
# STATE OF ILLINOIS

# OFFICE OF THE AUDITOR GENERAL

## PROGRAM AUDIT

## OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HUMAN SERVICES

DECEMBER 2006

WILLIAM G. HOLLAND

AUDITOR GENERAL

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SPRINGFIELD OFFICE:
ILES PARK PLAZA
740 EAST ASH • 62703-3154
PHONE: 217/782-6046
FAX: 217/785-8222 • TTY: 888/261-2887

CHICAGO OFFICE:
MICHAEL A. BILANDIC BLDG. • SUITE S-900
160 NORTH LASALLE • 60601-3103
PHONE: 312/814-4000
FAX: 312/814-4006

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 2006

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# REPORT DIGEST

**PROGRAM AUDIT OF**

**THE DEPARTMENT OF HUMAN SERVICES**

**OFFICE OF THE INSPECTOR GENERAL**

Released: December 2006

State of Illinois
Office of the Auditor General

**WILLIAM G. HOLLAND**
AUDITOR GENERAL

To obtain a copy of the report contact:
Office of the Auditor General
Iles Park Plaza
740 East Ash Street
Springfield, IL 62703
(217) 782-6046 or
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## SYNOPSIS

This is our ninth audit of the Department of Human Services' Office of the Inspector General's (OIG's) effectiveness in investigating allegations of abuse or neglect. The OIG addressed many of the recommendations from our 2004 audit. These included revising policies to require that investigators develop an investigative plan, detail when photographs are needed, and require investigators to complete five training courses each year.

In this audit we also reported that:

- While the OIG made improvements in the timeliness of investigations, 48 percent of investigations were not completed in 60 calendar days (29 percent were not completed within 60 working days) in FY06. Furthermore, a potential for future timeliness problems exists due to increased investigator caseloads and an increased number of allegations of abuse and neglect reported.
- OIG Directives require "critical" interviews to be completed within 5 working days but do not define what a "critical" interview is. We found on average it took 12 days to complete interviews with the alleged victim and 25 days to complete interviews with the alleged perpetrator.
- The OIG does not define physical harm; therefore, there were inconsistencies in how physical harm was interpreted relating to allegations of abuse and neglect.
- An alleged criminal act (rape) was reported to the OIG but was closed by the Hotline as a non-reportable allegation. While OIG officials noted that it was reported to local law enforcement, it was not reported to the Illinois State Police as required by law.
- The OIG is required to report individuals to the Nurse Aide Registry when the OIG has substantiated a finding of abuse or egregious neglect against them. In 22 of the 28 (79%) Registry cases appealed in FY05, the petitioners won their appeal. In FY06, 19 of the 32 (59%) petitioners that have had their hearing won their appeal. When the petitioner wins the appeal, OIG's substantiated finding is not listed on the Nurse Aide Registry.
- The Administrative Law Judge (ALJ) rejected 11 cases investigated during FY05 or FY06 that were referred to the Registry. In the 11 referrals, the ALJ found that the Department had not demonstrated by a preponderance of the evidence that the finding of abuse against the petitioner warranted reporting to the Registry.
- The Quality Care Board did not meet at all during FY05, and it did not meet during the first quarter of FY06.

# 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. Additionally, the Act requires the Office of the Auditor General (OAG) to conduct a biennial program audit of the Inspector General's compliance with the Act. This is the ninth audit conducted of the OIG since 1990.

Total allegations of abuse and neglect reported to the OIG have increased significantly since FY04. In FY04, 1,183 allegations were reported (977 abuse, 206 neglect). In FY06, 1,814 allegations were reported (1,485 abuse and 329 neglect). OIG officials attribute the increased allegations to the OIG's increased training on reporting requirements and to increased correspondence with facilities and community agencies. The OIG also notes that some of the increase in abuse allegations in FY05 was due to a few individuals from a facility in the South Bureau making frequent and typically unfounded allegations.

DHS facilities and community agencies are required to report allegations of abuse and neglect by calling into the OIG Hotline. The OIG Hotline investigator makes an assessment as to whether the allegation is abuse or neglect, thus reducing the number of inappropriate cases being investigated. We reviewed all 128 allegations deemed "non-reportable" by Hotline investigators from January 1, 2006 to March 31, 2006. We questioned and discussed with the OIG 27 decisions to close allegations as non-reportable. Our decision to question closing the allegation as non-reportable was based on requirements in 59 Ill. Adm. Code 50 (Rule 50), including whether there was any evidence or reason to believe that abuse or neglect may have occurred.

Seven of the non-reportable allegations we questioned fell into one of two categories: 1) unexplained injuries to non-verbal patients; and 2) instances where individuals were left unsupervised for a period of time. For both types of allegations, the OIG's determination that the allegation was non-reportable may have been consistent based on the current definitions of abuse, neglect, and mental injury as defined in Rule 50. However, given its mission to prevent abuse, neglect, and mistreatment of persons with mental and developmental disabilities, the OIG should investigate unexplained injuries to non-verbal patients and instances where clients were neglected and put in danger by being left unsupervised. Prior to the Rule 50 changes in January 2002, the definition of neglect in the

OIG's administrative rules included endangering an individual with or without an injury.

During fieldwork testing, we also found an instance where an alleged criminal act was reported to the OIG but was closed by the Hotline as a non-reportable allegation. While OIG officials noted it was reported to local law enforcement, it was not reported to the Illinois State Police as required by State law. The allegation was reported by a facility that a female resident was raped by another resident. The allegation was closed by the OIG Hotline as non-reportable since there was no allegation of abuse against staff. We questioned the OIG's decision to close this allegation as non-reportable and, as a result, the OIG has since opened an investigation.

The OIG continues to consider serious injuries without an allegation of abuse or neglect to be non-reportable. Until FY03, these cases were reported and were investigated by the OIG even though there was no allegation of abuse or neglect. The OIG 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. However, 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.

Timeliness of investigations has been an issue in all of the eight previous OIG audits. During this audit period, the OIG made improvements in its timeliness for completing investigations. In FY04, 39 percent of OIG investigations were completed in 60 calendar days. Timeliness improved in FY05 with 55 percent and in FY06 with 52 percent completed in 60 calendar days. In January 2002, the OIG amended Rule 50 to require investigations be completed within 60 *working* days. If working days are used, the OIG is still not completing its cases within the required 60-day period. Using working days, 76 percent of cases in FY05 and 71 percent of cases in FY06 were completed within 60 working days.

We found that a potential for increased timeliness problems exists due to increased investigator caseloads and an increased number of abuse and neglect allegations reported. Caseloads increased significantly in the North and Metro Bureaus from FY04 to FY06. The greatest increase was in the Metro Bureau where average caseloads increased by 233 percent from 9 in FY04 to 30 in FY06. From FY04 to FY06, allegations in the North Bureau increased by 123 percent (from 172 to 384), in the Metro Bureau by 57 percent (from 374 to 589), in the Central Bureau by 49 percent (from 310 to 463), and in the South Bureau by 39 percent (from 271 to 378).

In our testing of FY06 cases, 8 cases were referred to State Police. The OIG refers these cases to the State Police using its Checklist for Notification to the State Police. The OIG could not provide auditors with 3 of the 8 Checklists (38%). Additionally, the Checklist does not document when the OIG determined the allegation should be reported to the State Police. Therefore, OIG management cannot ensure that the allegation was reported within the 24-hour reporting requirement found in the Act.

The OIG Directives require all "critical" interviews to be completed by the assigned investigator within five working days of approval of the Investigative Plan; however, the Directives do not specifically define what a "critical" interview is for conducting investigations. During our case file review, we found on average it took investigators 12 days to complete interviews with the alleged victim and 25 days to complete interviews with the alleged perpetrator in each case.

OIG's investigative bureaus are inconsistent in the number of interviews being conducted per investigation, which may contribute to the timeliness of case completions. During our case file review, we found the South Bureau averaged fewer than 3 interviews per case during the time period, while the North averaged nearly 11 per case. The Central and Metro Bureaus had an almost identical average of 5.3 and 5.2 interviews per case, respectively.

During interviews with OIG supervisory staff, none of the staff felt the OIG's new case tracking system was beneficial. Some of the supervisory staff responded that the case tracking system did not help to alleviate time delays, but in fact, slowed down the process. The reason given was that now investigators are required to enter everything twice, once handwritten, and a second time in the tracking system. Several investigators responded that the increased time entering data was taking away from their necessary investigative duties.

Although there has been improvement since our 2004 audit, alleged incidents of abuse or neglect are not being reported to the OIG by State facilities and community agencies in the time frames required by OIG's administrative rule. In FY06, 6 percent of facility incidents and 29 percent of community agency incidents were not reported within the four-hour time requirement.

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. From our FY06 sample, we found that photographs were missing in 4 of 21 (19%) sampled cases where there was an allegation of an injury sustained. All files

contained an injury report for cases where there was an allegation of an injury sustained. During the review of our 126 sample cases, all files contained pertinent medical records, treatment plans, or progress notes. All six cases sampled where restraints were used contained the appropriate documentation.

OIG investigators are inconsistent in regard to the format used to document investigative interviews. In some instances, investigators use a summary format to document interviews while others use more of a question and answer format. When the summary format is used, the reviewer is unable to determine whether all appropriate and necessary questions were asked. Additionally, during file testing we found five examples from five different investigations where interview write-ups were almost verbatim for multiple individuals interviewed. In many of these write-ups, the investigator used the same summary write-up and changed the time and names of the other witnesses.

OIG's four investigative bureaus are decentralized, which has led to inconsistencies among the bureaus. There are few controls in place to ensure that the investigations by the bureaus within the OIG are consistent. In addition, we found inconsistencies between what is and is not accepted by the Bureau of Hotline and Intake as an allegation of abuse or neglect.

During our review of case files, we determined that, since the OIG does not define physical harm, there were inconsistencies in how physical harm was interpreted relating to allegations of abuse and neglect. Another factor that contributes to inconsistencies in OIG's findings is that all closed investigations are not reviewed in a similar manner. Investigative bureau chiefs are allowed to close unsubstantiated and unfounded investigations without any other review. Substantiated investigations are reviewed by the bureau chiefs and then by either the Inspector General or a designee. Inconsistencies between substantiated, unsubstantiated, and unfounded findings may have been identified by the OIG if all closed investigations were reviewed centrally.

The OIG referred 81 substantiated cases to the Nurse Aide Registry in FY05 and 47 in FY06. Of these 128 cases, only 2 (1.6%) were sent for substantiated egregious neglect while the other 126 were for substantiated abuse.

Of the 81 cases referred to the Nurse Aide Registry in FY05, 28 cases were appealed. In FY06, 36 of the 47 cases referred were appealed. In FY05, 22 of the 28 (79%) petitioners won their appeal, and in FY06, 19 of the 32 (59%) petitioners that have had their hearing won the appeal, which means the OIG's substantiated finding against an employee is **not** listed in the Nurse Aide Registry. The purpose of the mandate is to ensure

that there is a public record of such findings. Agencies and facilities are able to check the Nurse Aide Registry before hiring an employee to look for prior findings of physical or sexual abuse or egregious neglect. These individuals are barred from working with individuals with mental disabilities.

We reviewed all 11 substantiated cases referred to the Nurse Aide Registry that were investigated by the OIG during our audit period (FY05 or FY06) and rejected by the DHS administrative law judge (ALJ) in FY06. In the 11 referrals that were rejected, the ALJ found that the Department had not demonstrated by a preponderance of the evidence that the finding of abuse against the petitioner warranted reporting to the Nurse Aide Registry. In 4 of the 11 referrals (36%), the ALJ concluded that the evidence presented at the hearing was conflicting or insufficient to determine that the Petitioner committed the act.

During fieldwork, we reviewed numerous case files at the OIG. Our review included looking at the ALJ rulings for cases reported to the Nurse Aide Registry. During our review, we questioned the adequacy and consistency of findings being reported by the OIG to the Nurse Aide Registry. We identified two substantiated cases of physical abuse that were referred to the Nurse Aide Registry where the ALJ found that the two staff members acted instinctively toward a client after the client either inappropriately touched or punched the staff. In comparison, we found a case where a recipient was physically injured as a result of an employee's actions. Based on the actions by the employee, the allegation appears to meet the definition of physical injury as defined by the OIG. The case was categorized by the OIG as neglect, not abuse, and was therefore not reported to the Nurse Aide Registry.

Over the past 13 fiscal years (1994 to 2006), the Inspector General has not used sanctions against facilities. The Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6.2) gives the Inspector General broad authority to recommend sanctions.

During FY05 and FY06, the Quality Care Board (Board) did not have seven members as required by statute. Even after Board member appointments from the Governor in June and July of 2005, the Board still had only five members and two vacancies at the end of this audit period. However, the two vacant positions were filled in September 2006. In addition, the Board did not meet statutory requirements regarding quarterly meetings. The Board did not meet at all during FY05, and it did not meet during the first quarter of FY06. The Board did meet twice in the second quarter, and had meetings in each of the other quarters of the fiscal year, but the last meeting failed to have a quorum.

During FY05 and FY06, the OIG conducted unannounced site visits at all of the mental health and developmental centers as required by 210 ILCS 30/6.2. However, the OIG did not always comply with its established timeline for submitting site visit reports to facility directors or hospital administrators. According to an OIG Directive, site visit reports should be submitted to facility directors or hospital administrators within 60 days of the completion of the site visit. In FY05, 10 of the 18 (56%) mental health and developmental centers received a site visit report after the 60-working day timeline. In FY06, 6 of the 18 (33%) centers received a site visit report after the timeline.

## 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 July 1, 2006, the OIG had 59 employees, including four on leave. This represents a decrease of one position from staffing levels reported in our 2004 OIG audit. Investigative staff for abuse and neglect investigations decreased from 39 in FY00, to 27 in FY02, to 22 (including two on leave) in FY04, and to 21 (including three investigators on leave) in FY06.

In FY06, the Department of Human Services operated 18 facilities Statewide that served 13,417 individuals. In FY06, approximately 21,000 individuals with developmental disabilities and approximately 175,427 individuals with mental illness were served in 367 community agencies (operating over 5,700 programs) which were required to report to the OIG.

**This is the ninth audit related to the Office of the Inspector General.**

The Office of the Auditor General has conducted eight 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, 2002, and 2004. The OIG addressed many of the recommendations from our 2004 audit. These include revising policies to require that investigators develop an investigative plan, detail when photographs are needed, and require

investigators to complete five training courses each year. (pages 5-9, 18-20)

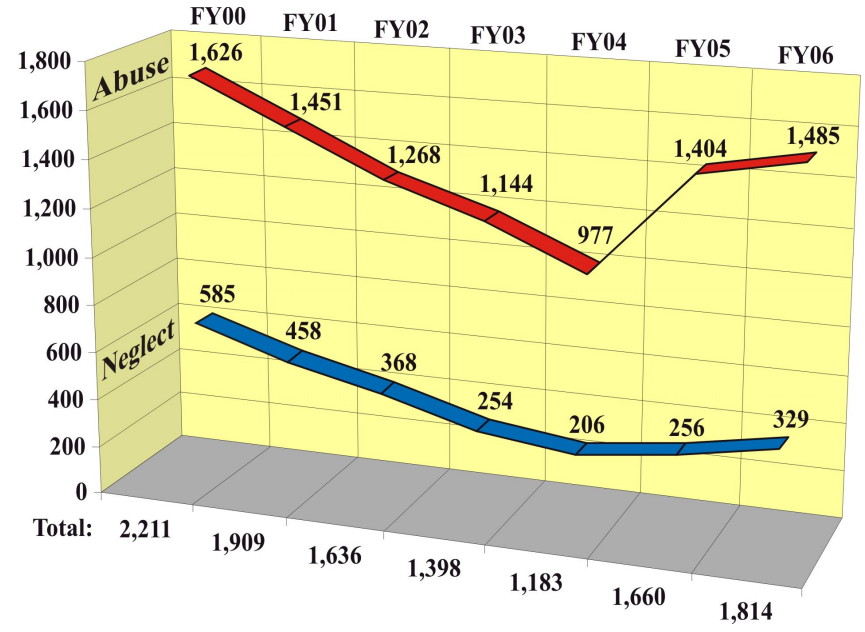
## REPORTING OF ALLEGATIONS

**Allegations of abuse and neglect reported to the OIG have increased since FY04.**

Allegations of abuse reported to the OIG have increased 52 percent since FY04. In FY04, there were 977 abuse allegations reported to the OIG. This compares to 1,485 in FY06. Allegations of neglect have increased 60 percent since FY04. In FY04, there were 206 neglect allegations reported to the OIG. This compares to 329 in FY06. Digest Exhibit 1 summarizes abuse or neglect allegations reported to the OIG for Fiscal Years 2000 to 2006.

