Training, Create/Modify Policy and Procedure, Modify Habilitation Plan
N-3 -Neglect in any non-serious injury	30	2	0	32	Written Reprimand Counseling, Suspended, Discharged, Resigned, Reassigned, Training, Create/Modify Policy and Procedure, Modify Habilitation Plan
N-4 -Neglect in an individual's absence	5	2	0	7	Written Reprimand Counseling, Suspended, Discharged, Training, Create/Modify Procedure
N-5 -Neglect in sexual activity between recipients	1	0	0	1	Suspended, Reassigned, Training, Create/Modify Policy, Modify Habilitation Plan
N-7 -Neglect with risk of harm or injury	5	3	0	8	Suspended, Discharged, Resigned, Training, Create/Modify Policy and Procedure
Total Neglect Cases	**62**	**7**	**0**	**69**	
D-4 -Death in residential program (not suicide or natural)	2	0	0	2	Discharged, Create/Modify Policy and Procedure
D-6 - death due to natural causes in a program	1	0	0	1	Discharged, Training, Create/Modify Procedure
D-7 -Any other reportable death	2	0	0	2	Training, Create/Modify Policy and Procedure
Total Death Cases	**5**	**0**	**0**	**5**	
TOTAL SUBSTANTIATED	**180**	**22**	**2**	**204**	

Note: DII is the Division of Internal Investigation at the Illinois State Police.

Source: OAG analysis of OIG data.

OIG SUBSTANTIATED CASE WRITTEN RESPONSES

In our 2000 and 2002 audit reports, we recommended that OIG establish a process to track and follow up on cases for which no written response for a substantiated case was received. The Inspector General established a policy through Directive as a response to a change in the Abused and Neglected Long Term Care Facility Residents Reporting Act (Act).

The Act was amended in December 2003. Section 6.2(c) now requires the facility or community agency to provide an implementation report to the Inspector General on the status of the corrective action implemented within 30 days after the Secretary of the Department of Human Services (DHS) has approved the written response. Within 60 days after the Secretary of DHS has approved the written response, the facility or community agency shall send an updated implementation report. The facility or community agency is required to continue sending updated implementation reports every 60 days until it sends a notice of the completion of the corrective action.

The Inspector General is now required to review any implementation that takes more than 120 days. The Inspector General is also required to monitor compliance through random reviews of completed corrective actions. These reviews may include site visits, telephone contacts, or requests for written documentation.

In the past, the Act required the facility or community agency to provide a written response for all substantiated cases of abuse or neglect. The statute states:

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

Under OIG administrative rules, 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 community agency followed the approved response.

The written response shall be completed on a prescribed form. The information shall include the actions that the facility or community agency will take or has taken to protect individuals from abuse or neglect, prevent recurrences, and eliminate problems. Implementation and completion dates shall also be included.

In Fiscal Year 2004, the OIG tracked cases where a written response was received. In addition, due to the change in State law, it began to monitor written responses more closely in April 2004. The OIG drafted a new protocol in November 2003 and revised its written response directive in February 2004. The OIG has designated three employees as Written Response Compliance Reviewers. Their responsibilities include:

- Developing a plan to verify and clarify all issues, collect information, and decide whether the follow-up will include a telephone contact, a request for documentation, a desk review and/or a site visit;
- Randomly sampling 20 percent of written responses;
- Contacting agencies/facilities to follow up on written response corrective action plans under review to obtain the details of the plans;
- Determining if the corrective action plan has been implemented and is in place; and
- Continuing to monitor agency or facility through 30-day status reports to check for evidence of corrective activity.

Since the OIG did not implement this until April 2004, we did not review compliance with the statute, protocol, and directive for this audit. However, compliance will be tested during our next audit covering Fiscal Years 2005 and 2006.

APPEALS PROCESS IN SUBSTANTIATED CASES

A requirement of the Abused and Neglected Long Term Care Facility Residents Reporting 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 Fiscal Year 2003 and Fiscal Year 2004, there were 44 people or agencies that requested an appeal of OIG recommendations. Of the 44, 8 referrals were supported, 16 were overturned, and 20 were still in process.

SANCTIONS

Over the past 11 fiscal years (1994 to 2004) 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. During our 2000 audit period, the Inspector General's Investigative Guidelines did include criteria to define conditions that would warrant a sanction and the procedures the OIG was to follow when recommending sanctions to the Department of Public Health and the Department of Human Services. At the end of our 2002 audit, the Inspector General was working to develop a new Directive that would specify criteria for when sanctions could be recommended.

In December 2002, the Inspector General developed a new Directive that specifies criteria on when to recommend sanctions, including procedures the OIG is to follow when imposing sanctions against an entity under the jurisdiction of the OIG. The criteria for imposing sanctions consist of a determination of risk to the well being of the individuals, repeated failure to respond to recommendations, and failure to cooperate with an investigation.

SITE VISITS

During Fiscal Years 2003 and 2004, the OIG conducted annual unannounced site visits of all State-operated facilities as required by 210 ILCS 30/6.2. Overall, the OIG made substantial improvements in meeting its established timelines for submitting site visit reports to State-operated facilities. During Fiscal Years 2001 and 2002, the OIG did not meet its established timelines. The OIG does not conduct site visits at community agencies because it does not have the specific statutory authority to do them.

Since the last OIG audit, the OIG developed a new protocol for Fiscal Year 2004 unannounced site visits and specific procedures for site visitors. The new protocol and procedures were implemented in July 2003. The protocol was developed with input from the site visit staff, the Inspector General and the Special Assistant to the Inspector General. In Fiscal Year 2003, the OIG conducted unannounced site visits at all the State-operated facilities using a site visit protocol implemented in September 2002. In addition, the OIG has a Directive for unannounced site visits that was effective in June 2002 and revised in April 2003. The Directive, protocols, and procedures provide a uniform process for site visitors to follow while conducting site visits.

The OIG provided us with site visit reports and other documentation for Fiscal Years 2003 and 2004 unannounced site visits. Based on a review of the information, the site visit protocols and Directive appeared to have been applied effectively, and site visit reports appeared to focus on pertinent issues and provide useful information to the facilities.

During Fiscal Year 2003, the site visitors reviewed samples of closed cases including all substantiated cases and cases with 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 addition, the site visitors reviewed facility policies and procedures for areas that may involve increased risk for abuse and neglect. These areas included sitter and/or escort services and unauthorized absences. There was also a review of the facility's actions to comply with Administrative Rule 50 revisions, including efforts to promote reporting, staff training, and preparedness regarding the checking of new hires to the Nurse Aide Registry. Moreover, site visitors followed up on issues from the previous year's site visit. Site visits generally lasted 1-2 days.

For Fiscal Year 2004 site visits, some procedures remained the same; however, there were some differences. Site visitors continued to review cases and cases with written responses. They also reviewed implementation plans for each written response, followed up on issues from the previous site visit, and reviewed policies and procedures related to a selected patient safety

activity for areas that may involve increased risk for abuse and neglect. Some of these areas included restraint use, medication administration procedures, and suicide and aggression prevention initiatives. However, as part of the new procedures for Fiscal Year 2004, site visitors interviewed employees regarding recognition of certain abuse and neglect areas. They also reviewed the impact of the Early Retirement Initiative on facilities, and they reviewed the facilities' investigations of incidents determined not to be reportable to the OIG. Site visits generally lasted one day.

Time Guidelines

During Fiscal Years 2003 and 2004, the OIG made substantial improvements in meeting its established timeline for submitting final site visit reports to facilities. In Fiscal Year 2003, all but two of the site visit reports (2 of 17) were completed and submitted to facility directors/hospital administrators within the required timeline (60 days). During Fiscal Year 2004, all of the site visit reports were completed and sent to the facility directors/hospital administrators within the required timeline.

This is an improvement since the prior audit. During Fiscal Years 2001 and 2002, OIG site visitors did not meet their established timelines for submitting final site visit reports to the facilities. In Fiscal Year 2001, 16 of the 19 facilities received a site visit report after the 90-day timeline. In Fiscal Year 2002, 8 of 17 facilities received a site visit report after the revised 60-day timeline. According to OIG officials, report format issues and other assignments contributed to the untimely reports.

Chapter Five

OTHER ISSUES

CHAPTER CONCLUSIONS

As in our last OIG audit, issues regarding training were again noted in this audit period. In our previous OIG audits, we have had eight recommendations on training in five of the audits. We recommended for this audit that the Inspector General ensure that statutory requirements are met by developing and implementing a comprehensive and ongoing training program.

The Quality Care Board (Board) did not meet statutory requirements regarding quarterly meetings. This is the second OIG audit where the Board has not met quarterly as required by statute. The Board met its quarterly meeting requirements in all of Fiscal Year 2003, but it failed to meet during the first quarter of Fiscal Year 2004. However, even though the Board met, it failed to have a quorum at 7 of the 8 meetings during Fiscal Years 2003 and 2004. In September 2004, the remaining three Board members' terms expired, leaving the Board without any current members.

The Office of the Inspector General did not timely submit its Fiscal Year 2003 Annual Report to the General Assembly and to the Governor in accordance with State law. The report, which is required to be submitted no later than January 1st of each year, was not printed until February 2004 and was not delivered until March 2004.

OIG INVESTIGATOR TRAINING

As in our last OIG audit, issues regarding training were again noted in this audit period. In our previous OIG audits, we have had eight recommendations on training in five of the audits. In Fiscal Years 2003 and 2004, we found that the OIG did not adhere to statutory requirements regarding training. We did find that two new investigators hired in Fiscal Year 2003 received all training as required by OIG's Training Directive.

Continuing Education

The OIG did not comply with the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6.5) to provide continuing education to its investigators. The 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.

During the prior audit, the Directive on training stated that OIG investigators were required to have 10 hours of continuing education annually in the following areas: Investigations; Report Writing; Systems Improvement; or Provision of Service to persons with developmental disabilities or mental illness. The current Directive states that continuing OIG training requirements for investigators, that are necessary, will be determined by the Inspector General, and the annual requirement for 10 hours of continuing education was removed.

In Fiscal Year 2003, 10 OIG investigators and two supervisory staff had less than 10 hours of training. Seven of the 12 only received a half of an hour of training on the Health Insurance Portability Accountability Act (HIPAA). This training was State-mandated and consisted of standards for the exchange of health information and the requirements for confidentiality and privacy concerning a person's personal health records and information.

In Fiscal Year 2004, 14 OIG investigators and three supervisory staff had less than 10 hours of training. The majority of this training was on two State-mandated courses: HIPAA Phase II and the State of Illinois Ethics Training Program. In addition, 10 of the 17 also had less than 10 hours of training during Fiscal Year 2003.

Exhibit 5-1
REQUIRED TRAINING FOR NEW OIG INVESTIGATORS

DHS ORIENTATION
- Prevention and Identification of Abuse and Neglect
- AIDS/HIV in the Workplace
- Sexual Harassment
- Employee Assistance Program [A]
- The Challenge of Inclusion [A]

INITIAL INVESTIGATOR
- Basic Investigations Skills
- Rule 50
- Rule 51
- Communications
- Introduction to Developmental Disabilities
- Introduction to Mental Illness
- Legal Issues
- Restraints

[A] Course is required when applicable.

Source: OIG Training Directive.

Although 10 hours of continuing education is no longer required by the OIG, Illinois statute requires a comprehensive training program where every person employed or newly hired to conduct investigations receives specific training on an **ongoing** basis. Therefore, the OIG should consider reinstating a minimum annual requirement for continuing education. This would help the OIG comply with statutory requirements and ensure that investigators receive ongoing training.

Initial Investigator Training

During Fiscal Years 2003 and 2004, the OIG's Directive listed training requirements for OIG staff. They included areas titled DHS Orientation Training Requirements and Initial OIG Training for Investigators. These two areas listed 13 training courses seen in Exhibit 5-1. We reviewed the training hours and courses for the two investigators hired in Fiscal Year 2003 and found that they both received all orientation and initial training courses. We also reviewed the training hours for the six investigators hired during Fiscal Year 2004. We found that all six investigators had more than 50 hours of training in various areas by the end of the fiscal year.

OIG INVESTIGATOR TRAINING	
RECOMMENDATION 10	***The Inspector General should ensure that statutory requirements are met by developing and implementing a comprehensive and ongoing training program.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	OIG has already taken steps to comply with training requirements set forth in its directives. In September 2004, OIG held its annual statewide training for all OIG staff which included two and a half days of investigative training, review of trends and patterns of allegations and findings, timeliness of investigations, investigative case planing, interviewing MI and DD persons and review of organizational performance. OIG's training directive has been revised to include specific classes and training goals. In addition, staff are assigned several Net Learning computer-based training courses which are required within a specific time frame. Targeted bureau level training specific to the needs of each bureau has begun. Lastly, individualized training objectives are established for each employee during evaluation periods.

QUALITY CARE BOARD

The Abused and Neglected Long Term Care Facility Residents Reporting Act establishes a Quality Care Board (Board) within the Department of Human Services' Office of the Inspector General. One of the requirements of the Board is to meet quarterly. The Board did not meet statutory requirements regarding quarterly meetings. This is the second OIG audit where the Board has not met quarterly as required by statute. The Board met quarterly in all of Fiscal Year 2003 and all but the first quarter of Fiscal Year 2004. However, even though the Board met, it failed to have a quorum at 7 of the 8 meetings during Fiscal Years 2003 and 2004. The Board, even without a quorum, followed other requirements established by the statute, but had difficulty fulfilling membership requirements.

Fulfillment of Statutory Requirements

Section 6.3 of the Act establishes a Quality Care Board created within the Office of the Inspector General to be comprised of seven members who are 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. There have only been four members serving on the Board since September 2002.

The Board met quarterly in Fiscal Year 2003 while meeting five times. However, it only met three times in Fiscal Year 2004. Furthermore, it did not have a quorum at 7 of the 8 meetings during Fiscal Years 2003 and 2004. The Board met in September 2002, October 2002, January 2003, March 2003, May 2003, November 2003, March 2004, and June 2004. The November 2003 meeting was the only meeting that had a quorum. A Board official stated that if one person is unable to attend, then they do not have a quorum and meetings have been cancelled due to the lack of a quorum. The Board has continued to meet even without a quorum. One former member continues to attend meetings while waiting for her reappointment. We did find

that the OIG reimbursed this former member $392 for automobile mileage for two meetings attended after the appointment expired.

The Board minutes indicated that it had difficulty maintaining membership during this audit period. Two of the Board's meeting minutes in Fiscal Year 2003, and all of the minutes in Fiscal Year 2004 noted difficulties the Board was having getting needed appointments and reappointments for Board members. According to a Board official, the Board has not received the needed appointments for successors to fill vacant positions, nor has it received reappointments for members whose terms have expired. In June 2004, one of the remaining Board members resigned, leaving the Board unable to have a quorum. In September 2004, the remaining three Board members' terms expired, leaving the Board without any current members.