OIG officials attribute the increased allegations to OIG's increased training on reporting requirements and to increased correspondence with facilities and community agencies. The OIG also notes that some of the increase in abuse allegations in FY05 was due to a few individuals from a facility in the South Bureau making frequent and typically unfounded allegations. (page 10)

Digest Exhibit 1
**TRENDS IN REPORTING ABUSE & NEGLECT**
Fiscal Years 2000 to 2006




Source: OIG data summarized by the OAG.

### Direct Reporting to the OIG Hotline

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

We reviewed all 128 allegations deemed "non-reportable" by Hotline investigators from January 1, 2006 to March 31, 2006. We questioned and discussed with the OIG 27 decisions to close allegations as non-reportable. Our decision to question closing the allegation as non-reportable was based on requirements in 59 Ill. Adm. Code 50 (Rule 50), including whether there was any evidence or reason to believe that abuse or neglect may have occurred.

During a review of allegations reported, we found:

- there were allegations reported that were deemed non-reportable by Hotline investigators that may have met the necessary criteria to be reported;
- an instance where an alleged criminal act was reported to the OIG but was closed by the Hotline as a non-reportable allegation. While OIG officials noted it was reported to local law enforcement, it was not reported to the Illinois State Police as required by State law; and
- the OIG does not capture data related to non-reportable allegations that would enable investigators to look for patterns. (pages 12-17)

## INVESTIGATION TIMELINESS

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

Timeliness of investigations has been an issue in all of the eight previous OIG audits. During this audit period, the OIG made improvements in its timeliness for completing investigations. In FY04, 39 percent of OIG investigations were completed in 60 calendar days. Timeliness improved in FY05 with 55 percent and in FY06 with 52 percent of investigations completed in 60 calendar days. Digest Exhibit 2 shows timeliness data for OIG investigations for the last six fiscal years.

Digest Exhibit 2
**CALENDAR DAYS TO COMPLETE ABUSE OR NEGLECT INVESTIGATIONS**
Fiscal Years 2001 to 2006

| Days to Complete Cases | FY01 % of Cases | FY02 % of Cases | FY03 % of Cases | FY04 % of Cases | FY05 % of Cases | FY06 % of Cases |
|---|---|---|---|---|---|---|
| **0-60** | **49%** | **46%** | **30%** | **39%** | **55%** | **52%** |
| 61-90 | 18% | 31% | 16% | 11% | 22% | 19% |
| 91-120 | 11% | 13% | 17% | 10% | 11% | 14% |
| 121-180 | 10% | 6% | 23% | 20% | 6% | 11% |
| 181-200 | 2% | 1% | 5% | 5% | 1% | 2% |
| >200 | 10% | 3% | 9% | 14% | 5% | 2% |
| **Total > 60 days** | **51%** | **54%** | **70%** | **61%** | **45%** | **48%** |
| Total Cases by FY | 1,883 | 1,442 | 1,248 | 1,472 | 1,659 | 1,597 |

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

Source: OAG analysis of OIG data.

Since the OIG changed the definition of days from calendar to a more lenient working days in Rule 50 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 FY03 cases and 51 percent of its FY04 cases within 60 working days. In FY05 and FY06, the OIG improved to 76 percent and 71 percent when using the working days standard.

The number of OIG investigations taking more than 200 calendar days to complete has also decreased significantly from FY04. In FY04, 206 cases took longer than 200 days to complete. By FY06, the cases taking longer than 200 days to complete decreased to 38. Investigations at State facilities completed during FY06 accounted for 29 percent (11 of 38) of the cases that took longer than 200 days to complete and community agency investigations accounted for 71 percent (27 of 38). (pages 24-27)

### Reporting to the State Police

In our testing of 126 FY06 cases, 8 cases were referred to State Police. The OIG refers these cases to the State Police using its Checklist for Notification to the State Police. The OIG could not provide auditors with 3 of the 8 Checklists (38%). Additionally, the Checklist does not document when the OIG determined the allegation should be reported to the State Police. Therefore, OIG management cannot ensure that the

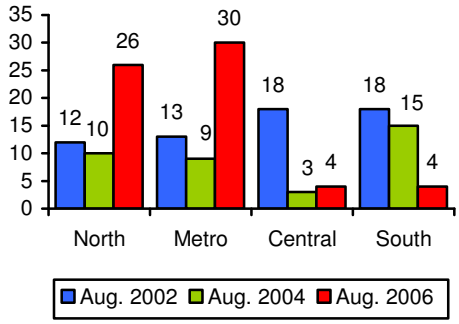
allegation was reported within the 24-hour reporting requirement found in the Act. (pages 28, 29)

### Investigator Caseloads

We found that a potential for increased timeliness problems exists due to increased investigator caseloads and an increased number of abuse and neglect allegations reported. Digest Exhibit 3 shows caseloads have increased significantly in the North and Metro Bureaus from FY04 to FY06. The greatest increase was in the Metro Bureau where average caseloads increased by 233 percent from 9 in FY04 to 30 in FY06. From FY04 to FY06, allegations in the North Bureau increased by 123 percent (from 172 to 384), in the Metro Bureau by 57 percent (from 374 to 589), in the Central Bureau by 49 percent (from 310 to 463), and in the South Bureau by 39 percent (from 271 to 378). Although timeliness has improved over the past two fiscal years, recent increases in the number of allegations reported will likely decrease timeliness of investigations in upcoming years. (page 30)

**Although timeliness has improved over the past two fiscal years, recent increases in the number of allegations reported will likely decrease timeliness of investigations in upcoming years.**

Digest Exhibit 3
**INVESTIGATOR CASELOADS**
By Bureau as of August 14, 2002, 2004, and 2006




Source: OIG data summarized by the OAG.

### Timeliness of Investigative Interviews

OIG Directives require all "critical" interviews to be completed by the assigned investigator within five working days of approval of the Investigative Plan; however, the Directives do not specifically define what a "critical" interview is for conducting investigations. During our case file review, we found on average it took investigators 12 days to complete interviews with the alleged victim and 25 days to complete interviews with the alleged perpetrator in each case.

OIG's investigative bureaus are inconsistent in the number of interviews being conducted per investigation, which may contribute to timeliness of case completion. During our case file review, we found the South Bureau averaged fewer than 3 interviews per case during the time period, while the North averaged nearly 11 per case. The Central and Metro Bureaus had an almost identical average of 5.3 and 5.2 interviews per case, respectively. (pages 31-33)

### Timeliness of Case File Reviews

**None of the bureaus are reviewing substantiated cases within the 7-day timeline delineated in the OIG Directive.**

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

In addition, during interviews with OIG supervisory staff, none of the staff felt OIG's new case tracking system was beneficial. Some of the supervisory staff responded that the case tracking system did not help to alleviate time delays, but in fact, slowed down the process. The reason given was that now investigators are required to enter everything twice, once handwritten, and a second time in the tracking system. Several investigators responded that the increased time entering data was taking away from their necessary investigative duties. (page 35)

### 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's administrative rule. The current administrative rules require that allegations of abuse or neglect be reported to the OIG within four hours of discovery. Digest Exhibit 4 shows that while there have been improvements in the timely reporting of incidents since the last audit in 2004, community agencies continue to have untimely reports in comparison to State facilities. (pages 36, 37)

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

| | Facility | Community Agency |
|---|---|---|
| FY03 | 15% | 42% |
| FY04 | 10% | 42% |
| FY05 | 6% | 34% |
| FY06 | 6% | 29% |

Source: OAG analysis of OIG data.

## INVESTIGATION THOROUGHNESS

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

OIG case reports generally were thorough, comprehensive, and addressed the allegation. All case files in our sample contained a Case Tracking Form and Case Routing/Approval Form. We found that photographs were missing in 4 of 21 (19%) cases sampled where there was an allegation of an injury sustained. All files contained an injury report for cases where there was an allegation of an injury sustained. During the review of our 126 sample cases, all files contained pertinent medical records, treatment plans, or progress notes. All six cases sampled where restraints were used contained the appropriate documentation.

### Investigation Inconsistencies

**OIG investigations are inconsistent among the investigative bureaus.**

During our review of OIG case files, we determined that the OIG investigations are inconsistent in the following areas:

- OIG investigators are inconsistent in regard to the format used to document investigative interviews. In some instances, investigators use a summary format to document interviews while others use more of a question and answer format. When the summary format is used, the reviewer is unable to determine whether all appropriate and necessary questions were asked. Additionally, during file testing we found five examples from five different investigations where interview write-ups were almost verbatim for multiple individuals interviewed.
- We found several examples of inconsistencies in how allegations and findings are classified among the OIG investigative bureaus. In addition, we found inconsistencies between what is and is not accepted by the Bureau of Hotline and Intake as an allegation of abuse or neglect.
- We determined that since the OIG does not define physical harm, there were inconsistencies in how physical harm was interpreted relating to allegations of abuse and neglect. Investigative Bureau Chiefs close unsubstantiated and unfounded investigations without any centralized review. Inconsistencies between substantiated, unsubstantiated, and unfounded findings may have been identified by the OIG if closed investigations were reviewed centrally. (pages 39-47)

# NURSE AIDE REGISTRY

Of the 81 cases referred to the Nurse Aide Registry in FY05, 28 cases were appealed. In FY06, 36 of the 47 cases referred were appealed. In FY05, 22 of the 28 (79%) petitioners won their appeal, and in FY06, 19 of the 32 (59%) petitioners that have had their hearing won the appeal, which means the OIG's substantiated finding against an employee is **not** listed in the Nurse Aide Registry. Of these 128 cases referred, only 2 (1.6%) were sent for substantiated egregious neglect while the other 126 were for substantiated abuse. The purpose of the mandate is to ensure that there is a public record of such findings. Agencies and facilities are able to check the Nurse Aide Registry before hiring an employee to look for prior findings of physical or sexual abuse or egregious neglect. These individuals are barred from working with individuals with mental disabilities.

**In the 11 referrals rejected, the ALJ found that the Department had not demonstrated by a preponderance of the evidence that the finding of abuse against the petitioner warranted reporting to the Nurse Aide Registry.**

### Review of Nurse Aide Registry Appeals Won

We reviewed all 11 substantiated cases referred to the Nurse Aide Registry that were investigated by the OIG during our audit period (FY05 or FY06) and rejected by the DHS administrative law judge (ALJ) in FY06. In the 11 referrals that were rejected, the ALJ found that the Department had not demonstrated by a preponderance of the evidence that the finding of abuse against the petitioner warranted reporting to the Nurse Aide Registry. In 4 of the 11 referrals (36%), the ALJ concluded that the evidence presented at the hearing was conflicting or insufficient to determine that the Petitioner committed the act.

### Inconsistency in Findings Reported to the Nurse Aide Registry

During our review, we questioned the adequacy and consistency of findings being reported by the OIG to the Nurse Aide Registry. We identified two substantiated cases of physical abuse that were referred to the Nurse Aide Registry where the ALJ found that the two staff members acted instinctively toward a client after the client either inappropriately touched or punched the staff. In comparison, we found a case where a recipient was physically injured as a result of an employee's actions. Based on the actions by the employee, the allegation appears to meet the definition of physical injury as defined by the OIG. The case was categorized by the OIG as neglect, not abuse, and was therefore not reported to the Nurse Aide Registry. (pages 56-61)

## SANCTIONS

Over the past 13 fiscal years (1994 to 2006) the Inspector General has not used sanctions against facilities. The Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6.2) gives the Inspector General broad authority to recommend sanctions. (page 62)

## QUALITY CARE BOARD

During FY05 and FY06, the Quality Care Board (Board) did not have seven members as required by statute. Even after Board member appointments from the Governor in June and July of 2005, the Board still had only five members and two vacancies at the end of this audit period. However, the two vacant positions were filled in September 2006. In addition, the Board did not meet statutory requirements regarding quarterly meetings. The Board did not meet at all during FY05, and it did not meet during the first quarter of FY06. The Board did meet twice in the second quarter, and had meetings in each of the other quarters of the fiscal year, but the last meeting failed to have a quorum. (pages 63, 64)

## SITE VISITS

During FY05 and FY06, the OIG conducted unannounced site visits at all of the mental health and developmental centers as required by 210 ILCS 30/6.2. However, the OIG did not always comply with their established timeline for submitting site visit reports to facility directors or hospital administrators. According to an OIG Directive, site visit reports should be submitted to facility directors or hospital administrators within 60 days of the completion of the site visit. In FY05, 10 of the 18 (56%) mental health and developmental centers received a site visit report after the 60-working day timeline. In FY06, 6 of the 18 (33%) centers received a site visit report after the timeline. (pages 64-66)

## RECOMMENDATIONS

The audit report contains 14 recommendations for Office of the Inspector General. The Inspector General generally agreed with all 14 recommendations. Appendix E to the audit report contains the Inspector General's responses.

WILLIAM G. HOLLAND
Auditor General

WGH\SAW

December 2006

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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 FY06, DHS operated 18 State facilities and licensed, certified, or funded 367 community agencies operating over 5,700 programs providing services to individuals with developmental disabilities or mental illness in community settings within Illinois. 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 ninth audit conducted of the OIG since 1990.

Total allegations of abuse and neglect reported to the OIG have increased significantly since FY04. In FY04, 1,183 allegations were reported (977 abuse, 206 neglect). In FY06, 1,814 allegations were reported (1,485 abuse and 329 neglect). OIG officials attribute the increased allegations to the OIG's increased training on reporting requirements and to increased correspondence with facilities and community agencies. The OIG also notes that some of the increase in abuse allegations in FY05 was due to a few individuals from a facility in the South Bureau making frequent and typically unfounded allegations.

DHS facilities and community agencies are required to report allegations of abuse and neglect by calling into the OIG Hotline. The OIG Hotline investigator makes an assessment as to whether the allegation is abuse or neglect, thus reducing the number of inappropriate cases being investigated. We reviewed all 128 allegations deemed "non-reportable" by Hotline investigators from January 1, 2006 to March 31, 2006. We questioned and discussed with the OIG 27 decisions to close allegations as non-reportable. Our decision to question closing the allegation as non-reportable was based on requirements in 59 Ill. Adm. Code 50 (Rule 50), including whether there was any evidence or reason to believe that abuse or neglect may have occurred.

Seven of the non-reportable allegations we questioned fell into one of two categories: 1) unexplained injuries to non-verbal patients; and 2) instances where individuals were left unsupervised for a period of time. For both types of allegations, the OIG's determination that the allegation was non-reportable may have been consistent based on the current definitions of abuse, neglect, and mental injury as defined in Rule 50. However, given its mission to prevent abuse, neglect, and mistreatment of persons with mental and developmental disabilities, the OIG should investigate unexplained injuries to non-verbal patients and instances where clients were neglected and put in danger by being left unsupervised. Prior to the Rule 50 changes in January

2002, the definition of neglect in the OIG's administrative rules included endangering an individual with or without an injury.

During fieldwork testing, we also found an instance where an alleged criminal act was reported to the OIG but was closed by the Hotline as a non-reportable allegation. While OIG officials noted it was reported to local law enforcement, it was not reported to the Illinois State Police as required by State law. The allegation was reported by a facility that a female resident was raped by another resident. The allegation was closed by the OIG Hotline as non-reportable since there was no allegation of abuse against staff. We questioned the OIG's decision to close this allegation as non-reportable, and as a result, the OIG has since opened an investigation.

The OIG continues to consider serious injuries without an allegation of abuse or neglect to be non-reportable. Until FY03, these cases were reported and were investigated by the OIG even though there was no allegation of abuse or neglect. The OIG 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. However, 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.