The Act also requires the Quality Care Board to monitor and oversee the operations, policies, and procedures of the Inspector General to assure the prompt and thorough investigation of allegations of neglect and abuse. Based on our review of Board's meeting minutes for Fiscal Years 2003 and 2004, and a discussion of the role of the Board with OIG officials and a Board member, it appears that the Quality Care Board is attempting to meet its statutory requirements.

QUALITY CARE BOARD	
RECOMMENDATION 11	***The Secretary of the Department of Human Services and the Inspector General should work with the Governor's Office to get members appointed and reappointed to the Board, and should assure that the Board meets quarterly as required by statute (210 ILCS 30/6.3).***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	OIG has been working closely with the Governor's Office of Boards and Commissions regarding the appointment of board members. We will also continue to work closely with the President of the Board to encourage quarterly meetings.

ANNUAL REPORT

The Office of the Inspector General did not submit its Fiscal Year 2003 Annual Report to the General Assembly and to the Governor in accordance with 210 ILCS 30/6.7. The Annual Report is to include a summary of investigations made for the prior fiscal year for residents of institutions under the jurisdiction of the Department of Human Services. The report is also to include a trend analysis of the number of reported allegations and their disposition, for each facility and department-wide, for the most recent 3-year period and a statement of staffing-to-patient ratios for each facility. The report is also required to include detailed recommended administrative actions and matters for consideration by the General Assembly.

Section 6.7 of the Abused and Neglected Long Term Care Facility Residents Reporting Act requires the OIG to submit the Annual Report to the General Assembly and to the Governor no later than January 1st of each year. Although the transmittal letter accompanying the Annual Report addressed to the members of the General Assembly and to the Governor was dated

December 2003, the report was not printed until February 2004 and was not delivered until March 2004.

ANNUAL REPORT	
RECOMMENDATION 12	***The Inspector General should ensure that its Annual Report is submitted to the Governor and to the General Assembly no later than January 1st of each year as required by the Abused and Neglected Long Term Care Facility Residents Reporting Act.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	The Inspector General will ensure that all future Annual Reports are submitted timely. The FY04 Annual Report has been completed and has been approved for printing.

APPENDICES

APPENDIX A
(210 ILCS 30/6.8)

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 of Human Services and in making recommendations for sanctions to the Departments of Human Services and Public Health. The Auditor General shall conduct the program audit according to the provisions of the Illinois State Auditing Act and shall report its findings to the General Assembly no later than January 1 of each odd-numbered year.

(Source: P.A. 92-358, eff. 8-15-01; 93-636, eff. 12-31-03.)

APPENDIX B
Sampling & Analytical Methodology

Appendix B

SAMPLING & ANALYTICAL METHODOLOGY

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

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

We interviewed representatives and obtained information and documentation from the Inspector General's Office, the Department of Human Services, the Department of Public Health, Department of State Police, and the Department of Children and Family Services. We analyzed OIG's electronic database from Fiscal Years 2003 and 2004. 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 of investigators hired since our last OIG audit and reviewed investigators' 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 seven previous OIG audits released in 1990, 1993, 1994, 1996, 1998, 2000, and 2002. 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 2004 and fieldwork was concluded in October 2004. In order to test case files for thoroughness of investigation methods, we selected a sample of cases closed in Fiscal Year 2004. Using a data collection instrument, we gathered certain information from case files and developed a database of sample information to analyze. That information included verification of data from the OIG electronic system. Our sample was chosen from the universe of cases closed in Fiscal Year 2004. We took a systematic random sample of 125 cases with a confidence level of at least 90 percent and an acceptable error rate of 10 percent. Our random sample was stratified into the two following case classifications:

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

We also performed analyses of timeliness and thoroughness based on an electronic database of OIG reported cases from Fiscal Years 2003 and 2004 and did comparisons of similar data from prior OIG audits. The validity of electronic data was verified as part of our case file testing described above.

APPENDIX C

Rate of Substantiated Abuse or Neglect Cases by Facility

FY 2002, FY 2003 and FY 2004

Appendix C

RATE OF SUBSTANTIATED ABUSE OR NEGLECT CASES BY FACILITY

(Includes Allegations Categorized as Abuse, Neglect or Death at Intake)

Fiscal Years 2002, 2003 and 2004

	Fiscal Year 2002			Fiscal Year 2003			Fiscal Year 2004		
Facility	Number Closed	Number Substantiated by OIG	Substantiation Rate	Number Closed	Number Substantiated by OIG	Substantiation Rate	Number Closed	Number Substantiated by OIG	Substantiation Rate
Alton	79	2	3%	61	0	0%	56	2	4%
Chester	131	1	1%	112	1	1%	126	2	2%
Chicago-Read	25	1	4%	16	0	0%	34	1	3%
Choate	133	2	2%	132	0	0%	168	5	3%
Elgin	154	13	8%	99	8	8%	37	2	5%
Fox	2	1	50%	8	0	0%	9	2	22%
Howe	47	2	4%	100	3	3%	119	8	7%
Jacksonville	51	3	6%	93	5	5%	78	6	8%
Kiley	26	4	15%	65	9	14%	46	10	22%
Lincoln [B]	44	7	16%	56	8	14%	0	0	0%
Ludeman	29	1	3%	45	1	2%	41	5	12%
Mabley	23	3	13%	13	0	0%	14	6	43%
Madden	27	3	11%	16	0	0%	25	0	0%
McFarland	18	1	6%	24	1	4%	22	0	0%
Murray	14	2	14%	21	3	14%	24	7	29%
Shapiro	64	6	9%	42	1	2%	60	6	10%
Singer	39	8	21%	14	1	7%	31	3	10%
Tinley Park	35	2	6%	28	0	0%	25	1	4%
Zeller [B]	13	0	0%	27	0	0%	0	0	0%
Community Agencies [A]	905	206	23%	613	88	14%	724	138	19%
Totals	**1,859**	**268**	**14%**	**1,585**	**129**	**8%**	**1,639**	**204**	**12%**

[A] Aggregate numbers from all Community Agencies.

[B] Lincoln and Zeller both closed in FY03.

Source: OAG analysis of OIG data.

APPENDIX D

Allegations by Facility

FY 2002 through FY 2004

CATEGORIES FOR ALLEGATIONS AND OTHER INCIDENTS

Allegations of **Abuse**

A1 -- Physical abuse with imminent danger alleged

A2 -- Physical abuse with serious harm alleged

A3 -- Physical abuse without serious harm alleged

A4 -- Sexual abuse alleged

A5 -- Mental injury (verbal) alleged

A6 -- Mental injury (psychological) alleged

A7 -- Exploitation alleged (no longer reportable)

Allegations of **Neglect**

N1 -- Neglect with imminent danger alleged

N2 -- Neglect in any serious injury

N3 -- Neglect in any non-serious injury

N4 -- Neglect in an individual's absence

N5 -- Neglect in sexual activity between recipients

N6 -- Neglect in theft of recipient property

N7 -- Neglect with risk of harm or injury

Recipient **Deaths**

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

D2 -- Suicide within 14 days after discharge

D3 -- Suicide – all other

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

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

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

D7 -- Death - any other reportable death

Serious and Other Injuries

S1 -- Serious injury by other recipient (no longer reportable)

S2 -- Suicide attempt with injury (no longer reportable)

S3 -- Serious injury - self-inflicted (no longer reportable)

S4 -- Serious injuries - accidental or unknown cause (no longer reportable)

S5 -- Repeated injuries (no longer reportable)

S6 -- Multiple victims (no longer reportable)

S7 -- Multiple aggressors (no longer reportable)

Other **Reportable** Incidents

R1 -- Domestic abuse (DAP only)

R2 -- Domestic neglect (DAP only)

R3 -- Domestic exploitation (DAP only)

R4 -- Criminal conduct reported to State Police

R5 -- Theft of State property

R6 -- Theft of recipient property

R7 -- Any incident deemed reportable by Authorized Representative

Appendix D
ALLEGATIONS BY FACILITY
FY 2002 through FY 2004

Location	Abuse Allegations								
	A1 physical abuse - imminent danger			A2 physical abuse - serious injury			A3 other physical abuse		
	FY02	FY03	FY04	FY02	FY03	FY04	FY02	FY03	FY04
DD Facilities									
Fox	0	0	0	0	0	0	0	1	0
Howe	0	0	0	3	3	2	33	58	41
Jacksonville	0	0	1	1	0	1	41	35	43
Kiley	0	0	0	1	2	0	21	30	20
Lincoln [A]	1	0	0	0	0	0	15	2	0
Ludeman	0	0	0	0	0	0	17	15	18
Mabley	0	0	0	0	0	0	9	8	5
Murray	0	0	1	1	0	0	4	13	8
Shapiro	0	1	0	2	0	1	40	47	20
MH Facilities									
Alton	0	0	0	1	0	0	43	25	31
Chester	0	0	1	0	6	3	79	87	90
Chicago-Read	0	0	0	1	2	0	9	7	7
Elgin	0	0	0	2	0	0	38	15	7
Madden	0	1	0	0	1	0	9	6	10
McFarland	0	0	0	1	0	1	11	8	9
Tinley Park	0	1	0	0	0	0	7	10	6
Zeller [A]	0	0	0	0	0	0	6	0	0
Dual Facilities									
Choate	0	0	1	0	0	0	95	117	104
Singer [A]	0	1	0	0	2	0	18	9	16
Community Agencies [C]	0	9	6	5	11	8	259	269	242
Special Cases	0	0	0	0	0	0	0	0	0
Totals	**1**	**13**	**10**	**18**	**27**	**16**	**754**	**762**	**677**

[A] Lincoln DD, Zeller MH and Singer DD were closed in FY03. Therefore, Singer is no longer a dual facility.
[B] A7 and Serious Injury Cases are no longer reported. R1, R2, R3 are Domestic Abuse only.
[C] Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

Appendix D
ALLEGATIONS BY FACILITY
FY 2002 through FY 2004

Abuse Allegations											
A4 sexual abuse			**A5 verbal abuse**			**A6 psychological abuse**			**A7 exploitation by an employee** [B]		
FY02	**FY03**	**FY04**	**FY02**	**FY03**	**FY04**	**FY02**	**FY03**	**FY04**	**FY02**	**FY03**	**FY04**
0	0	0	0	0	0	0	0	0	0	-	-
2	0	1	3	7	6	7	3	7	0	-	-
0	2	5	3	6	3	3	6	4	0	-	-
0	0	1	3	2	1	0	1	1	0	-	-
0	1	0	3	0	0	1	0	0	1	-	-
0	0	1	1	0	0	3	0	1	0	-	-
0	0	1	1	1	0	0	1	0	0	-	-
1	0	1	1	2	0	2	1	0	0	-	-
0	0	0	7	1	0	2	1	0	0	-	-
19	9	6	9	11	4	8	6	2	0	-	-
3	1	3	16	5	3	13	16	9	0	-	-
0	2	3	2	3	4	3	4	1	0	-	-
8	7	5	49	7	4	17	9	7	0	-	-
0	0	2	8	7	1	0	4	5	0	-	-
1	1	1	4	1	2	3	2	2	0	-	-
0	2	3	14	6	2	3	5	1	0	-	-
2	0	0	5	0	0	1	0	0	0	-	-
4	11	13	17	9	4	9	9	7	0	-	-
6	4	2	1	2	0	2	0	1	0	-	-
39	53	46	119	45	23	59	66	31	7	-	-
0	0	0	0	0	0	0	0	0	0	-	-
85	**93**	**94**	**266**	**115**	**57**	**136**	**134**	**79**	**8**	**-**	**-**

Appendix D
ALLEGATIONS BY FACILITY
FY 2002 through FY 2004

Location	Neglect Allegations								
	N1 neglect- imminent danger			N2 neglect- serious injury			N3 neglect- non-serious injury		
	FY02	FY03	FY04	FY02	FY03	FY04	FY02	FY03	FY04
DD Facilities									
Fox	1	0	0	0	1	2	0	0	1
Howe	0	0	0	2	3	1	2	5	4
Jacksonville	0	0	0	2	2	1	0	6	4
Kiley	0	0	1	1	3	1	3	8	2
Lincoln [A]	3	0	0	13	1	0	8	1	0
Ludeman	0	0	0	3	3	1	0	5	3
Mabley	0	0	0	1	0	0	2	4	2
Murray	1	0	0	1	2	1	0	0	0
Shapiro	0	0	0	0	1	0	0	3	1
MH Facilities									
Alton	0	0	0	0	0	0	0	1	2
Chester	0	0	0	1	0	0	3	2	2
Chicago-Read	0	0	0	1	1	2	1	0	3
Elgin	0	0	0	5	0	0	20	6	1
Madden	0	0	0	0	1	0	1	1	1
McFarland	0	0	0	0	0	0	1	3	3
Tinley Park	0	0	0	3	0	0	4	2	3
Zeller [A]	1	0	0	0	0	0	2	0	0
Dual Facilities									
Choate	1	2	0	1	2	3	1	3	2
Singer [A]	0	0	0	0	2	0	1	2	1
Community Agencies [C]	3	2	3	40	18	21	49	78	56
Special Cases	0	0	0	0	0	0	0	0	0
Totals	**10**	**4**	**4**	**74**	**40**	**33**	**98**	**130**	**91**

[A] Lincoln DD, Zeller MH and Singer DD were closed in FY03. Therefore, Singer is no longer a dual facility.
[B] A7 and Serious Injury Cases are no longer reported. R1, R2, R3 are Domestic Abuse only.
[C] Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

Appendix D
ALLEGATIONS BY FACILITY
FY 2002 through FY 2004

Neglect Allegations											
N4 neglect in individual absence			**N5 neglect in recipient sexual activity**			**N6 Neglect in theft of recipient property**			**N7 Neglect with risk of harm or injury**		
FY02	**FY03**	**FY04**	**FY02**	**FY03**	**FY04**	**FY02**	**FY03**	**FY04**	**FY02**	**FY03**	**FY04**
0	0	0	0	0	0	0	0	0	0	0	0
2	2	0	0	0	0	0	0	0	1	3	1
6	2	1	0	1	1	0	0	0	2	3	0
1	0	0	0	0	0	0	0	1	4	2	3
2	1	0	0	0	0	0	0	0	10	0	0
0	1	0	0	0	0	0	0	0	2	1	0
3	1	0	0	0	0	0	0	0	3	1	2
0	3	0	0	0	0	0	0	0	4	0	2
2	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	3	0	0
0	0	0	0	0	0	0	0	0	3	0	0
0	2	0	0	0	1	0	0	0	2	1	1
1	1	0	1	0	0	0	0	0	5	1	1
2	0	0	0	0	0	0	0	0	1	0	0
2	0	0	0	0	0	0	0	0	1	0	0
0	0	0	0	0	0	0	0	0	2	0	0
0	0	0	0	0	0	0	0	0	0	0	0
1	0	1	0	1	2	0	0	0	8	6	3
3	0	0	0	1	0	0	0	0	1	1	0
11	4	6	7	4	2	0	0	0	90	37	38
0	0	0	0	0	0	0	0	0	0	0	0
36	**17**	**8**	**8**	**7**	**6**	**0**	**0**	**1**	**142**	**56**	**51**