Timeliness of investigations has been an issue in all of the eight previous OIG audits. During this audit period, the OIG made improvements in its timeliness for completing investigations. In FY04, 39 percent of OIG investigations were completed in 60 calendar days. Timeliness improved in FY05 with 55 percent and in FY06 with 52 percent completed in 60 calendar days. In January 2002, the OIG amended Rule 50 to require investigations be completed within 60 *working* days. If working days are used, the OIG is still not completing its cases within the required 60-day period. Using working days, 76 percent of cases in FY05 and 71 percent of cases in FY06 were completed within 60 working days.

We found that a potential for increased timeliness problems exists due to increased investigator caseloads and an increased number of abuse and neglect allegations reported. Caseloads increased significantly in the North and Metro Bureaus from FY04 to FY06. The greatest increase was in the Metro Bureau where average caseloads increased by 233 percent from 9 in FY04 to 30 in FY06. From FY04 to FY06, allegations in the North Bureau increased by 123 percent (from 172 to 384), in the Metro Bureau by 57 percent (from 374 to 589), in the Central Bureau by 49 percent (from 310 to 463), and in the South Bureau by 39 percent (from 271 to 378).

In our testing of FY06 cases, 8 cases were referred to State Police. The OIG refers these cases to the State Police using its Checklist for Notification to the State Police. We requested copies of the eight Checklists that were sent to the State Police. The OIG could not provide auditors with 3 of the 8 Checklists (38%). Additionally, the Checklist does not document when the OIG determined the allegation should be reported to the State Police. Therefore, OIG management cannot ensure that the allegation was reported within the 24-hour reporting requirement found in the Act.

The OIG Directives require all "critical" interviews to be completed by the assigned investigator within five working days of approval of the Investigative Plan; however, the Directives do not specifically define what a "critical" interview is for conducting investigations. During our case file review, we found on average it took investigators 12 days to complete interviews with the alleged victim and 25 days to complete interviews with the alleged perpetrator in each case.

OIG's investigative bureaus are inconsistent in the number of interviews being conducted per investigation, which may contribute to the timeliness of case completions. During our case file review, we found the South Bureau averaged fewer than 3 interviews per case during the time period, while the North averaged nearly 11 per case. The Central and Metro Bureaus had an almost identical average of 5.3 and 5.2 interviews per case, respectively.

During interviews with OIG supervisory staff, none of the staff felt the OIG's new case tracking system was beneficial. Some of the supervisory staff responded that the case tracking system did not help to alleviate time delays, but in fact, slowed down the process. The reason given was that now investigators are required to enter everything twice, once handwritten, and a second time in the tracking system. Several investigators responded that the increased time entering data was taking away from their necessary investigative duties.

Although there has been improvement since our 2004 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's administrative rule. In FY06, 6 percent of facility incidents and 29 percent of community agency incidents were not reported within the four-hour time requirement.

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. From our FY06 sample, we found that photographs were missing in 4 of 21 (19%) sampled cases where there was an allegation of an injury sustained. All files contained an injury report for cases where there was an allegation of an injury sustained. During the review of our 126 sample cases, all files contained pertinent medical records, treatment plans, or progress notes. All six cases sampled where restraints were used contained the appropriate documentation.

OIG investigators are inconsistent in regard to the format used to document investigative interviews. In some instances, investigators use a summary format to document interviews while others use more of a question and answer format. When the summary format is used, the reviewer is unable to determine whether all appropriate and necessary questions were asked. Additionally, during file testing we found five examples from five different investigations where interview write-ups were almost verbatim for multiple individuals interviewed. In many of these write-ups, the investigator used the same summary write-up and changed the time and names of the other witnesses.

OIG's four investigative bureaus are decentralized, which has led to inconsistencies among the bureaus. There are few controls in place to ensure that the investigations by the bureaus within the OIG are consistent. In addition, we found inconsistencies between what is and is not accepted by the Bureau of Hotline and Intake as an allegation of abuse or neglect.

During our review of case files, we determined that since the OIG does not define physical harm, there were inconsistencies in how physical harm was interpreted relating to allegations of abuse and neglect. Another factor that contributes to inconsistencies in OIG's findings is that all closed investigations are not reviewed in a similar manner. Investigative bureau chiefs are allowed to close unsubstantiated and unfounded investigations without any other review. Substantiated investigations are reviewed by the bureau chiefs and then by either the Inspector General or a designee. Inconsistencies between substantiated, unsubstantiated, and unfounded findings may have been identified by the OIG if all closed investigations were reviewed centrally.

The OIG referred 81 substantiated cases to the Nurse Aide Registry in FY05 and 47 in FY06. Of these 128 cases, only 2 (1.6%) were sent for substantiated egregious neglect while the other 126 were for substantiated abuse.

Of the 81 cases referred to the Nurse Aide Registry in FY05, 28 cases were appealed. In FY06, 36 of the 47 cases referred were appealed. In FY05, 22 of the 28 (79%) petitioners won their appeal, and in FY06, 19 of the 32 (59%) petitioners that have had their hearing won the appeal, which means the OIG's substantiated finding against an employee is **not** listed in the Nurse Aide Registry. The purpose of the mandate is to ensure that there is a public record of such findings. Agencies and facilities are able to check the Nurse Aide Registry before hiring an employee to look for prior findings of physical or sexual abuse or egregious neglect. These individuals are barred from working with individuals with mental disabilities.

We reviewed all 11 substantiated cases referred to the Nurse Aide Registry that were investigated by the OIG during our audit period (FY05 or FY06) and rejected by the DHS administrative law judge (ALJ) in FY06. In the 11 referrals that were rejected, the ALJ found that the Department had not demonstrated by a preponderance of the evidence that the finding of abuse against the petitioner warranted reporting to the Nurse Aide Registry. In 4 of the 11 referrals (36%), the ALJ concluded that the evidence presented at the hearing was conflicting or insufficient to determine that the Petitioner committed the act.

During fieldwork, we reviewed numerous case files at the OIG. Our review included looking at the ALJ rulings for cases reported to the Nurse Aide Registry. During our review, we questioned the adequacy and consistency of findings being reported by the OIG to the Nurse Aide Registry. We identified two substantiated cases of physical abuse that were referred to the Nurse Aide Registry where the ALJ found that the two staff members acted instinctively toward a client after the client either inappropriately touched or punched the staff. In comparison, we found a case where a recipient was physically injured as a result of an employee's actions. Based on the actions by the employee, the allegation appears to meet the definition of physical injury as defined by the OIG. The case was categorized by the OIG as neglect, not abuse, and was therefore not reported to the Nurse Aide Registry.

Over the past 13 fiscal years (1994 to 2006), 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. In December 2002, the Inspector General developed a new Directive that specifies criteria on when to recommend sanctions. At the end of this audit, there were no changes to the Directives regarding sanctions.

During FY05 and FY06, the Quality Care Board (Board) did not have seven members as required by statute. Even after Board member appointments from the Governor in June and July of 2005, the Board still had only five members and two vacancies at the end of this audit period. However, the two vacant positions were filled in September 2006. In addition, the Board did not meet statutory requirements regarding quarterly meetings. The Board did not meet at all during FY05, and it did not meet during the first quarter of FY06. The Board did meet twice in the second quarter, and had meetings in each of the other quarters of the fiscal year, but the last meeting failed to have a quorum.

During FY05 and FY06, the OIG conducted unannounced site visits at all of the mental health and developmental centers as required by 210 ILCS 30/6.2. However, the OIG did not always comply with its established timeline for submitting site visit reports to facility directors or hospital administrators. According to an OIG Directive, site visit reports should be submitted to facility directors or hospital administrators within 60 days of the completion of the site visit. In FY05, 10 of the 18 (56%) mental health and developmental centers received a site visit report after the 60-working day timeline. In FY06, 6 of the 18 (33%) centers received a site visit report after the timeline.

## 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). This includes State-operated mental health centers and developmental centers, Community Integrated Living Arrangements (CILAs), developmental training programs, and outpatient mental health services.

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. The administrative rules were revised with an emergency rule and then a final rule effective May 24, 2002.

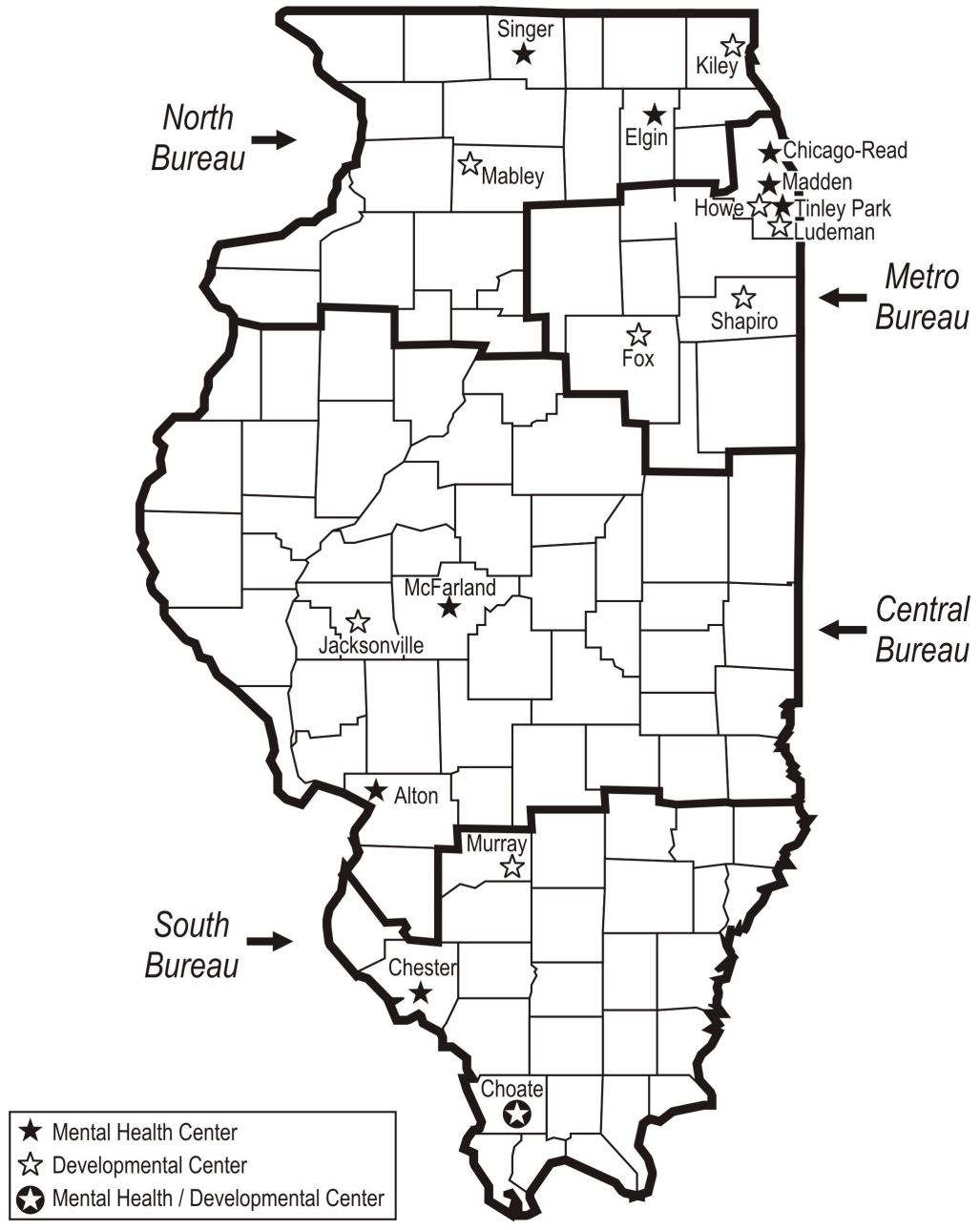
The Inspector General is located within the Department of Human Services and is appointed by the Governor and confirmed by the Senate for a four-year term. The current Inspector General was appointed in February 2006.

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 FY06, the Department of Human Services operated 18 facilities Statewide that served 13,417 individuals. Eight facilities served the developmentally disabled only, eight facilities served the mentally ill, and a dual facility which served both (Choate MHC and Choate DC). Exhibit 1-1 shows the location of the DHS operated facilities, and indicates whether the facilities are part of the OIG's North, Metro, Central, or South bureau.

In addition, DHS licenses, certifies, or provides funding for approximately 367 community agencies operating over 5,700 programs providing services to individuals with developmental disabilities or mental illness in community settings within Illinois. These community agency programs provide transportation services, workshops, or community living arrangements. In FY06, approximately 21,000 individuals with developmental disabilities and approximately 175,427 individuals with mental illness were served in community agencies required to report to the OIG.

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



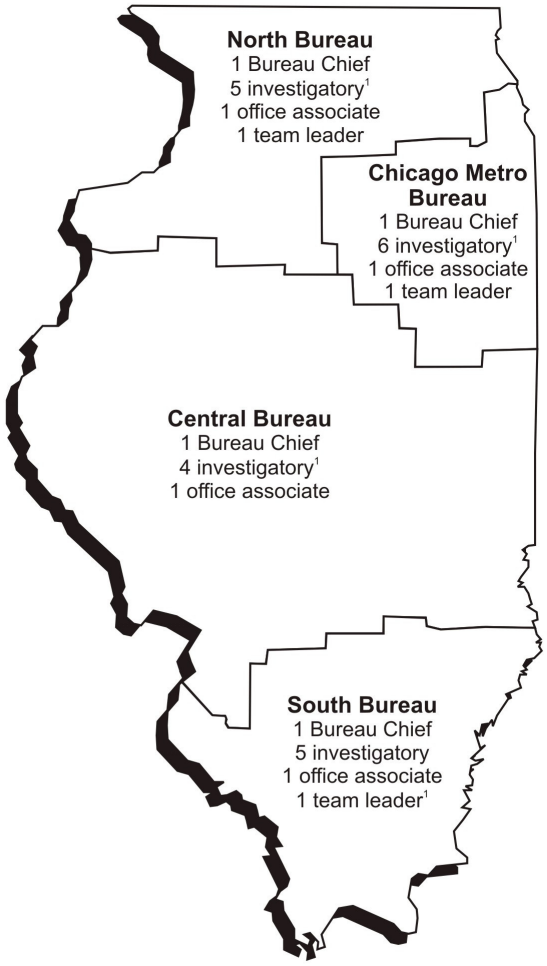

Source: OIG data summarized by OAG.

Exhibit 1-2
**OIG ORGANIZATIONAL CHART**
As of July 1, 2006

**INSPECTOR GENERAL**

**RULE 50 INVESTIGATIVE BUREAUS**

The Bureau of Investigations has 31 employees, and is responsible for investigating the cases of abuse or neglect at State-operated DHS facilities and at community agencies. Investigative responsibilities are divided into four bureaus: the North, Chicago Metro, Central and South.




**INSPECTOR GENERAL'S STAFF**

The Inspector General has 10 staff. The staff has responsibility for human resources and finances for the Office, training of investigative staff and other Inspector General employees, legislation/policy development, and two clinical coordinators who each cover two regions.

**BUREAU OF COMPLIANCE AND EVALUATION**

This Bureau has 6 employees, and handles a variety of statutory responsibilities, information management, and technical support activities for OIG. These responsibilities include: annual unannounced site visits to DHS facilities, Compliance Reviews, OIG Annual Report, and software development and support.

**BUREAU OF HOTLINE AND INTAKE**

This Bureau has 5 employees, and is responsible for overseeing the OIG 24-hour Hotline that receives allegations of suspected abuse and neglect. Bureau investigators are responsible for recording allegations into the OIG database, providing initial investigative direction and electronically transmitting the intake to the appropriate bureau.

**BUREAU OF DOMESTIC ABUSE**

This Bureau has 6 employees and 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: [1] Includes one staff member on leave.

Source: OIG data summarized by OAG.