Appendix D
ALLEGATIONS BY FACILITY
FY 2002 through FY 2004

Location	Deaths								
	D1 suicide in program			D2 suicide within 14 days after discharge			D3 Suicide -all other		
	FY02	FY03	FY04	FY02	FY03	FY04	FY02	FY03	FY04
DD Facilities									
Fox	0	0	0	0	1	0	0	0	0
Howe	0	2	0	0	0	0	1	0	0
Jacksonville	0	0	0	0	1	0	0	0	0
Kiley	0	0	0	0	0	0	0	0	0
Lincoln [A]	0	0	0	0	0	0	0	0	0
Ludeman	0	0	0	0	0	0	2	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	1	0	0	0	1	1	0	0	0
Elgin	1	0	0	0	0	0	2	0	0
Madden	0	0	1	0	0	1	0	0	0
McFarland	0	0	0	0	0	0	0	0	1
Tinley Park	0	0	0	1	0	1	0	0	0
Zeller [A]	0	0	0	0	0	0	0	0	0
Dual Facilities									
Choate	0	0	0	0	0	0	1	0	0
Singer [A]	1	0	0	0	0	0	1	0	0
Community Agencies [C]	1	2	2	0	0	0	22	0	0
Special Cases	0	0	0	0	0	0	0	0	0
Totals	**4**	**4**	**3**	**1**	**3**	**3**	**29**	**0**	**1**

[A] Lincoln DD, Zeller MH and Singer DD were closed in FY03. Therefore, Singer is no longer a dual facility.
[B] A7 and Serious Injury Cases are no longer reported. R1, R2, R3 are Domestic Abuse only.
[C] Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

Appendix D

ALLEGATIONS BY FACILITY

FY 2002 through FY 2004

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 reportable deaths		
FY02	**FY03**	**FY04**	**FY02**	**FY03**	**FY04**	**FY02**	**FY03**	**FY04**	**FY02**	**FY03**	**FY04**
0	0	1	0	0	0	3	7	4	0	0	0
0	3	2	0	0	0	3	4	0	0	1	0
0	1	0	0	0	0	6	4	1	0	0	0
1	0	0	0	0	0	1	2	1	0	0	0
0	0	0	1	0	0	6	0	0	0	1	0
1	1	0	0	0	1	0	2	4	0	1	0
0	0	0	0	0	0	2	0	1	0	0	0
0	1	0	0	0	0	1	1	3	1	1	0
0	1	2	1	2	1	5	5	9	0	0	0
0	0	0	0	0	0	0	0	0	0	1	0
0	1	2	0	0	0	1	1	1	0	1	0
0	0	0	4	0	0	0	1	1	1	0	0
0	1	0	0	0	0	0	0	1	0	0	2
0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	1	1	0	1	1
0	0	1	0	0	0	0	0	0	1	1	1
0	0	0	0	0	0	1	0	0	1	0	0
0	1	1	0	0	1	0	1	1	0	1	0
0	2	1	0	0	0	1	1	0	0	1	0
7	30	22	12	2	2	59	54	56	124	7	3
0	0	0	0	0	0	0	0	0	0	0	0
9	**42**	**32**	**18**	**4**	**5**	**89**	**84**	**84**	**128**	**17**	**7**

Appendix D
ALLEGATIONS BY FACILITY
FY 2002 through FY 2004

Location	Serious and Other Injuries								
	S1 inflicted by a non-staff person [B]			S2 suicide attempt [B]			S3 self-inflicted [B]		
	FY02	FY03	FY04	FY02	FY03	FY04	FY02	FY03	FY04
DD Facilities									
Fox	0	-	-	0	-	-	0	-	-
Howe	20	-	-	0	-	-	21	-	-
Jacksonville	19	-	-	0	-	-	5	-	-
Kiley	5	-	-	0	-	-	14	-	-
Lincoln [A]	6	-	-	0	-	-	10	-	-
Ludeman	11	-	-	0	-	-	17	-	-
Mabley	1	-	-	0	-	-	1	-	-
Murray	2	-	-	0	-	-	9	-	-
Shapiro	0	-	-	0	-	-	5	-	-
MH Facilities									
Alton	2	-	-	0	-	-	0	-	-
Chester	6	-	-	1	-	-	3	-	-
Chicago-Read	2	-	-	0	-	-	1	-	-
Elgin	10	-	-	4	-	-	6	-	-
Madden	1	-	-	0	-	-	1	-	-
McFarland	1	-	-	0	-	-	5	-	-
Tinley Park	7	-	-	0	-	-	3	-	-
Zeller [A]	0	-	-	0	-	-	3	-	-
Dual Facilities									
Choate	6	-	-	1	-	-	6	-	-
Singer [A]	1	-	-	0	-	-	1	-	-
Community Agencies [C]	32	-	-	2	-	-	15	-	-
Special Cases	0	-	-	0	-	-	0	-	-
Totals	**132**	**-**	**-**	**8**	**-**	**-**	**126**	**-**	**-**

[A] Lincoln DD, Zeller MH and Singer DD were closed in FY03. Therefore, Singer is no longer a dual facility.
[B] A7 and Serious Injury Cases are no longer reported. R1, R2, R3 are Domestic Abuse only.
[C] Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

Appendix D
ALLEGATIONS BY FACILITY
FY 2002 through FY 2004

Serious and Other Injuries											
S4 accidental or unknown cause [B]			**S5 repeated injuries** [B]			**S6 multiple recipient victims** [B]			**S7 multiple recipient aggressors** [B]		
FY02	**FY03**	**FY04**	**FY02**	**FY03**	**FY04**	**FY02**	**FY03**	**FY04**	**FY02**	**FY03**	**FY04**
8	-	-	0	-	-	0	-	-	0	-	-
109	-	-	6	-	-	5	-	-	1	-	-
69	-	-	10	-	-	15	-	-	0	-	-
65	-	-	1	-	-	3	-	-	0	-	-
53	-	-	1	-	-	3	-	-	0	-	-
125	-	-	0	-	-	5	-	-	0	-	-
20	-	-	3	-	-	0	-	-	0	-	-
37	-	-	11	-	-	0	-	-	0	-	-
59	-	-	0	-	-	0	-	-	0	-	-
4	-	-	1	-	-	1	-	-	0	-	-
12	-	-	3	-	-	2	-	-	1	-	-
4	-	-	0	-	-	0	-	-	0	-	-
18	-	-	2	-	-	4	-	-	1	-	-
1	-	-	0	-	-	0	-	-	0	-	-
2	-	-	0	-	-	0	-	-	0	-	-
3	-	-	0	-	-	0	-	-	0	-	-
7	-	-	0	-	-	1	-	-	0	-	-
39	-	-	1	-	-	5	-	-	0	-	-
17	-	-	1	-	-	2	-	-	0	-	-
376	-	-	1	-	-	1	-	-	0	-	-
0	-	-	0	-	-	0	-	-	0	-	-
1,028	**-**	**-**	**41**	**-**	**-**	**47**	**-**	**-**	**3**	**-**	**-**