## OIG Organization

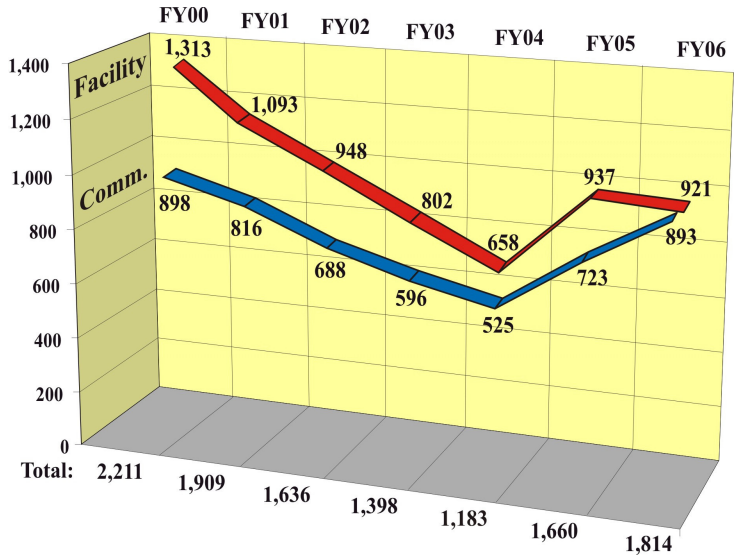
Exhibit 1-2 shows the organizational structure of the OIG and the number of staff in each of the regions. As of July 1, 2006, the OIG had 59 employees, including four on leave. This represents a decrease of one position from staffing levels reported in our 2004 OIG audit. Investigative staff for abuse and neglect investigations decreased from 39 in FY00, to 27 in FY02, to 22 (including two on leave) in FY04, and to 21 (including three investigators on leave) in FY06. The OIG had an appropriation of $5.8 million for FY04. In FY05, the OIG's appropriation was $5.3 million and for FY06 the appropriation was $4.4 million.

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 North, Metro, and South Bureaus have an investigative team leader (ITL) who is responsible primarily for case file review. The ITL from the South Bureau was on leave as of July 1, 2006. According to OIG officials, the North and Metro Bureaus only had one ITL until the last two months of FY06 and the ITL in the South Bureau was on leave for all of FY05 and FY06.

## Trends in Allegations of Abuse or Neglect

Between FY00 and FY04, allegations of abuse and neglect reported to the OIG steadily decreased each year. However, since FY04, abuse and neglect allegations increased significantly. In FY06, a total of 1,814 allegations of abuse or neglect were reported to the OIG (921 from State facilities and 893 from community agencies). Exhibit 1-3 summarizes abuse or neglect allegations reported to the OIG from the two sources for Fiscal Years 2000 to 2006. State facilities served 2,841 individuals with developmental disabilities and 10,576 individuals with mental illness in FY06. Community agencies served 21,000 individuals with developmental disabilities and 175,427 individuals with mental illness in FY06.

Exhibit 1-3
**TOTAL ABUSE OR NEGLECT ALLEGATIONS REPORTED TO OIG**
Fiscal Years 2000 to 2006



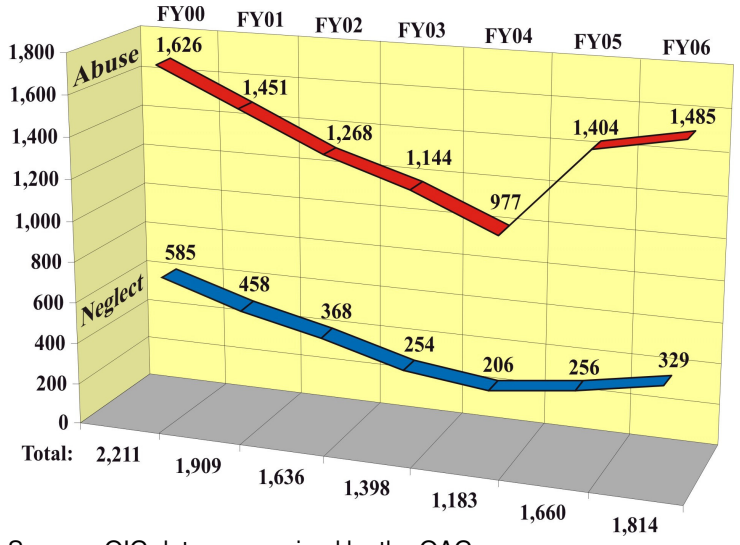

Note: State facilities served 2,841 individuals with developmental disabilities and 10,576 individuals with mental illness in FY06. Community agencies served approximately 21,000 individuals with developmental disabilities and approximately 175,427 individuals with mental illness in FY06.

Source: OIG data summarized by the OAG.

Allegations of abuse reported to the OIG have increased 52 percent since FY04. In FY04, there were 977 abuse allegations reported to the OIG. This compares to 1,485 in FY06.

Allegations of neglect have increased 60 percent since FY04. In FY04, there were 206 neglect allegations reported to the OIG. This compares to 329 in FY06. Exhibit 1-4 shows the trends in reporting of abuse and neglect to the OIG.

Exhibit 1-4
**TRENDS IN REPORTING ABUSE & NEGLECT**
Fiscal Years 2000 to 2006




Source: OIG data summarized by the OAG.

OIG officials attribute the increased allegations to OIG's increased training on reporting requirements and to increased correspondence with facilities and community agencies. The OIG also notes that some of the increase in abuse allegations in FY05 was due to a few individuals from a facility in the South Bureau making frequent and typically unfounded allegations.

## OIG INVESTIGATION PROCESS

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

**Abuse**

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

**Neglect**

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

**Physical Injury**

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

OIG Directives require investigators to complete an Investigative Plan within three working days of assignment. Additionally, the Directive requires the investigator to complete all critical interviews within five working days from approval of the Investigative Plan. When the investigator completes an investigation, an investigative report is developed in accordance with OIG Directives and is

forwarded via e-mail to the investigative team leader (if applicable) and the bureau chief for initial review and approval. According to OIG Directive, the case is required to be reviewed, absent extenuating circumstances, within seven working days of receipt. Once the bureau chief reviews and approves a substantiated case of physical abuse, sexual abuse, or egregious neglect, it will then be sent to the Inspector General or his/her designee for review. According to Rule 50, the Investigative Report shall be submitted to the Inspector General within 60 working days of the assignment unless there are extenuating circumstances.

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

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

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

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

The OIG also sends 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 working days after the receipt of the clarification or denial of reconsideration. The Inspector General shall provide a complete investigative report within 10 calendar days to the Secretary of Human Services when abuse or neglect is substantiated or administrative action is recommended.

# REPORTING OF ALLEGATIONS

Total allegations of abuse and neglect reported to the OIG have increased significantly since FY04. In FY04, 1,183 allegations were reported (977 abuse, 206 neglect). In FY06, 1,814 allegations were reported (1,485 abuse and 329 neglect).

## Direct Reporting to the OIG Hotline

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

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

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

During a review of allegations reported, we determined there were allegations reported that were deemed non-reportable by Hotline investigators that may have met the necessary criteria to be reported. Below are examples of allegations reported to Hotline investigators that may have met one of the necessary criteria to be reported and investigated but were closed as non-reportable.

**Examples of Allegations Closed as Non-reportable**

- A client's mother called and alleged that her son isn't being cared for by staff. The allegation was deemed non-reportable "due to there not being an allegation of abuse or neglect against a staff-member".
- It was reported by a facility that a resident stated to staff that people are raping her. The resident could not be more specific and refused to talk. The allegation was deemed non-reportable due to no allegation against staff.
- Caller noted that a non-verbal resident who is unable to communicate has faint yellow bruises on the inside of the right bicep. The caller spoke to staff that stated they had concerns about two staff members due to observing the resident "flinch" when

approached after the two staff had worked. The allegation was closed due to no observed abuse by staff and due to another resident that has a history of grabbing others by the arm to direct them.

- Staff at a day program reported that a non-verbal client who cannot communicate arrived at the Center with a red mark on her forehead and a red mark on the side of her head. Caller also stated that the client did not eat her lunch, which was unusual, was not herself, and did not want to get back on the agency van at the end of the day. The allegation was deemed non-reportable due to no allegation against staff.

We reviewed all 128 allegations deemed "non-reportable" by Hotline investigators from January 1, 2006 to March 31, 2006. We questioned and discussed with the OIG 27 decisions to close allegations as non-reportable. Our decision to question closing the allegation as non-reportable was based on requirements in Rule 50, including whether there was any evidence or reason to believe that abuse or neglect may have occurred.

Seven of the non-reportable allegations we questioned fell into one of two categories: 1) unexplained injuries to non-verbal patients; and 2) instances where individuals were left unsupervised for a period of time. For both types of allegations, the OIG's determination that the allegation was non-reportable may have been consistent based on the current definitions of abuse, neglect, and mental injury as defined in Rule 50. However, given its mission to prevent abuse, neglect, and mistreatment of persons with mental and developmental disabilities the OIG should investigate unexplained injuries to non-verbal patients and instances where clients were neglected and put in danger by being left unsupervised. Prior to the Rule 50 changes in January 2002, the definition of neglect in the OIG's administrative rules included endangering an individual with or without an injury.

OIG current administrative rule (Rule 50) defines abuse, neglect, and mental injury as:

- **Abuse** -any physical injury, sexual abuse, or mental injury inflicted on an individual other than by accidental means.

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

- **Mental Injury** -harm caused by an act or omission that precipitates emotional distress or maladaptive behavior in the individual, or could precipitate emotional distress or maladaptive behavior, including the use of words, signs, gestures or other actions toward or about and in the presence of individuals.

Although the questionable non-reportable allegations may not meet the definitions found in the OIG's current administrative rule, the OIG should consider revising its investigative directives and administrative rules to ensure these types of allegations are investigated. The OIG should ensure that non-verbal individuals with unexplained injuries are being protected. Additionally, the OIG should ensure that failures by facility or agency administration, which

causes clients to be neglected by leaving them alone for periods of time without supervision, are addressed before a client is physically or mentally injured.

| NON-REPORTABLES | |
|---|---|
| **RECOMMENDATION 1** | ***The Office of the Inspector General should ensure that all allegations reported to the Hotline are investigated appropriately as required by 59 Ill. Adm. Code 50. Additionally, the OIG should consider revising its Investigative Directives and Administrative Rule to ensure that all potential allegations of abuse and neglect are investigated.*** |
| **OFFICE OF THE INSPECTOR GENERAL RESPONSE** | OIG agrees. As the auditors noted, OIG is in compliance with its statutory mandate to investigate abuse and neglect as defined in Rule 50. OIG's statutory jurisdiction covers alleged or suspected abuse/neglect, not *potential* abuse/neglect. OIG's Bureau of Hotline and Intake assesses every call for an allegation or suspicion of abuse or neglect.<br><br>Following the FY 2004 audit, OIG began the process of amending Rule 50, including revising some definitions. However, on June 5, 2006, the department's Legal Services recommended suspending the process, since some revisions would require statutory changes. Any revision to Rule 50 or to OIG's Investigative Directives must follow statutory changes.<br><br>However, a cross-bureau team in OIG is currently reviewing its Investigative Directives for needed clarifications or improvements. While some directives can be revised to improve operations without statutory changes, all revisions must be consistent with the current statute and Rule 50. |
| | *AUDITOR COMMENT: The auditors' review of Hotline referrals closed without an investigation identified instances where non-verbal clients received unexplained injuries and instances where clients were left unsupervised. Based on the documentation provided, it was unclear whether the injuries or the lack of supervision was the result of abuse or neglect. The auditors are recommending that the OIG take the necessary steps, including possibly revising its Investigative Directive or Administrative Rule, to ensure that all allegations reported to the Hotline that involve the possible abuse or neglect of a client are appropriately investigated.* |

## Reporting Criminal Acts

During fieldwork testing, we also found an instance where an alleged criminal act was reported to the OIG but was closed by Hotline investigators as a non-reportable allegation. While OIG officials noted it was reported to local law enforcement, it was not reported to the

Illinois State Police as required by State law (see Hotline Case Example in the following section). The allegation was reported by a facility that a female resident was raped by another resident. The allegation was closed by the OIG Hotline as non-reportable since there was no allegation that staff committed the abuse. We questioned the OIG's decision to close this allegation as non-reportable, and as a result, the OIG has since opened an investigation.

State law requires the OIG to report any suspected abuse or neglect that indicates a possible criminal act has been committed to the Illinois State Police within 24 hours. The State Police shall investigate any report from a facility indicating a murder, rape, or other felony. Since the OIG did not investigate this allegation and closed it as non-reportable, the Illinois State Police was not notified as required by 210 ILCS 30/6.2(b). If the facility reported the allegation to local law enforcement, it was not documented by the OIG when the allegation was reported.

| **REPORTING CRIMINAL ACTS** | |
|---|---|
| **RECOMMENDATION 2** | ***The Office of the Inspector General should ensure that all allegations of suspected abuse or neglect that indicate any possible criminal act has been committed are reported to the Illinois State Police as required by 210 ILCS 30/6.2(b).*** |
| **OFFICE OF THE INSPECTOR GENERAL RESPONSE** | OIG agrees. The statute requires that, if OIG determines that a criminal act may have been committed, the incident is to be reported to the Illinois State Police or to an appropriate local law enforcement entity. In the only incident cited by the auditors, the facility reported that the female resident had been taken to the hospital for a rape kit, which involves automatic reporting to local law enforcement. OIG confirmed that the Cook County Sheriff's office had responded to the report, and thus notification of the Illinois State Police was not also necessary.<br><br>OIG Intake investigators will continue to ensure that non-reportable claims of rape, murder, or other felony are reported to the Illinois State Police or local law enforcement within 24 hours of determining credible evidence that a criminal act may have occurred. OIG will revise its directive to more clearly specify responsibility for this determination. |
| | *AUDITOR COMMENT: Notification of the Illinois State Police, rather than a local law enforcement agency,* ***was*** *required by State law in this case. The Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6.2(b)) specifically requires that "the Department of State Police shall investigate any report from a State-operated facility indicating a possible murder, rape, or other felony."* |

### Non-Reportable Allegation Data

The OIG does not capture data related to non-reportable allegations that would enable investigators to look for patterns. In regard to the case noted in the above section, the rape allegation came only four days *after* the facility reported to the OIG that the perpetrator was on precaution for sexual behavior and staff were told to watch the residents closely as noted in the earlier allegation on January 20, 2006. Since the initial allegation of sexual behavior was unfounded at the time of the second call, the OIG did not know the perpetrator was on precautions and therefore, did not investigate the allegation as neglect against the facility. Whether the perpetrator raped the victim or had consensual sex with the victim as the perpetrator alleged, the facility either failed to protect the victim or failed to closely watch the perpetrator who was on precautions.

**Hotline Case Example**

A female resident at a facility alleged that on January 19, 2006 a male resident inappropriately touched her and made sexual remarks to her. At the time, it was noted by facility staff that the male resident was on precaution for sexual behavior. On January 20, 2006, the Hotline closed the allegation as non-reportable because the allegation was not against staff.

Three days later on January 22, 2006 a different resident alleged that the same male perpetrator raped her. The perpetrator admitted to having consensual sex with the victim. The OIG Hotline investigator closed the allegation as non-reportable since there was no allegation against staff.

It appears that the OIG Hotline investigator was unaware that both allegations were against the same male resident. Additionally, if the rape or consensual sex actually occurred the OIG may have found that the facility neglected the victim, since the facility was aware of the male resident's history and had him on precautions at the time of the alleged rape. Finally, the Hotline investigator closed the allegation as non-reportable. While OIG officials noted it was reported to local law enforcement, it was not reported to the Illinois State Police as required by State law.

Source: Review of a sample of OIG non-reportable allegations.

### Serious Injuries

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

In our 2004 audit, we recommended that the OIG capture data for all allegations of serious injuries in its database. 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.

| OIG INVESTIGATIVE DATABASE | |
|---|---|
| **RECOMMENDATION 3** | ***The Office of the Inspector General should record data for non-reportable allegations and serious injuries in its investigative database.*** |
| **OFFICE OF THE INSPECTOR GENERAL RESPONSE** | OIG agrees that non-reportable complaints (which includes some serious injuries) should be recorded in the database when received; with the assistance of the department's Management Information Systems, OIG expects to complete development of that capability shortly. As noted by the auditors, out of the 128 calls they reviewed, they found only one *(0.8%)* that possibly met the current definitions in Rule 50.<br><br>Rule 50 requires reporting of serious injuries only if alleged or suspected to have been the result of abuse or neglect by staff. Requiring agencies and facilities to report all other serious injuries to OIG would require a change in the statute. |
| | *AUDITOR COMMENT: As stated in the audit report, of the 128 allegations deemed "non-reportable" by Hotline staff from January 1, 2006 to March 31, 2006, auditors questioned the closing of 27 of these cases.* |

## 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, the OIG's administrative rule has stipulated that *"when two or more State agencies could investigate an allegation of abuse or neglect at a community agency or facility, OIG shall not conduct an investigation that is redundant to an investigation conducted by another State agency unless another State agency has requested that OIG participate in the investigation."* A finding in our 2000 OIG audit recommended that the Inspector General clarify the investigatory role of each agency through signed interagency agreements.