Appendix D
ALLEGATIONS BY FACILITY
FY 2002 through FY 2004

Location	Other Reportable Incidents								
	R4 criminal conduct			R5 theft of State property			R6 theft of recipient property		
	FY02	FY03	FY04	FY02	FY03	FY04	FY02	FY03	FY04
DD Facilities									
Fox	0	0	0	1	0	0	0	0	0
Howe	2	0	0	5	0	0	0	1	0
Jacksonville	1	0	0	1	2	0	1	0	0
Kiley	1	0	0	0	0	0	1	0	0
Lincoln [A]	0	0	0	0	1	0	0	0	0
Ludeman	2	1	0	0	1	0	0	0	0
Mabley	0	0	0	0	0	0	1	0	0
Murray	1	1	0	0	1	0	0	0	0
Shapiro	3	0	0	1	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	1	0	0	0	0	0	0	0	0
Elgin	0	1	0	0	1	0	2	0	0
Madden	0	1	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 [A]	0	0	0	0	0	0	0	0	0
Dual Facilities									
Choate	0	0	0	0	0	0	1	0	0
Singer [A]	1	0	0	0	0	0	0	0	0
Community Agencies [C]	0	0	0	0	0	0	0	0	0
Special Cases	0	0	0	0	0	0	0	0	0
Totals	**12**	**4**	**0**	**8**	**6**	**0**	**6**	**1**	**0**

[A] Lincoln DD, Zeller MH and Singer DD were closed in FY03. Therefore, Singer is no longer a dual facility.
[B] A7 and Serious Injury Cases are no longer reported. R1, R2, R3 are Domestic Abuse only.
[C] Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

Appendix D
ALLEGATIONS BY FACILITY
FY 2002 through FY 2004

Location	Other Reportable Incidents		
	R7 any other occurrence		
	FY02	**FY03**	**FY04**
DD Facilities			
Fox	0	0	0
Howe	6	2	0
Jacksonville	3	1	0
Kiley	2	0	0
Lincoln [A]	7	0	0
Ludeman	2	0	0
Mabley	0	0	0
Murray	1	0	0
Shapiro	0	0	0
MH Facilities			
Alton	0	0	0
Chester	0	0	0
Chicago-Read	0	0	0
Elgin	49	3	0
Madden	2	0	0
McFarland	0	0	0
Tinley Park	2	0	0
Zeller [A]	0	0	0
Dual Facilities			
Choate	5	3	0
Singer [A]	3	0	0
Community Agencies [C]	7	2	0
Special Cases	0	0	0
Totals	**89**	**11**	**0**

APPENDIX E

Agency Responses

Note: This Appendix contains the written responses of the Office of the Inspector General and the Illinois State Police. Following the Agency Responses are 15 numbered Auditor Comments. The number for the comment appears in the margin of the Agency Response. Due to the length of the exhibits that the OIG references in its response, the exhibits have not been included in this report, but can be viewed on-line with the report at www.state.il.us/auditor or at the Auditor General's Springfield or Chicago Offices.

Rod R. Blagojevich, *Governor*

Illinois Department of Human Services

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

Office of the Inspector General
160 N. LaSalle, 7th Floor
Chicago, IL 60601

November 19, 2004

William Holland
Auditor General
Office of the Auditor General
740 East Ash Street
Springfield, Il 62703

Dear Auditor General Holland:

I appreciate the opportunity to respond to the recommendations in the FY04 Audit Report of the Office of the Inspector General, ("OIG"). As in years past, OIG values this report and has worked during the interim to address prior recommendations. I am pleased to inform you that despite increased demands, loss of staff and resources, OIG implemented nearly all the recommendations noted in your last audit. Following this report's exit interview however, OIG has noted that the audit report still contains pejorative statements, suppositions and inaccuracies. **1** **2**

The Long Term Care Act, 210 ILCS 30/6 *et. seq* instructs the Inspector General to promulgate rules establishing minimum requirements for completing investigations. Through an amendment to Administrative Rule 50, OIG promulgated that "days" shall refer to working days. It is our position that working days is a fairer interpretation of completion time than calendar days as staff within this office do not work weekends or holidays. To assert that the interpretation of the word "day" to mean working days, instead of calendar days translates into a **relaxing** and more **lenient** interpretation of the time requirement is unnecessarily opinionated and unsupported by any evidence (*see introduction and chapter 2: Investigation Timeliness*). As such, I respectfully request that all opinionated statements either be referenced as opinions, supported by data in the audit, or removed from the audit report. **3** **4** **5**

Other misleading statements and/or statements unsupported by facts are as follows:

- "In addition, community agencies are not being properly trained in basic investigative skills ... (*see introduction and Chapter 3: Community Agency Investigations*). This audit includes no data regarding the quality of training we provide or the methodology used to train persons attending our basic investigative skills. **6**
- Chapter 2: Investigation Timeliness contains the following adverse implication with no supporting data: "Prior OIG investigative guidance required that investigations be completed as expeditiously as possible and should not exceed 60 calendar days absent extenuating circumstances" This statement implies that an expeditious investigation is no **7**

longer the goal of this office which is clearly not the case. OIG investigators are instructed daily on the importance of completing their cases as expeditiously as possible. This is also captured in OIG's statement of core values.

- The statement that OIG does not maintain a record of when cases are referred to the Illinois State Police is not only unsupported by the data in the report but is inaccurate. Each case file either has a notation in the case tracking form or a copy of a fax referral sheet documenting referral. This statement is made both in the introduction and repeated in Chapter 2: Illinois State Police. **8**
- The statement that mental injury no longer addresses verbal and psychological injury is misleading. A review of the old Rule 50 definitions of verbal and psychological abuse in comparison to the amended Rule's definitions will reveal that the definition of mental injury now subsumes the old definitions of verbal and psychological abuse. **9**

The audit also makes extensive use of the word "may". For instance, the audit notes that "investigative guidance 'may' continue to leave investigative staff ... unclear on .... (*see introduction, chapter 2: Investigative Guidance*). A similarly unfair and speculative statement in chapter 2 reads as follows: "These elements of an investigation are now left to the judgment of the investigator and if not followed properly **might** impede the investigation". Chapter 3 section *Community Agency Investigations* contains the following statement: "In addition without proper training the community agency 'may' not correctly ... To document that an adverse consequence may occur without similarly noting that it may not, misleads the reader, is not factual, speculative and not supported by data. While there are additional uses throughout the report, these are just a few examples of inappropriate uses of the word "may". Accordingly, I urge you to reconsider any reference to what "may" occur and request that the report address those matters which have been proven. **10**

I respectfully request that you revise the draft report to remove unsupported adverse inferences thereby providing an audit wherein all statements are provable and supported by the evidence. As reflected in the attached responses, OIG again intends to implement most of the recommendations provided. **11**

Your consideration is greatly appreciated.