### Illinois State Police

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

enforcement entity. The Department of State Police shall investigate any report from a State-operated facility indicating a possible murder, rape, or other felony.

In the past, the agreement between the State Police and the OIG did not meet the statutory requirements established in the Abused and Neglected Long Term Care Facility Residents Reporting Act (Act). The changes made to the Act from PA 094-0428 effectively brings the agreement into statutory compliance. Since the last audit, the OIG and the Illinois State Police signed an interagency agreement in July 2005.

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

### Department of Public Health

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

### Department of Children and Family Services

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

## PRIOR AUDIT FINDINGS

The audit of the OIG released in December 2004 contained 12 recommendations to the OIG. Eleven were to the Inspector General and/or DHS, and one was to both the Inspector

General and the State Police. The Inspector General implemented seven of the recommendations from the 2004 audit. The following summarizes what the OIG has done to implement the seven audit recommendations.

- **Timeliness of Investigative Interviews** -The OIG amended its directive relating to the assignment of the investigation requiring the investigator to develop an Investigative Plan within three working days of assignment to the case. The OIG also amended the directive relating to the assignment of the investigation requiring the assigned investigator to complete all critical interviews within five working days of the Investigative Plan absent extenuating circumstances.

- **Investigative Guidance** -The OIG has promulgated a new policy directive, which details when photographs are necessary. In addition, the OIG revised the directive relating to the handling of evidence and developed and mandated the completion of an Investigative Plan.

- **Investigating Criminal Allegations** -Effective August 2, 2005, P.A. 94-428 amended the Abused and Neglected Long Term Care Facility Residents Reporting Act. The Act now requires reporting to the appropriate law enforcement entity and not specifically the State Police when a possible criminal act has been committed. Additionally, a new interagency agreement between DHS, the OIG, and the State Police was adopted on July 11, 2005.

- **Case Management System** -The OIG implemented a new component of its case tracking beginning June 1, 2005. Investigators and investigative supervisors were provided training on the system in June 2005. The system allows investigators the ability to enter investigative actions into the system for review and comment by investigative supervisors.

- **Community Agency Investigations** -The OIG made available an electronic copy of the Investigative Protocol for Community Agencies to all agencies on the Department of Human Services Website. The OIG also began offering a new First Responder class and a Rule 50 training module to help make sure that agencies and facilities respond properly to allegations and investigations. Additionally, the OIG developed and distributed a new handbook in July 2005: "Reporting Abuse and Neglect of Adults with Disabilities."

- **OIG Investigative Training** -The OIG revised its training directive requiring all OIG investigators to participate in five courses each year. The OIG indicated that the staff training is monitored by OIG Training Coordinators, who also are responsible for creating an annual plan for ensuring that these continuing education requirements are met.

- **Annual Report** -The OIG FY04 Annual Report was printed and distributed in November 2004, and has been available online since December 14, 2004. The FY05

Annual Report was printed and distributed in November 2005, and has been available online since November 23, 2005.

## 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 March 2006 and fieldwork was concluded in October 2006. We interviewed representatives from the Inspector General's Office, the Illinois State Police, the Department of Public Health, and the Department of Children and Family Services. We reviewed documents 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 FY06 and analyzed electronic data from Fiscal Years 2005 and 2006. Additionally, our audit work included follow-up on previous OIG audit recommendations. A more complete description of our testing and analyses is in Appendix B of this report.

We assessed risk by reviewing recommendations from previous OIG audits, OIG internal documents, policies and procedures, management controls, and the OIG's administrative rule. 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 eight 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, 2002, and 2004.

## REPORT ORGANIZATION

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

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

**Chapter Two**

# TIMELINESS OF ABUSE OR NEGLECT INVESTIGATIONS

## CHAPTER CONCLUSIONS

Timeliness of investigations has been an issue in all of the eight previous OIG audits. During this audit period, the OIG made improvements in its timeliness for completing investigations. In FY04, 39 percent of OIG investigations were completed in 60 calendar days. Timeliness improved in FY05 with 55 percent and in FY06 with 52 percent completed in 60 calendar days. In January 2002, the OIG amended its administrative rules to require investigations be completed within 60 *working* days. Even with the more lenient standard, the OIG only completed 76 percent and 71 percent of its cases in FY05 and FY06 respectively when using the working days standard.

In our testing of FY06 cases, 8 cases were referred to the State Police. The OIG refers these cases to the State Police using its Checklist for Notification to the State Police. We requested copies of the eight Checklists that were sent to the State Police. OIG could not provide auditors with 3 of the 8 Checklists (38%). Additionally, the Checklist does not document when the OIG determined that the allegation should be reported to the State Police. Therefore, OIG management cannot ensure that the allegation was reported within the 24-hour reporting requirement found in the Act.

We found that a potential for future timeliness problems exists due to increased investigator caseloads and an increased number of allegations of abuse and neglect reported. Caseloads increased significantly in the North and Metro Bureaus from FY04 to FY06. The greatest increase was in the Metro Bureau where average caseloads increased by 233 percent from 9 in FY04 to 30 in FY06. From FY04 to FY06, allegations in the North Bureau increased by 123 percent (from 172 to 384), in the Metro Bureau by 57 percent (from 374 to 589), in the Central Bureau by 49 percent (from 310 to 463), and in the South Bureau by 39 percent (from 271 to 378).

OIG Directives require all "critical" interviews to be completed by the assigned investigator within five working days of approval of the Investigative Plan; however, the Directives do not specifically define what a "critical" interview is for conducting investigations. During our case file review, we found on average it took investigators 12 days to complete interviews with the alleged victim and 25 days to complete interviews with the alleged perpetrator in each case.

OIG's investigative bureaus are inconsistent in the number of interviews being conducted per investigation, which may contribute to timeliness of case completion. During our case file review, we found the South Bureau averaged fewer than 3 interviews per case during the time

period, while the North averaged nearly 11 per case. The Central and Metro Bureaus had an almost identical average of 5.3 and 5.2 interviews per case, respectively.

During interviews with OIG supervisory staff, none of the staff felt OIG's new case tracking system was beneficial. Some of the supervisory staff responded that the case tracking system did not help to alleviate time delays, but in fact, slowed down the process. The reason given was that now investigators are required to enter everything twice, once handwritten, and a second time in the tracking system. Several investigators responded that the increased time entering data was taking away from their necessary investigative duties.

Although there has been improvement since our 2004 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's administrative rule. In FY06, 6 percent of facility incidents and 29 percent of community agency incidents were not reported within the four-hour time requirement.

## INVESTIGATION TIMELINESS

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

The OIG changed the definition of days in its administrative rules in January 2002 to be working rather than calendar days. Sixty working days generally works out to over 80 calendar days. Although we will consider working days in 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 eight previous OIG audits. During this audit period, the OIG made improvements in its timeliness for completing investigations. In FY04, 39 percent of OIG investigations were completed in 60 calendar days. Timeliness improved in FY05 with 55 percent and in FY06 with 52 percent completed in 60 calendar days.

In FY03, the average was 106 days and the median was 97 days. In FY04, the average increased to 109 days but the median decreased to 87 days. In FY05, the average was 70 days and the median was 54 days. In FY06, the average was 69 days and the median was 57 days.

Exhibit 2-1
**CALENDAR DAYS TO COMPLETE ABUSE OR NEGLECT INVESTIGATIONS**
Fiscal Years 2001 to 2006

| Days to Complete Cases | FY01 % of Cases | FY02 % of Cases | FY03 % of Cases | FY04 % of Cases | FY05 % of Cases | FY06 % of Cases |
|---|---|---|---|---|---|---|
| **0-60** | **49%** | **46%** | **30%** | **39%** | **55%** | **52%** |
| 61-90 | 18% | 31% | 16% | 11% | 22% | 19% |
| 91-120 | 11% | 13% | 17% | 10% | 11% | 14% |
| 121-180 | 10% | 6% | 23% | 20% | 6% | 11% |
| 181-200 | 2% | 1% | 5% | 5% | 1% | 2% |
| >200 | 10% | 3% | 9% | 14% | 5% | 2% |
| **Total > 60 days** | **51%** | **54%** | **70%** | **61%** | **45%** | **48%** |
| Total Cases by FY | 1,883 | 1,442 | 1,248 | 1,472 | 1,659 | 1,597 |

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

Source: OAG analysis of OIG data.

Exhibit 2-1 shows the percentage of cases completed in terms of ranges of the number of days to completion for Fiscal Years 2001 to 2006. 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 Rule 50 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 FY03 cases and 51 percent of its FY04 cases within 60 working days. In FY05 and FY06, the OIG improved to 76 percent and 71 percent when using the working days standard.

Although there has been improvement, timeliness of cases taking longer than 60 working days to complete continued to be a problem for investigative bureaus for cases closed during FY06. Exhibit 2-2 shows that the Central Bureau had the smallest percentage of cases taking longer than 60 working days with 2 percent. The percentages for the North, Metro, and South Bureaus were greater. The percentage of cases taking longer than 60 working days was 20 percent for the South Bureau, and 55 percent for both the Metro and North Bureaus.

Exhibit 2-2
**CASES WITH INVESTIGATIONS GREATER THAN 60 WORKING DAYS**
Cases Closed During FY06

| OIG Bureaus | Number of Cases Greater Than 60 Days | Total Cases Closed | Percent Greater Than 60 Days |
|---|---|---|---|
| North | 146 | 264 | 55% |
| Metro | 232 | 424 | 55% |
| Central | 10 | 489 | 2% |
| South | 80 | 401 | 20% |
| Other [1] | 1 | 19 | 5% |
| **Total** | **469** | **1,597** | **29%** |

Note:
[1] Other includes cases assigned to Training, Domestic Abuse and Hotline investigators.

Source: OIG data summarized by the OAG.

## Cases Over 200 Days

The number of OIG investigations taking more than 200 calendar days to complete has also decreased significantly from FY04. In FY04, 206 cases took longer than 200 days to complete. By FY06, the cases taking longer than 200 days to complete decreased to 38. Exhibit 2-3 shows the types of allegations taking more than 200 calendar days to complete from FY04 through FY06. Investigations at State facilities completed during FY06 accounted for 29 percent (11 of 38) of the cases that took longer than 200 days to complete and community agency investigations accounted for 71 percent (27 of 38).

Exhibit 2-3
**TYPES OF ALLEGATIONS IN CLOSED CASES OVER 200 CALENDAR DAYS TO COMPLETE**
Fiscal Years 2004 to 2006

| Type of Allegation | FY04 | FY05 | FY06 |
|---|---|---|---|
| Physical Abuse | 81 | 43 | 16 |
| Neglect | 80 | 21 | 16 |
| Verbal Abuse | 17 | 2 | 2 |
| Death | 14 | 0 | 0 |
| Sexual Abuse | 5 | 10 | 3 |
| Psychological Abuse | 9 | 7 | 1 |
| **Total** | **206** | **83** | **38** |

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

Source: OAG analysis of OIG data.

In FY04, the Metro Bureau had the largest percentage of investigations taking longer than 200 days with 39 percent. In FY06, the Metro Bureau continued to have the largest percent of

investigations taking longer than 200 days with 68 percent, while the North Bureau had 26 percent, and both the Central Bureau and South Bureau had 3 percent.

In FY04, investigations at Howe Developmental Center (23%) accounted for the largest portion of the State facility cases over 200 days old, followed by Tinley Park Mental Health Center (11%) and Singer Mental Health Center (11%). In FY06, investigations at Howe Developmental Center (36%) accounted for the largest portion of the State facility cases over 200 days old, followed by Singer Mental Health Center (27%) and Tinley Park Mental Health Center (18%).

| **TIMELINESS OF CASE COMPLETION** | |
|---|---|
| **RECOMMENDATION 4** | ***The Office of the Inspector General should continue to work to improve the timeliness of investigations of abuse and neglect.*** |
| **OFFICE OF THE INSPECTOR GENERAL RESPONSE** | OIG agrees and reaffirms its commitment to completing investigations more quickly and efficiently without sacrificing quality. The auditors noted that, in this audit period, OIG made substantial improvements in timeliness. In addition, the average time it took OIG to complete its investigations fell from 74 days in FY 2004 to 50 days in FY 2006, a reduction of 32 %.<br><br>OIG notes that the auditors use *calendar* days when evaluating timeliness issues, even though Rule 50 has used *working* days since FY 2002. OIG maintains that audits should evaluate timeliness based on the legal measure governing its operation and that working days is a more accurate gauge of the actual time worked by salaried employees. OIG hopes that by the FY 2008 audit, six years of using working days will provide sufficient data for the auditors to evaluate trends.<br><br>The auditors also observed that the OIG now has significantly fewer investigators than in FY 2000. In addition, three investigator positions are currently vacant and three others have only recently been filled. Yet, since FY 2005, OIG has received 52% more allegations. Further, since OIG has only two clinical investigators, their involvement can slow an investigation, as the auditors noted. Adding a third clinical investigator would improve investigative timeliness. OIG is continuing to fill positions as expeditiously as possible in a difficult fiscal climate. |

# OTHER TIMELINESS ISSUES

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

## Illinois State Police

As a result of our 2004 audit, the OIG created a new version of its Checklist for Notification to the State Police and initiated changes to the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6.2 (b)) (Act). The requirement for reporting any possible act to the State Police was changed from shall report "within 24 hours after receiving a report…" to shall report "within 24 hours after determining that a reported allegation of suspected abuse or neglect indicates that any possible criminal act has been committed or that special expertise is required in the investigation…."

Additionally, the Act changed what was reported to and investigated by the Illinois State Police. In the past, the Act required the State Police to investigate any report indicating a possible murder, rape, or other felony. The Act now only requires the State Police to investigate any possible murder, rape, or other felony from a State-operated facility.

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

In our testing of FY06 cases, 8 cases were referred to State Police. The OIG refers these cases to the State Police using its Checklist for Notification to the State Police. We requested copies of the eight Checklists that were sent to the State Police. The OIG could not provide auditors with 3 of the 8 Checklists (38%). Additionally, the Checklist does not document when the OIG determined that the allegation should be reported to the State Police. Therefore, OIG management cannot ensure that the allegation was reported within the 24-hour reporting requirement found in the Act.

The State Police either conducts an investigation or refers the case back to OIG. In some instances, the OIG will conduct an investigation in a case even if the State Police conducted an investigation. The State Police investigation is a criminal investigation and the OIG's is administrative. According to OIG's investigative guidance, the OIG conducts no further investigative activity when the State Police accepts a case unless requested to do so by 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 2003 to 2006

| Disposition | Number of Cases | | | |
|---|---|---|---|---|
| | **FY03** | **FY04** | **FY05** | **FY06** |
| Referred back to OIG without investigation | 83 | 44 | 63 | 57 |
| Declined by Prosecutor | 10 | 1 | 15 | 5 |
| Not Sustained | 26 | 7 | 21 | 10 |
| Conviction | 5 | 2 | 6 | 0 |
| Unfounded | 5 | 1 | 2 | 1 |
| Dismissed | 3 | 0 | 1 | 1 |
| **Total** | **132** | **55** | **108** | **74** |

Source: OAG analysis of Illinois State Police data.

| **REPORTING TO THE STATE POLICE** | |
|---|---|
| **RECOMMENDATION 5** | ***The Office of the Inspector General should maintain the necessary documentation to monitor referrals to the Illinois State Police. Monitoring should be in place to ensure that the referrals are timely as required by State law.*** |
| **OFFICE OF THE INSPECTOR GENERAL RESPONSE** | OIG agrees that the documentation should show whether notification to the Illinois State Police or appropriate local law enforcement was within 24 hours of determining credible evidence of a possible criminal act. OIG has modified its law enforcement notification form to include the date and time of that determination and is currently deciding the most appropriate way to monitor timely notification. |

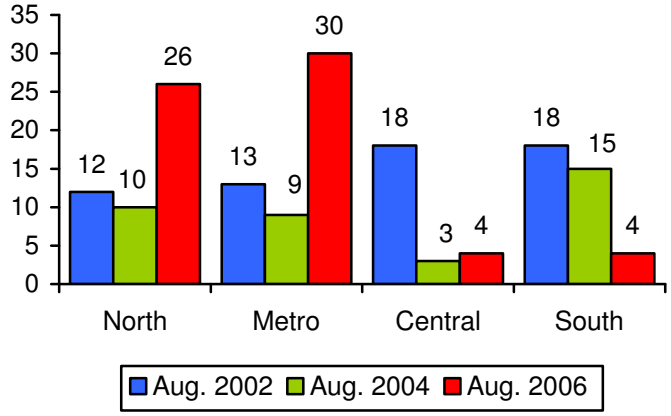
### Clinical Services Cases

In both the previous and current audit periods, OIG's Clinical Coordinators handled 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 2004 OIG audit, we reported the average completion time for cases referred to the Clinical Coordinator was 72 days. This was a significant improvement over the 138 days reported in the 2002 audit. In FY06 the average completion time for these cases improved to 66 days.

## Investigator Caseloads

Investigator caseloads may be a factor in untimely investigations in the North and Metro Bureaus. Exhibit 2-5 shows that caseloads increased significantly in the North and Metro Bureaus from FY04 to FY06. The greatest increase was in the Metro Bureau where average caseloads increased by 233 percent from 9 in FY04 to 30 in FY06.

Exhibit 2-5
**INVESTIGATOR CASELOADS**
By Bureau as of August 14, 2002, 2004, and 2006




Source: OIG data summarized by the OAG.

Exhibit 2-6 shows that in FY06, the highest average cases completed per month by investigator and bureau was 10.3 in the Central Bureau. The lowest monthly average cases completed per investigator was 5.1 in the North Bureau. The average days to complete a case in FY06 ranged from 33 in the Central Bureau to 124 days in the Metro Bureau. In addition, the North Bureau took an average of 114 days and the South Bureau took an average of 62 days to complete investigations. The OIG should continue to work to increase the average number of investigations completed per month for the North and Metro Bureaus to help reduce its backlog of cases in order for them to conduct more timely investigations.

## Potential for Future Timeliness Problems

Although timeliness has improved over the past two fiscal years, recent increases in the number of allegations reported will likely decrease timeliness of investigations in upcoming years. Exhibit 2-5 shows that as of August 14, 2006, investigators in the North and Metro Bureaus have much larger caseloads than they have had in past years.

As seen in Exhibit 2-6, all of the investigative bureaus have had an increase in the number of allegations reported since FY04. From FY04 to FY06, allegations in the North Bureau increased by 123 percent (from 172 to 384), in the Metro Bureau by 57 percent (from 374 to 589), in the Central Bureau by 49 percent (from 310 to 463), and in the South Bureau by 39 percent (from 271 to 378). Due to the increase in reported allegations, the North Bureau had 100 investigations open at the end of FY06 compared to 50 at the end of FY04. The Metro Bureau had 120 open at the end of FY06 compared to 84 at the end of FY04.

Exhibit 2-6
**INVESTIGATIONS COMPLETED AND INVESTIGATION TIMELINESS BY BUREAU**
Fiscal Years 2004 and 2006

| | Cases Reported | | Investigations Completed | | Investigations Open at End of Fiscal Year | | Monthly Cases Completed Per Investigator | | Avg. Calendar Days to Complete | |
|---|---|---|---|---|---|---|---|---|---|---|
| | FY04 | FY06 | FY04 | FY06 | FY04 | FY06 | FY04 | FY06 | FY04 | FY06 |
| North | 172 | 341 | 210 | 308 | 50 | 100 | 3.8 | 5.1 | 185 | 114 |
| Metro | 374 | 524 | 447 | 537 | 84 | 120 | 5.6 | 6.4 | 126 | 124 |
| Central | 310 | 459 | 366 | 489 | 18 | 14 | 7.6 | 10.3 | 68 | 33 |
| South | 271 | 378 | 300 | 438 | 50 | 8 | 5.5 | 7.4 | 87 | 62 |
| **Totals** | **1,127** | **1,702** | **1,323** | **1,772** | **202** | **242** | **5.6** | **7.3** | **113** | **83** |

Source: OIG data summarized by the OAG.

| **INVESTIGATOR CASELOADS** | |
|---|---|
| **RECOMMENDATION 6** | ***The Office of the Inspector General should take proactive measures to ensure that increased allegations, especially in the North and Metro Bureaus, do not negatively impact its case completion timeliness.*** |
| **OFFICE OF THE INSPECTOR GENERAL RESPONSE** | OIG agrees that the North and Metro Bureaus have experienced higher caseloads and greater backlogs than the other bureaus. In addition, these two bureaus have each: lost an investigator position in the past three years; had an investigator on an extended leave of absence during the audited period; had a vacant investigator position for nearly a year; and been in the process of filling an investigator position.<br><br>To address this issue, OIG has taken the following actions:<br><br>· Established regular meetings of the investigative bureau chiefs to discuss issues and caseload;<br><br>· Assigns all investigations using a "task" function in email that alerts the supervisor when a case reaches 20 days old, so the supervisor can follow-up if it has not yet been completed; |
| **Agency Response (continued on next page)** | |

| | |
|---|---|
| **Agency Response (continued)** | · Revised OIG Directive INV 02-019 to further standardize a process of 30-day and over 45-day reviews for all active investigations;<br><br>· Directed that, to avoid duplicating investigative efforts, OIG investigators should, where appropriate, rely on interviews conducted by trained facility/agency investigators;<br><br>· Since June 2006, enabled the Bureau of Hotline and Intake to complete investigations when the alleged victim recants the allegation;<br><br>· Proposed allowing the Bureau of Hotline and Intake to assign and then monitor investigations of alleged mental injury to agencies that have an OIG-approved investigative protocol; and<br><br>· Is acquiring ten laptops for use by investigators, to facilitate their investigative efforts. |

### Timeliness of Investigative Interviews

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

Since the last audit, the OIG Directives were amended to include a required timeline for conducting interviews with those involved. Assigned investigators are to complete the Investigative Plan within three working days of assignment. The Directives state that all "critical" interviews are to be completed by the assigned investigator within five working days of approval of the Investigative Plan. However, the current OIG Directives do not specifically define what a critical interview is for conducting investigations. In case files reviewed, it took investigators an average of 12 days to complete interviews with the alleged victim, which was an improvement from the 37 days it took in FY04. It took investigators an average of 25 days to complete interviews with the alleged perpetrator in each case.

### Number of Interviews Conducted

The number of interviews conducted by the investigative bureaus differs significantly which may be another factor relating to the timeliness of case completion. In case files reviewed, the South Bureau averaged fewer than 3 interviews per investigation during the time period, while the North averaged nearly 11 per investigation. The Central and Metro Bureaus had an almost identical average of 5.3 and 5.2 interviews per investigation, respectively. Exhibit 2-7 shows the average number of interviews per investigation by bureau.

Exhibit 2-7
**AVERAGE NUMBER OF INTERVIEWS PER INVESTIGATION BY BUREAU**

| | Number of Interviews |
|---|---|
| North | 10.8 |
| Central | 5.3 |
| Metro | 5.2 |
| South | 2.9 |

Source: OAG sample of 126 closed investigations from FY06.

The differing number of interviews may be a result of differences in how the bureaus conduct investigations. According to OIG officials, the North investigators did not rely on statements taken by facility and agency investigators and were required to conduct interviews with all involved parties. On the other hand, the South investigators relied on the statements taken by facility and agency investigators and, as a result, conducted far fewer interviews per investigation. Another reason that the South investigators had fewer interviews on average is due to a larger number of individuals who make numerous allegations and recant the allegations almost immediately.

In FY06 the North investigators averaged 61 completed investigations annually. The investigators in the other three bureaus all averaged a higher number of investigations annually. The Metro investigators averaged 77 investigations, the Central investigators averaged 123, and the South investigators averaged 89. The higher number of interviews being conducted per investigation by the North investigators may be a factor in the bureau's low number of investigations completed annually.

| **INTERVIEWS CONDUCTED** | |
|---|---|
| **RECOMMENDATION 7**<br><br>**Agency Response on next page** | ***The Office of the Inspector General should:***<br>• ***define in the OIG Directives what is considered to be a critical interview to provide additional guidance, and***<br>• ***ensure that its investigative bureaus conduct investigations in a similar manner.*** |

| | |
|---|---|
| **OFFICE OF THE INSPECTOR GENERAL RESPONSE** | OIG has maintained that, since each investigation is unique and requires judgment based on investigative skill and experience, it is impossible to specify what interviews are necessary and in what order, based simply upon the intake information. Important leads often develop later during the course of the investigation.<br><br>In response to an FY 2004 audit recommendation, OIG attempted to create a "critical" interview time requirement. Establishing these blanket time requirements, however, has neither provided meaningful guidance in investigations nor resulted in faster case completion. For these reasons, OIG determined that this approach is not workable and has been examining other approaches.<br><br>At the same time, OIG promulgated a standard Investigative Plan, where the investigator and supervisor identify specific leads to pursue at the outset of the investigation. OIG also mandated the use of the "task" function, to prompt an automatic 20-day review, and standardized 30-day and "over 45-day" reviews. These steps allowed for professional judgment, yet also addressed timeliness.<br><br>OIG agrees that the interview of the alleged perpetrator is vital. OIG responds that proper investigative practice often dictates this interview may take place after many, if not all, of the other interview statements and evidence have been gathered. This is another reason why adherence to a strict timetable is not applicable.<br><br>As the auditors noted, the timeliness of OIG's interviews improved greatly; the time to interview all alleged victims fell 67% from the previous audit period. OIG will continue to review this progress, building upon what has worked, in order to further improve investigative timeliness. |
| | *AUDITOR COMMENT: The 2004 recommendation was that the OIG "should develop specific time requirements for conducting interviews of the alleged perpetrator, victim, and any witnesses." The OIG, not the OAG, established the 5-day "critical interview" requirement. The recommendation in the 2004 audit was made as a result of auditors determining that, on average, 37 days elapsed from the time the allegation was reported until the time when the alleged victim was interviewed. In many instances, auditors had found that when the alleged victim was eventually interviewed, the victim recanted the allegation.* |

## Timeliness of Case File Reviews

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

Exhibit 2-8
**AVERAGE CALENDAR DAYS FROM DATE SUBMITTED FOR REVIEW UNTIL FINAL REVIEW BY BUREAU CHIEF**
Fiscal Years 2004 to 2006

| | Substantiated Cases [1] | | | Unsubstantiated Cases [1] | | |
|---|---|---|---|---|---|---|
| | **FY04** | **FY05** | **FY06** | **FY04** | **FY05** | **FY06** |
| North | 51 | 51 | 35 | 7 | 4 | 8 |
| Metro | 83 | 61 | 68 | 22 | 16 | 19 |
| Central | 45 | 29 | 21 | 5 | 3 | 9 |
| South | 61 | 82 | 28 | 10 | 6 | 7 |
| **Total Avg.** | **60** | **50** | **36** | **13** | **8** | **11** |

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

Source: OAG analysis of OIG data.

The ITL or the Bureau Chief may send the case back to the investigator for further investigation. The Directive states that the investigator will complete the additional work and ensure that the case is returned to the ITL or Bureau Chief within seven working days of the receipt of the returned case. Once the Bureau Chief reviews and approves a substantiated case, Directives require that it be forwarded to the Deputy Inspector General for review and approval. The Inspector General shall review all Nurse Aide Registry cases. OIG's database does not track cases that were sent back for additional investigation. Therefore, our analysis only shows the total calendar days from date submitted for review until the Bureau Chief signs the case as reviewed. Without tracking cases sent back for additional investigations, OIG management cannot effectively monitor how long it takes for cases to be reviewed.

Exhibit 2-8 shows that none of the bureaus are reviewing substantiated cases within the 7-day timeline delineated in the OIG Directive. The Metro Bureau takes much longer to review substantiated cases than the other three bureaus. The review of substantiated cases is taking a large percent of the 60-day time requirement that the OIG has to complete its investigations. Improvements in the time it takes to review substantiated cases could have a substantial effect on the overall timeliness of case completions at the OIG.

## Case Management System

Beginning in FY06, the OIG expanded its case monitoring to include an automated case tracking system, as recommended in our 2004 OIG audit. The system is intended to assist OIG management in overseeing and managing cases. The automated system is designed to be a "real-time" system. The OIG Directives require all investigative activity be entered into the automated case tracking part of the OIG database as soon as possible, but no later than one week after completion of the activity. OIG documents note that the system allows supervisors to independently view actions and to add additional comments without requesting the case file. The OIG training documents state that Bureau Chiefs may run a series of specified reports from the case tracking system at least weekly.

During interviews with OIG supervisory staff, none of the staff felt the case tracking system was beneficial. Some of the supervisory staff responded that the case tracking system did not help to alleviate time delays, but in fact, slowed down the process. The reason given was that now investigators are required to enter everything twice, once handwritten, and a second time in the tracking system. Several investigators responded that the increased time entering data was taking away from their necessary investigative duties.

| CASE MANAGEMENT SYSTEM | |
|---|---|
| **RECOMMENDATION 8** | ***The Office of the Inspector General should improve its electronic case tracking system to help manage investigations and case file review timeliness.*** |
| **OFFICE OF THE INSPECTOR GENERAL RESPONSE** | OIG agrees. With the help of the department's Management Information Systems, OIG is developing a web-enabled version of the Investigative Case Actions form, which should significantly speed the entry of actions taken and allow for entry even when off-site.<br><br>OIG case reviewers have now begun entering review dates into the database to allow tracking and ensure case review timeliness. |

## TIMELY REPORTING OF ALLEGATIONS

While there has been an improvement in the timely reporting of incidents to the OIG since the last audit in 2004, alleged incidents of abuse and neglect are not being reported by facilities and community agencies in the time frames required by OIG's administrative rule. The current administrative rules require allegations to be reported to the OIG within four hours of initial discovery of the incident of alleged abuse or neglect. In January 2002, the OIG increased the required reporting time from one hour to four hours. Community agencies continue to have a larger percentage of untimely reports in comparison to facilities. Exhibit 2-9 shows allegations of abuse and neglect not reported within four hours of discovery for State facilities and community agencies from FY03 through FY06.

Exhibit 2-9
**ALLEGATIONS OF ABUSE OR NEGLECT NOT REPORTED WITHIN FOUR HOURS OF DISCOVERY**

| | Facility | Community Agency |
|---|---|---|
| FY03 | 15% | 42% |
| FY04 | 10% | 42% |
| FY05 | 6% | 34% |
| FY06 | 6% | 29% |

Source: OAG analysis of OIG data.

- **Facility** - 6 percent of facility incidents were not reported within the four-hour time requirement in FY06 compared to 10 percent in FY04.
- **Community Agency** - 29 percent of community agency incidents were not reported within the four-hour time requirement in FY06 compared to 42 percent in FY04.

| ALLEGATION REPORTING | |
|---|---|
| **RECOMMENDATION 9** | ***The Office of the Inspector General should continue to work with State facilities and community agencies to ensure that allegations of abuse or neglect are reported within the time frame specified in OIG's administrative rule.*** |
| **OFFICE OF THE INSPECTOR GENERAL RESPONSE**<br><br>**Agency Response (continued on next page)** | OIG agrees. Timeliness of self-reports to OIG has steadily improved, from 75% on time in FY 2003 to 83% on time in FY 2006. Since the last audit, OIG has accomplished the following:<br>· Wrote and sent to all facilities and agencies a handbook entitled, "Reporting and Investigating Abuse and Neglect of Adults with Disabilities," which emphasizes timeliness;<br>· Created and e-mailed to all facilities and agencies a self-contained training module on Rule 50; |

| | |
|---|---|
| **Agency Response (continued)** | · Placed two automated flags on the intake form, which appear when an intake is reported late;<br><br>· Routinely cites late reporting as an issue in the investigative case report when it has occurred, which requires a Written Response from the agency or facility listing corrective actions;<br><br>· Sends monthly reports to the program divisions listing late reporting by facilities and agencies;<br><br>· Discussed the issue with the program divisions at the quarterly OIG Coordination Committee for their follow-up; and<br><br>· Proposed a new law (P.A. 94-853, effective June 13, 2006) making intentional late reporting or non-reporting a Class A misdemeanor. |

**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. We found that photographs were missing in 4 of 21 (19%) cases where there was an allegation of an injury sustained from our FY06 sample. All files contained an injury report for cases where there was an allegation of an injury sustained. During the review of our 126 sample cases, all files contained pertinent medical records, treatment plans, or progress notes. All six cases sampled where restraints were used contained the appropriate documentation.