Kind regards,

Sydney R. Roberts, J.D.
Inspector General
Illinois Department of Human Services

C: Secretary Carol L. Adams, Ph.D.
Illinois Department of Human Services

Recommendation 1

The Office of Inspector General ("OIG") agrees that each investigation should have a written plan of action prior to the commencement of any investigation to ensure that all investigations proceed in a timely manner. However, OIG contends that staff are provided with clear and consistent investigative direction; in fact, we note that in but two instances did the audit find OIG's directives to be vague. First, newly hired investigators must complete an extensive 3 month training program which clearly and explicitly explains the entire investigative process, covering such topics as investigative planning, the collection of evidence and when and how to take photographs *(see exhibit 1)*. Moreover, all OIG staff receive the OIG training manual which clearly outlines exactly how to collect different types of evidence as well as how and when to take photographs. Thus, while the Directives Manual does not cover all investigative techniques, the Training Manual does provide this level of detail and serves as a "How To" guide. Secondly, this information is reiterated at bureau meetings, in net-learning modules, and in-service training classes. OIG urges the Auditor General to recognize that certain critical investigative decisions must be left to the discretion of investigators and their supervisors to ensure that we devote our resources where most beneficial to the investigation. We specifically take issue with any recommendation that OIG formulate a directive requiring investigators to take photographs in all physical abuse cases. Where the taking of a photograph will not reveal evidence nor disprove evidence of an injury, photographs are of no evidentiary value, are not fiscally prudent, and are not an efficient use of investigative time. In fact, photographs that do not show an apparent injury can undermine a substantiated finding of physical abuse. **12**

Recommendation 2

OIG's current operating procedures do ensure that all allegations of abuse and neglect as defined by 59 Ill. Admin. Code 50, (Rule 50), are reported and thoroughly investigated. Moreover, although the language of the audit report suggests otherwise, the report fails to demonstrate that allegations are not being reported or thoroughly investigated in accordance with both the statute and Rule 50. While an argument can be made that capturing data on serious injuries may reveal evidence of abuse or neglect, OIG's years of research and analysis of data revealed that most often serious injuries were the result of an accident or the individual engaging in self-injurious behaviors. Such injuries, though a matter of concern, are not covered by 210 ILCS 30/6.2 et. seq nor Rule 50 and fall outside our purview. Additionally, this information as well as resident on resident incidents are captured and analyzed by the DHS Division of Mental Health and the Division of Developmental Disabilities, state operated facilities and community agencies. These are quality assurance issues, not an issue of abuse and neglect. Where abuse or neglect are suspected, the division will contact OIG and an investigation will commence. To ensure the most efficient use of our resources, Rule 50 was amended in 2002 and no longer requires the reporting of serious injuries absent an allegation of abuse or neglect. Lastly, we encourage the Auditor General to review the amended definition of mental injury as it subsumes both the old definitions of verbal and psychological abuse (*see exhibit II*). **13**

Recommendation 3

The OIG provided the Auditor General with OIG's legislative proposal, which was not enacted, to give OIG the authority to contact the local law enforcement authority upon a report of a possible felony. OIG intends to again submit the proposal during the 95th Legislative Session. Although it is not the practice of the Illinois State Police to investigate such matters that occur in non-state facilities and involve non-state employees, OIG will contact ISP pending passage of the legislative proposal. However, to ensure that crimes against the disabled in non-state facilities are thoroughly investigated, OIG will continue to contact the local police department.

Recommendation 4

OIG will continue to work to improve the timeliness of investigations. At the end of the first quarter of Fiscal Year 2005, the average number of days required to complete investigations was shortened to 47.6 days. However, OIG takes issues with the reference that OIG has a more lenient time requirement for completing cases. Under the old Rule 50, investigators had 60 calendar days to complete an investigation. Because OIG investigators do not work holidays or weekends, this interpretation did not provide the investigator with 60 days but rather considerably less, particularly during a month in which there was a holiday. Converting to working days is a much fairer, not lenient, interpretation of the 60 day requirement. **14**

Recommendation 5

The Auditor General noted in numerous places throughout the report that OIG does not keep a record in our case file of when we refer cases to the Illinois State Police. However in their 5 case sampling OIG referred to the case file and was in fact able to provide them with the dates of referrals. Thus, their contention that OIG does not maintain this data is not supported by their own narrative. OIG reminds the Auditor General that our investigators may not uncover evidence of a crime for some time after initiating an investigation, which is only fitting to avoid burdening law enforcement with non-criminal matters. In the one case mentioned by the Auditor General, it was not clear upon review of the intake that this case was appropriate for referral. Only after the investigator completed several investigative steps did he uncover evidence of possible criminal conduct. Thus, once OIG obtained the requisite evidence, the referral was made immediately, consistent with the other cases involving police referrals reviewed in this audit. OIG is currently developing an electronic case management system which will include a component for capturing cases referred to the Illinois State Police. **8**

Recommendation 6

Although we agree with this Recommendation's aim of completing case reviews faster, we believe that instituting a case management system (Recommendation 7) will achieve this goal more effectively. As noted, this office already directs investigators to interview certain individuals within specific time frames. Establishing additional interim deadlines may expose otherwise thorough and timely investigations to meaningless criticism. Each investigation is unique, so effective case management depends upon giving investigators the appropriate flexibility and discretion to conduct interviews and compile evidence in a manner that leads to a thorough and efficient conclusion. For example, although this office instructs investigators to interview the victim before the alleged perpetrator, factors present in individual cases may not allow such an orderly progression. **15**

Unforeseen unavailability of witnesses and efficiency may sometimes require an investigator to interview other available witnesses after traveling several hours to the location. Forcing investigators to follow an excessively formulaic approach will hamper their ability to react to specific situations and exercise good judgment appropriately. We urge the Auditor General to maintain focus on the goal of completing cases within sixty days, and the case management system as the best tool for achieving that goal, rather than upon interim deadlines.

Recommendation 7

OIG is currently developing an electronic case management system to improve upon our timeliness and enhance the management of our cases. However, it cannot be stressed enough that Exhibit 2-7 is not a true reflection of the actual number of days a completed case is in review for final approval. As noted by the Auditor General, the information in our existing database does not accurately account for cases initially submitted for review that are returned to the investigator for additional investigative work. Our review of the Auditor General's sample case reviews indicated that nearly all cases, once fully investigated, were reviewed within the time frames set forth within the OIG Directives Manual.

Recommendation 8

OIG is pleased that the audit documents improvements in the reporting of allegations of abuse and neglect within the four hour time frame. OIG will continue to work with providers to assure that reporting requirements are met. To assist in this process, OIG generates detailed reports of late reporters and tracks trends. In one case, OIG sent a letter threatening sanctions. Additionally, OIG seeks explanations for late reporting when the report is initially made, allowing ample time for follow up. OIG sends advisories to the provider and DHS division director responsible for monitoring that provider's performance. OIG case reports always recommend that agencies whose staff have reported allegations in a tardy fashion address that deficiency and require that the provider submit a corrective action plan to prevent further non-compliance. Finally, OIG offers on-site training and other technical assistance to those agencies experiencing difficulty with meeting required time frames.

Recommendation 9

OIG investigates all community agency cases where an agency has indicated that they do not want the authority to conduct their own. Of the tens of thousands of agency employees, only staff trained in Basic Investigative Skills took investigative action in the sixty three cases handled by agencies. Moreover, any initial action requested of persons not trained in Basic Investigative Skills rarely include more than providing copies of relevant documents. Untrained staff were not asked to conduct interviews, collect sensitive evidence, take needed photographs or take any other investigative related steps. OIG takes issue with any inference that untrained agency personnel conduct investigations and maintains that, in accordance with OIG directives, they are not engaging in investigative practices, nor does the report demonstrate that they have. Additionally, OIG does provide technical support to agency investigators, along with any necessary re-training needed to address noted deficiencies within their cases. It should be noted that all agency investigations are subject to the same supervisory review approval process that applies to OIG investigations. Given

the small number of cases, which are referred to the agencies, requiring adherence to the Protocol by agencies who do not wish to conduct investigations will unduly interfere with OIG investigations *(see exhibit III)*.