OIG investigators are inconsistent in regard to the format used to document investigative interviews. In some instances, investigators use a summary format to document interviews while others use more of a question and answer format. When the summary format is used, the reviewer is unable to determine whether all appropriate and necessary questions were asked. Additionally, during file testing we found five examples from five different investigations where interview write-ups were almost verbatim for multiple individuals interviewed. In many of these write-ups, the investigator used the same summary write-up and changed the time and names of the other witnesses.

We found several examples of inconsistencies in how allegations and findings are classified among the OIG investigative bureaus. In addition, we found inconsistencies between what is and is not accepted by the Bureau of Hotline and Intake as an allegation of abuse or neglect.

During our review of case files, we determined that since the OIG does not define physical harm, there were inconsistencies in how physical harm was interpreted relating to allegations of abuse and neglect. Investigative Bureau Chiefs close unsubstantiated and unfounded investigations without any centralized review. Inconsistencies between substantiated, unsubstantiated, and unfounded findings may have been identified by the OIG if closed investigations were reviewed centrally.

## 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

In response to our 2004 audit, the OIG amended its Investigative Directives. Investigators are now required to complete an Investigative Plan prior to the start of the investigation. Additionally, specific time requirements were added to the Directives. These time requirements mandate that the Investigative Plan be completed within three working days after assignment and that all critical interviews be completed within five days after approval of the Investigative Plan. The Directives were also amended to require that photographs be taken whenever an allegation of abuse or neglect is received alleging an injury, whether or not the injury is visible. With only a few exceptions, the case files we sampled from FY06 were generally thorough and contained the appropriate documentation.

The evidence used for our testing included: interviews, photographs, medical records/treatment plans/progress notes, injury reports (including documentation that no injury occurred), and restraint/seclusion records. In our testing related to these elements we found:

- **Photographs:** Photographs were missing in 4 of 21 (19%) cases from our sample where there was an allegation of an injury sustained.
- **Injury Report:** All files contained an injury report for cases where there was an allegation of an injury sustained.
- **Medical Records/Treatment Plans/Progress Notes:** During the review of our 126 sample cases, all files contained pertinent medical records, treatment plans, or progress notes.
- **Restraint/Seclusion Records:** All six cases sampled where restraints were used contained the appropriate documentation.

## Interview Thoroughness

Investigative interviews conducted during the investigation are the essential fact finding instruments used by the investigators to determine what happened related to an allegation. Interviews often identify the involved parties (victims, perpetrators, witnesses). At the completion of the investigation, the OIG investigators produce an Investigative Report that is based on the information obtained during the course of the investigation, including interviews and statements given by the victim, perpetrator, or witnesses.

The OIG investigators are inconsistent in regard to the format used to document investigative interviews. In some instances, investigators use a summary format to document interviews while others use more of a question and answer format. When the summary format is used, the reviewer is unable to determine whether all appropriate and necessary questions were asked. OIG's training manual states "Do not ask leading questions." However, if the questions asked are not listed in the summary write-up, OIG management cannot be assured whether or not the appropriate questions were asked. Additionally, during file testing we found five examples from five different investigations where interview write-ups were almost verbatim for multiple individuals interviewed. In many of these write-ups, the investigator used the same summary write-up and changed the time and names of the other witnesses.

The adequacy and accuracy of interview documentation is of particular importance when a substantiated case of abuse or egregious neglect is sent to the Nurse Aide Registry for review by the Administrative Law Judge (ALJ). Poor documentation of interviews could result in an ALJ's decision to keep the abuse or neglect from being reported on the Nurse Aide Registry.

| DOCUMENTATION OF INTERVIEWS | |
|---|---|
| **RECOMMENDATION 10** | ***The Office of the Inspector General should develop criteria for documenting investigative interviews.*** |
| **OFFICE OF THE INSPECTOR GENERAL RESPONSE** | OIG agrees that investigative interviews should be documented, and OIG has both a directive requiring investigators to document interviews and a standard form for that purpose. Each interview is unique, however, and OIG relies on the skill and experience of the investigator and supervisor to determine the best approach to the interview and to documenting it.<br><br>Further, when reviewing the submitted case report, the supervisor ensures that all appropriate interviews were done and are accurately reflected in the report. In one instance of verbatim interview statements identified by the auditors, the witnesses had all said they were in the room and had not observed the alleged abuse. The interviews were thus short and identical. The bureau chiefs carefully review such verbatim statements to ensure that they properly record the particulars of the interviews.<br><br>The auditors highlight the training manual's guidance against asking leading questions. This sentence is under the description of the "Initial Interview." Two pages later, the manual states: "Follow-up interviews differ from initial interviews in that they are specific in nature." That is, after analyzing the initial statements, an interviewer may need to ask specific leading questions in a follow-up interview. Such questions may be appropriate in other interviews, such as with an expert or a hostile witness. Again, the interview and its documentation must rely on professional judgment. |

## CASE MONITORING AND SUPERVISORY REVIEW

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

According to the OIG Investigative 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, a consultant, or another office. All 126 sample cases tested contained a Case Routing/Approval Form.

### Investigative Reports

The OIG Investigative Reports that we tested from FY06 were generally thorough, comprehensive, and addressed the allegation. A well-written Investigative Report is also essential to an effective investigation because it often provides a basis for management's decision on the action warranted in the case. Once the Investigator completes the Investigative Report it is reviewed by management who must "sign off" on the case before a recommendation is sent to the facility or agency. Therefore, it is important that the Investigative Report be clear and convincing to anyone who reads it. The Report should address all relevant aspects of the investigation and reveal what the investigation accomplished.

## CONSISTENCY AMONG INVESTIGATIVE BUREAUS

During the course of the audit, we reviewed a random sample of investigative files. We also reviewed a discovery sample of files, reviewed incidents that were determined to be non-reportable at intake, and also reviewed cases that were reported to the Nurse Aide Registry. As a result of our extensive file review, we determined that there were inconsistencies between investigative bureaus related to how the bureaus classify allegations and findings. In addition, we found inconsistencies between what is and is not accepted by the Bureau of Hotline and Intake as an allegation of abuse or neglect.

## Classifications by Bureau

OIG's four investigative bureaus are decentralized, which has led to inconsistencies among the bureaus. There are few controls in place to ensure that the investigations by the bureaus within the OIG are consistent. While the investigative bureaus use standard forms, there is no centralized review. These standard forms include the Investigative Plan, the Case Tracking Form, the Case Routing Form, and the Case Closure Checklist. Substantiated cases of abuse or neglect are reviewed by the Inspector General or his designee to ensure consistency. However, investigations that are closed as either unfounded or unsubstantiated are closed by the Bureau Chief from each bureau and are not reviewed centrally.

We found examples of inconsistencies in how allegations and findings are classified. Exhibit 3-1 displays three cases each from different bureaus that contained similar allegations of neglect. All three cases involve clients eloping from their caregivers in a similar manner, however each case has a different outcome.

Case 1 involves a client who eloped (ran away) from a CILA van and was lost for an extended period of time. This case was **substantiated** as neglect, and the employees involved were both terminated. Case 2 involves a client that was found by an off duty staff member six blocks away from his CILA walking in the middle of the street. The client's Residential Supervision Needs Assessment states that victim cannot cross streets safely alone, cannot go to or return to or from a destination in an allotted time, and cannot appropriately respond when approached by strangers. This case was determined to be **unsubstantiated**. Case 3 involves a client that did not want to cross a bridge from a building back to the home unit at the facility because she was mad at another recipient in the group. The employee instructed the client to return back to the building. The client was found three blocks away at a restaurant. The caller stated that the recipient had a history of this kind of behavior, but this case was determined to be **non-reportable** by the Bureau of Hotline and Intake because the recipient was returned to the facility without incident and was not injured.

Exhibit 3-1
**CASE COMPARISONS: NEGLECT**

| Case | Case Description | Agency/ Facility | OIG Bureau |
|---|---|---|---|
| Case 1 **(Substantiated)** | Evidence: Recipient got off a CILA van alone and was lost for an extended period of time. The recipient's plan says that a van rider (staff person) must sit next to him to prevent him from leaving because he has a history of walking away. The staff person had been sitting up front with the driver, which contributed to the disappearance.<br><br>OIG Finding: **Substantiated** neglect because the staff person did not follow the recipient's plan. | Comm. Agency | Metro Bureau |
| Case 2 **(Unsubstantiated)** | Evidence: Staff person found recipient alone walking in the middle of the street six blocks away from the CILA on her way home from work. The recipient's Needs Assessment notes victim "will elope from designated areas." The Assessment also says he cannot cross streets safely alone, cannot go to or return from a destination in an allotted time, and cannot appropriately respond when approached by strangers.<br><br>OIG Finding: **Unsubstantiated** neglect with other issues because the OIG concluded the recipient did not suffer any injuries or harm during the elopement. The other issues include installing an alarm, reviewing the controls and procedures, retraining on communication procedures between staff, and disciplinary action against staff. | Comm. Agency | North Bureau |
| Case 3 **(Non-Reportable)** | Evidence: Recipient refused to cross a bridge while being escorted along with several other recipients by staff. Recipient was left alone and later found three blocks away at a restaurant. The recipient's Unit Administrator said she had a history of this behavior (no behavior plan available).<br><br>OIG Finding: **Non-Reportable** because the recipient was returned to the DHS facility without incident and was not injured. | State Facility | Hotline Bureau |

Source: OAG summary of OIG files.

Exhibit 3-2 shows examples of two mental injury investigations that were similar from two different bureaus. Case 1 involves an employee that used profanity towards a client while distributing medications. Two other recipients witnessed the incident. The Office of the Inspector General **substantiated** mental injury with recommendations because of the "credible responses of the two witnesses". The accused employee was ultimately terminated from his job. Case 2 involves a staff person who also used profanity towards a client. This act was committed in an attempt to redirect the recipient into their room. It was determined from the investigation that three witnesses heard the staff use profanity toward the recipient. During the alleged perpetrator's interview, he stated that it was possible that he may have used profanity. This case was **unsubstantiated** with recommendations. The employee was not discharged in this instance. The Office of the Inspector General recommended that the facility review the actions of the employee and take appropriate administrative action.

Exhibit 3-2
**CASE COMPARISONS: MENTAL INJURY AS A RESULT OF VERBAL ABUSE**

| Case | Case Description | Agency/ Facility | OIG Bureau |
|---|---|---|---|
| Case 1 **(Substantiated)** | Evidence: This case was investigated by the community agency. Based on the testimony of two recipient witnesses, a staff person directed profanity toward a recipient one morning while administering medication. After recipient asked to get his medication, staff person allegedly responded, "Take your [expletive] meds, its my job."<br><br>OIG Finding: **Substantiated** mental injury (verbal) with recommendations because witnesses provided "credible responses to the events." OIG recommended that immediate disciplinary action be taken against the accused staff and that the staff member who initially received the report be retrained on reporting procedures. Subsequently, the accused was discharged from employment. | Comm. Agency | Metro Bureau |
| Case 2 **(Unsubstantiated)** | Evidence: The OIG investigated this case. Based on testimony of three witnesses, a staff person directed profanity toward a recipient in an attempt to get her to go to her room. In a loud voice, the staff person said, "go to your [expletive] room." Staff person did not deny he said what was alleged.<br><br>OIG Finding: **Unsubstantiated** mental injury (verbal) with recommendations. It was recommended in the written response that the facility review staff person's actions and take appropriate administrative actions. | State Facility | Central Bureau |

Source: OAG summary of OIG files.

## Definition of Physical Harm

It appears that one of the reasons for the inconsistencies between the investigative bureaus may be due to different interpretations for the definition of physical harm. OIG's definitions of abuse and neglect in its administrative rules both include the term "physical injury." As seen in Exhibit 3-3, 59 Ill. Adm. Code 50.10 (Rule 50) defines physical injury as physical harm. Physical harm is not defined in the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/3) or in Rule 50.

Exhibit 3-3
**DEFINITION OF PHYSICAL INJURY AND PHYSICAL HARM**

**Physical Injury**

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

**Physical Harm**

- Not defined in the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/3)
- Not defined in 59 Ill. Adm. Code 50.10
- Only defined in OIG Training Manual as a **WRONG OR INJUSTICE**

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

During our review of case files, we determined that there were inconsistencies in how physical harm was interpreted relating to allegations of abuse and neglect. OIG's response was that physical harm is defined as a wrong or injustice. For example:

- In one case, a staff member thrust her hand out in front of her to protect herself after a client punched her in the eye, giving the staff member a black eye. The client had no visible injury when examined. The staff member sought medical treatment for her injury. The OIG **substantiated abuse** in this case, and the staff member was dismissed from her job.

- In another case, a staff person found recipient alone walking in the middle of the street six blocks away from the CILA. The recipient's plan says he cannot cross streets safely and cannot go to or return from a destination in an allotted time. Plan notes victim "will elope from designated areas." The OIG **unsubstantiated neglect** with other issues in this case because it concluded the recipient did not suffer any injuries or harm during the elopement.

Another factor that contributes to inconsistencies in OIG's findings is that all closed investigations are not reviewed in a similar manner. Investigative Bureau Chiefs are allowed to close unsubstantiated and unfounded investigations without any other review. Substantiated investigations are reviewed by the Bureau Chiefs and then by either the Inspector General or a designee. Inconsistencies between substantiated, unsubstantiated, and unfounded findings may have been identified by the OIG if all closed investigations were reviewed in the same manner. Rule 50 defines unfounded as "no credible evidence to support the allegation that abuse or neglect occurred."

To ensure that clients are being protected, the OIG should make sure that its investigative bureaus conduct investigations in a consistent manner. The Inspector General should clearly define what constitutes physical injury and physical harm. Additionally, the Inspector General should ensure that all closed cases whether substantiated, unsubstantiated, or unfounded are reviewed by either himself or a designee to ensure consistency.

| **INVESTIGATIVE CONSISTENCY** | |
|---|---|
| **RECOMMENDATION 11** | ***To address investigative inconsistencies among bureaus, the Office of the Inspector General should:***<br>• ***clearly define what constitutes physical injury and physical harm, and***<br>• ***establish a centralized review process of substantiated, unsubstantiated, and unfounded investigations to help ensure consistency of its investigations.*** |
| **OFFICE OF THE INSPECTOR GENERAL RESPONSE** | OIG agrees and believes that the issue of definitions would be resolved by revisions to the statute. Until the statute is revised, however, such a change to Rule 50 would be premature. However, in the meantime, OIG will reinforce that physical "harm" is a physical " wrong or injustice."<br><br>Since one designee could not adequately review 2,000 cases/year nor spot every inconsistency, OIG will instead implement quarterly reviews conducted by the Deputy Inspector General and one investigative bureau chief selected on a rotating basis. The reviews will examine a sampling of unfounded and unsubstantiated cases to ensure consistency across bureaus. Findings will be discussed at OIG Leadership Team meetings and at investigative bureau chiefs' meetings. |

**Chapter Four**

# ACTIONS, SANCTIONS, AND RECOMMENDATIONS

## CHAPTER CONCLUSIONS

In our review of the Nurse Aide Registry appeals requested, 28 substantiated cases were appealed in FY05 of 81 referred and 36 cases were appealed in FY06 of 47 referred. In FY05, 22 of the 28 (79%) petitioners won their appeal, and in FY06, 19 of the 32 (59%) petitioners that have had their hearing won the appeal, which means the OIG's substantiated finding is **not** listed in the Nurse Aide Registry. The purpose of the mandate is to ensure that there is a public record of such findings. Agencies and facilities are able to check the Nurse Aide Registry before hiring an employee to look for prior findings of physical or sexual abuse or egregious neglect. These individuals are barred from working with individuals with mental disabilities.