Recommendation 10

OIG has already taken steps to comply with training requirements set forth in its directives. In September 2004, OIG held its annual statewide training for all OIG staff which included two and a half days of investigative training, review of trends and patterns of allegations and findings, timeliness of investigations, investigative case planing, interviewing MI and DD persons and review of organizational performance. OIG's training directive has been revised to include specific classes and training goals. In addition, staff are assigned several Net Learning computer-based training courses which are required within a specific time frame. Targeted bureau level training specific to the needs of each bureau has begun. Lastly, individualized training objectives are established for each employee during evaluation periods.

Recommendation 11

OIG has been working closely with the Governor's Office of Boards and Commissions regarding the appointment of board members. We will also continue to work closely with the President of the Board to encourage quarterly meetings.

Recommendation 12

The Inspector General will ensure that all future Annual Reports are submitted timely. The FY04 Annual Report has been completed and has been approved for printing.

AUDITOR COMMENTS

1 The 2002 audit contained eight recommendations. In this audit, 4 of the 8 (50%) prior audit recommendations have been repeated.

2 As evidenced by the following auditor comments addressing issues raised by the Inspector General, the Office of the Auditor General does not concur with the Inspector General's conclusions regarding the audit report.

3 The requirement to promulgate rules is located in the "Abused and Neglected Long Term Care Facility Residents Reporting Act" (210 ILCS 30/6.2)

4 The audit continues to report timeliness on a calendar day basis for comparison purposes over time (and also reports timeliness using the new working day standard as well). Furthermore, changing the requirement from 60 calendar days to 60 working days **is** a more lenient time requirement. Using working days, the OIG has over 80 calendar days to complete an investigation compared to the 60 calendar day requirement. Regardless of which standard is used, the OIG is far short of completing cases in a timely manner.

5 No change was made.

6 Over 190,000 individuals with mental illness or developmental disabilities were served by approximately 400 community agencies in fiscal year 2004. The audit is not questioning the training that the OIG provides to community agencies that chose to send staff to such training. Rather, the audit is noting that community agency staff who have not been trained may fail to correctly assess whether an incident of abuse or neglect has occurred which needs to be reported to the OIG. Also, since several days may pass before an OIG investigator arrives on-site at the community agency, it would seem reasonable for the OIG to take steps to help ensure that community agency staff are knowledgeable so that an investigation is not compromised by improper evidence handling before an OIG investigator arrives.

Based on analysis of OIG investigations at community agencies from our sample cases, it took the OIG an average of 42 days to conduct interviews with victims. In 22 of the 36 investigations, the first OIG interview with the victim was conducted after a week had passed.

7 The requirement that investigations be completed as expeditiously as possible and should not exceed 60 calendar days absent extenuating circumstances is from OIG's prior investigative guidance. The auditors are not inferring that an "expeditious" investigation is no longer a goal of the OIG, but rather, simply reporting that the OIG's timeliness standard for completing cases has changed from 60 calendar days to over 80 calendar days, with the adoption of the 60 *working day* requirement.

8 To test compliance with the reporting requirement to State Police, we requested documentation from the OIG for the five cases in our sample referred to the State Police. We were told by OIG staff that no documentation was maintained. On August 26, 2004, auditors sent an e-mail to the Inspector General to verify that documentation was not kept. We subsequently received referral dates to the State Police from the OIG, but the OIG did not provide documentation, such as fax referral sheets. We noted that one of the referral dates differed from the date in OIG's computer system. Since the OIG provided two different dates for the same case, we requested and received the documentation for the one case from the State Police. The date in OIG's computer system was incorrect. The case was not investigated by the OIG for five days and was not reported to the State Police for nine days.

9 The Inspector General appears to be referring to a bullet on page 9 of the report where auditors note that the definition of mental injury no longer **specifically** includes verbal or psychological abuse or exploitation. A review of the old rule shows that it included definitions for verbal abuse, for psychological abuse, and for exploitation. These definitions are **not** included in the new rule. As a result, we noted they are no longer **specifically** included.

10 One of the primary purposes of an audit is to identify a deficiency or weakness so that corrective action can be taken by an agency preferably **before** a serious problem occurs. For example, audits contain findings on inadequate segregation of duties and contain recommendations to correct the weaknesses identified before problems (such as theft, fraud) arise. Similarly, this audit identifies items that, if unaddressed, **may** have a undesirable future impact.

11 The items noted by the Inspector General have been addressed and no additional changes to the report were made.

12 As noted by the Inspector General, evidence handling is addressed in training manuals and net-learning modules, and reiterated at bureau meetings and in-service training classes. The auditors concluded that evidence handling also should be included in the Directives that are intended to provide guidance to investigators (as prior OIG Investigations Guidelines have done). Specifically regarding photographs, the auditors stand by the recommendation that photographs should be taken in all abuse and neglect cases where injuries are alleged. Furthermore, the Inspector General's position in response to this audit report appears to contradict both the OIG's community agency protocol and OIG training materials. The protocol still requires photographs to be taken "when injuries are the result of an alleged incident of abuse or neglect . . . even if the injury is not evident at the time of report/discovery." (see OIG Exhibit III, p. 11 on-line at www.state.il.us/auditor) Training material provided by the OIG also states that "Photographs document the existence of injuries or the lack thereof." (see OIG Exhibit I Photographs section on-line at www.state.il.us/auditor)

13 The Inspector General notes that serious injuries are a matter of concern but are not covered by 210 ILCS 30/6.2. In fact, the Abused and Neglected Long Term Care Facility Residents Reporting Act defines "abuse" as "**any physical injury, sexual abuse or mental injury inflicted on a resident other than by accidental means".** This broad statutory definition seems to include injuries to residents, unless they are clearly accidental. Regarding neglect and mental injury, the auditors noted a 79 percent decrease in mental injury (verbal) allegations from fiscal year 2002 to 2004, and a 64 percent decrease in neglect with risk of harm or injury allegations over the same time period. Because of this large decrease in incidents, it does not appear that the old definition has been fully "subsumed" into the new one.

14 The audit continues to report timeliness on a calendar basis for comparison purposes over time. Additionally, using working days **is** a more lenient time requirement. Using working days, the OIG has over 80 calendar days to complete an investigation compared to the 60 calendar day requirement.

15 The audit is not proposing a formulaic approach to investigations, but rather, recommending a control mechanism to help ensure that interviews are conducted in a timely manner. An average timeframe of 43 days, based on our sample, to interview victims for facility and community agency cases, is too long. If the OIG has other methods or controls to help ensure that interviews are completed more timely, we suggest that they implement them.

ILLINOIS STATE POLICE
Office of the Director

Rod R. Blagojevich
Governor

Larry G. Trent
Director

November 17, 2004

Mr. Ed Wittrock, Audit Manager
Office of the Auditor General
Iles Park Plaza
740 East Ash Street
Springfield, Illinois 62703-3154

Dear Mr. Wittrock:

This is in response to your correspondence dated October 28, 2004, concerning a program audit of the Department of Human Services (DHS), Office of the Inspector General. I have reviewed portions of the attached confidential draft report relating specifically to the Illinois State Police (ISP). I concur with those findings as they relate directly to the ISP.

The ISP is collaborating with the DHS to re-draft an interagency agreement to comply with the statutory requirements set forth under the Abused and Neglected Long Term Care Facility Residents Reporting Act. Additionally, while past efforts have met with little success, both agencies will continue to work toward ensuring current administrative rules are consistent with the Act.

Thank you for the opportunity to review the ISP's portion of the draft report. Please contact me at 217/782-7263 if you have any questions or require further information.

Sincerely,

Larry G. Trent
Director

LGT:dc
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