We reviewed all 11 substantiated cases referred to the Nurse Aide Registry that were investigated by the OIG during our audit period (FY05 or FY06) and rejected by the DHS administrative law judge (ALJ) in FY06. In the 11 referrals that were rejected, the ALJ found that the Department had not demonstrated by a preponderance of the evidence that the finding of abuse against the petitioner warranted reporting to the Nurse Aide Registry. In 4 of the 11 referrals (36%), the ALJ concluded that the evidence presented at the hearing was conflicting or insufficient to determine that the Petitioner committed the act.

During our review, we questioned the adequacy and consistency of findings being reported by the OIG to the Nurse Aide Registry. We identified two substantiated cases of physical abuse that were referred to the Nurse Aide Registry where the ALJ found that the two staff members acted instinctively toward a client after the client either inappropriately touched or punched the staff. In comparison, we found a case where a recipient was physically injured as a result of an employee's actions. Based on the actions by the employee, the allegation appears to meet the definition of physical injury as defined by the OIG. The case was categorized by the OIG as neglect, not abuse, and was therefore not reported to the Nurse Aide Registry.

Over the past 13 fiscal years (1994 to 2006) 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. In December 2002, the Inspector General developed a new Directive that specifies criteria on when to recommend sanctions. At the end of this audit, there were no changes to the Directives regarding sanctions.

## SUBSTANTIATED ABUSE AND NEGLECT CASES

In FY06, the OIG closed a total of 1,657 investigations of allegations of abuse or neglect. The OIG substantiated 210 of the abuse or neglect allegations, resulting in a 13 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.

Overall, the annual number of substantiated abuse and neglect cases, for both facilities and community agencies, has decreased since FY00. The substantiation rate at facilities has stayed fairly consistent since FY03. However, the substantiation rate at community agencies has been significantly lower since FY02. In FY02 the substantiation rate was 31 percent. The rate was 20 percent in both FY05 and FY06.

Exhibit 4-1
**ABUSE AND NEGLECT CASES CLOSED AND SUBSTANTIATED**
(Allegations Categorized as Abuse or Neglect at Intake)
Fiscal Years 1998 to 2006

| | Individuals Served[1] | Closed Cases | Substantiated Cases | Substantiated % |
|---|---|---|---|---|
| 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%** |
| FY05 Facility | 12,679 | 904 | 43 | 5% |
| FY05 Community | 193,279 | 724 | 147 | 20% |
| **FY 2005 Total** | **205,958** | **1,628** | **190** | **12%** |
| FY06 Facility | 13,417 | 876 | 57 | 7% |
| FY06 Community | 196,427 | 781 | 153 | 20% |
| **FY 2006 Total** | **209,844** | **1,657** | **210** | **13%** |

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

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

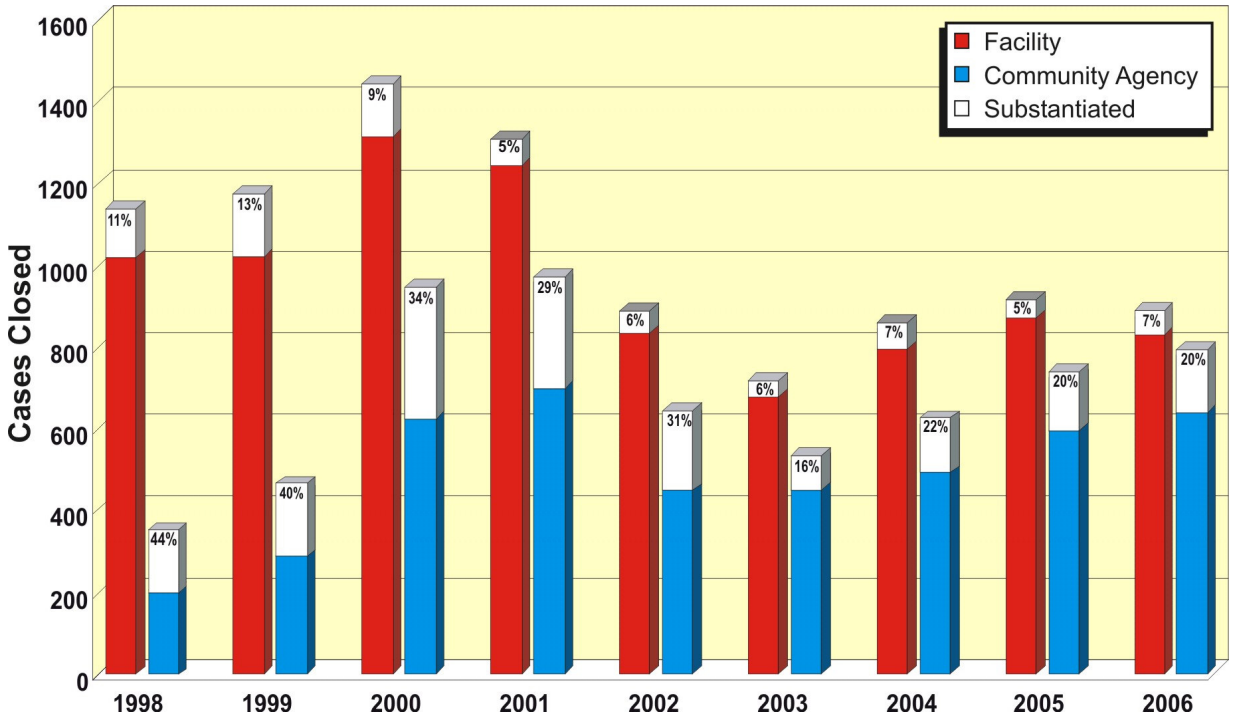
Source: OIG information summarized by OAG.

## 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 4-2
**ABUSE AND NEGLECT CASES CLOSED AND SUBSTANTIATED FOR STATE FACILITIES AND COMMUNITY AGENCIES**
(Allegations Categorized as Abuse or Neglect at Intake)
Fiscal Years 1998 to 2006




Note: State facilities served 2,841 individuals with developmental disabilities and 10,576 individuals with mental illness in FY06. Community agencies served approximately 21,000 individuals with developmental disabilities and approximately 175,427 individuals with mental illness in FY06.

Source: OIG information summarized by OAG.

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 212 substantiated cases by the type of recommended action and by the investigating agency. In our 2004 audit, administrative action was recommended in 47 percent of the cases and was the most frequently used action in both the OIG and community agency investigations. In FY06, administrative action was the recommended action in 31 percent of the cases. Administrative actions include, but are not limited to, suspension, termination, and reprimand. In FY06, recommended actions of "no action" and "retraining" increased. No action recommended increased from 7 percent in

FY04 to 20 percent in FY06 and retraining increased from 7 percent in FY04 to 22 percent in FY06.

Exhibit 4-4 shows the type of allegation and the actions taken in the 212 substantiated cases closed in FY06. 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 FY04 through FY06.

Exhibit 4-3
**RECOMMENDED ACTIONS FOR SUBSTANTIATED CASES**
(All Allegations Regardless of Category at Intake) [2]
Fiscal Year 2006

| RECOMMENDED ACTION | INVESTIGATED BY | | | TOTAL |
|---|---|---|---|---|
| | OIG | Community Agency | State Police | |
| No Action | 39 | 3 | 0 | 42 |
| Retraining | 42 | 4 | 0 | 46 |
| Policy Creation or Revision | 5 | 0 | 0 | 5 |
| Other Administrative Action | 40 | 26 | 0 | 66 |
| Referral to Other Agency | 1 | 0 | 0 | 1 |
| Nurse Aide Registry | 47 | 0 | 0 | 47 |
| Unknown [1] | 4 | 1 | 0 | 5 |
| **Total Substantiated** | **178** | **34** | **0** | **212** |

Notes:

[1] Recommended action data missing from OIG's database.

[2] Data in Exhibit 4-3 includes two death cases that were not included in Exhibits 4-1 and 4-2 since they were not categorized as abuse or neglect at intake.

Source: OAG analysis of OIG data.

Exhibit 4-4
**SUBSTANTIATED CASES BY TYPE OF ALLEGATION AND ACTIONS TAKEN**
(All Allegations Regardless of Category at Intake)
Fiscal Year 2006

| TYPE OF ALLEGATION | INVESTIGATED BY | | | | ACTIONS TAKEN |
|---|---|---|---|---|---|
| | OIG | Community Agency | DII | Total | |
| A-1 -Physical abuse with imminent danger alleged | 1 | 0 | 0 | 1 | Discharge |
| A-2 -Physical abuse with serious harm alleged | 6 | 0 | 0 | 6 | Suspended, Discharged, Resigned, Training |
| A-3 -Physical abuse without serious harm alleged | 74 | 0 | 0 | 74 | Written Reprimand, Counseling, Suspended, Discharged, Resigned, Reassigned, Training |
| A-4 -Sexual abuse alleged | 16 | 0 | 0 | 16 | Written Reprimand, Counseling, Suspended, Discharged, Resigned, Training, Supervision, Performance |
| A-5 -Mental injury (verbal) alleged | 16 | 11 | 0 | 27 | Written Reprimand, Suspended, Discharged, Resigned, Reassigned, Training |
| A-6 -Mental injury (psychological) alleged | 18 | 13 | 0 | 31 | Oral and Written Reprimand, Counseling, Suspended, Discharged, Resigned, Training, Supervision, Performance |
| **Total Abuse Cases** | **131** | **24** | **0** | **155** | |
| N-1 -Neglect with imminent danger alleged | 2 | 0 | 0 | 2 | Discharged, Training |
| N-2 -Neglect in any serious injury | 17 | 1 | 0 | 18 | Written Reprimand, Counseling, Suspended, Discharged, Reassigned, Training |
| N-3 -Neglect in any non-serious injury | 21 | 6 | 0 | 27 | Oral and Written Reprimand, Counseling, Suspended, Discharged, Resigned, Training, Supervision |
| N-4 -Neglect in an individual's absence | 2 | 0 | 0 | 2 | Discharged |
| N-7 -Neglect with risk of harm or injury | 3 | 3 | 0 | 6 | Suspended, Discharged, Training |
| **Total Neglect Cases** | **45** | **10** | **0** | **55** | |
| D-6 - Death by natural cause in residential (or after transfer) | 2 | 0 | 0 | 2 | Suspended, Discharged |
| **Total Death Cases** | **2** | **0** | **0** | **2** | |
| **Total Substantiated** | **178** | **34** | **0** | **212** | |

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

Source: OAG analysis of OIG data.

# OIG SUBSTANTIATED CASE WRITTEN RESPONSES

The Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6.2) requires the Inspector General to require a facility or community agency to submit a written response for all substantiated cases of abuse or neglect, or cases with other administrative issues. The statue 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))*

According to OIG Directives, the facility or agency is directed to submit a written response to either the Division of Mental Health or Division of Developmental Disabilities for approval. Substantiated cases as well as those where OIG recommends administrative action are reported to the Secretary of Human Services. The Secretary of DHS has the authority to accept or reject the written response and establish how DHS will determine if the facility or agency followed the written response. As of September 7, 2006, DHS had received written responses for 435 of 495 cases requiring a written response closed in FY06.

The Act also requires the facility or community agency to provide an implementation report to the Inspector General on the status of the corrective action implemented. The Inspector General is required to review any implementation that takes more than 120 days. Based on the law, the OIG conducts random compliance reviews to ensure that what was identified in an approved Written Response was actually implemented.

The OIG has two employees as Written Response Compliance Reviewers. Their responsibilities include:

- Obtain the monthly report of facility and community agency completed corrective actions;
- Generate a 20% random sample of completed Written Response, stratified by general location (facilities vs. community agencies);
- Determine compliance, which may include, but need not be limited to, written and verbal request for documentation, phone contacts, or site visits; and
- Mail a letter indicating the findings of the compliance review to the facility or community agency within thirty days of the final determination.

Exhibit 4-5 shows that during FY06, the Office of Inspector General conducted compliance reviews of 73 written responses (44 community agency and 29 facility cases). In our review of written response files, we randomly selected ten files to test compliance reviews conducted by the OIG. All ten files contained a written response compliance review sheet that identified the issue, actions taken, date of action taken, review plan, and the status of actions taken. All written response files reviewed contained documentation supporting the reviews conducted by the Compliance Reviewers as outlined in the OIG Directives.

Exhibit 4-5
**WRITTEN RESPONSE COMPLIANCE REVIEWS CONDUCTED**
Fiscal Years 2005 and 2006

| | FY05 | FY06 |
|---|---|---|
| Agency | 50 | 44 |
| Facility | 26 | 29 |
| **Total** | **76** | **73** |

Source: OIG compliance review data.

## APPEALS PROCESS IN SUBSTANTIATED CASES

After the investigative report review process is completed and the report has been accepted by the Inspector General, the facility or community agency is notified of the investigation results and finding. A notice of the finding is also sent to the complainant, the individual who was allegedly abused or neglected or his or her legal guardian, and the person alleged to have committed the offense. When the OIG substantiates a finding of abuse or neglect against an individual at a facility or community agency, there are distinct levels of appeal. A substantiated finding can be appealed to the Inspector General, and the action taken and the reporting to the Nurse Aide Registry can be appealed to the Department of Human Services (DHS). We will discuss the Nurse Aide Registry appeals later in this chapter.

### Reconsideration or Clarification

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

According to data provided by the OIG, the OIG received 75 requests for reconsideration or clarification in FY05 and 73 requests in FY06. In FY05, 16 of 75 (21%) and in FY06, 16 of 73 (22%) requests for reconsideration or clarification were granted by the OIG. In FY05, only one Investigative Report was revised and in FY06 four Investigative Reports were revised as a result of a reconsideration or clarification request. Of the five Investigative Reports that were revised, only one resulted in a changed finding. After the investigative report is sent, and if no

response for reconsideration or clarification is submitted to the OIG, the case is closed after 30 days and the case is considered final.

### Appeal of Action Taken

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

According to DHS officials, 41 appeals were filed during FY05 and FY06. Of the 41 appeals filed, 15 were dismissed due to the filing of the appeal before the OIG investigation was closed or other reasons, 11 were dismissed based on petitioners' failure to appear at the hearing, 11 were withdrawn by the petitioner, 3 hearings found in favor of the community agency, and 1 hearing found in favor of the petitioner.

## NURSE AIDE REGISTRY

The Department of Public Health maintains the Nurse Aide Registry that lists of individuals who have been trained as nurse aides for hospitals, nursing homes, and other settings with medically involved persons. The Abused and Neglected Long Term Care Facility Residents Reporting Act was amended effective January 1, 2002, requiring the OIG to report individuals with substantiated findings of physical or sexual abuse or egregious neglect to the Nurse Aide Registry.

The purpose of the mandate is to ensure that there is a public record of such findings. Agencies and facilities are able to check the Nurse Aide Registry before hiring an employee to look for prior findings of physical or sexual abuse or egregious neglect. These individuals are barred from working with individuals with mental disabilities.

### Nurse Aide Registry Appeals

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

The OIG referred 81 substantiated cases to the Nurse Aide Registry in FY05 and 47 in FY06. Of these 128 cases, only 2 (1.6%) were sent for substantiated egregious neglect while the other 126 were for substantiated abuse.

In our review of the Nurse Aide Registry appeals requested, 28 substantiated cases were appealed in FY05 and 36 cases were appealed in FY06. In FY05, 22 of the 28 (79%) petitioners won their appeal, and in FY06, 19 of the 32 (59%) petitioners that have had their hearing won the appeal, which means the OIG's substantiated finding is **not** listed in the Nurse Aide Registry. Exhibit 4-6 shows the number of appeals won and lost by petitioners for FY05 and FY06.

Exhibit 4-6
**NURSE AIDE REGISTRY APPEALS**
Fiscal Years 2005 and 2006

| | **FY05** | **FY06** |
|---|---|---|
| Petitioner Won Appeal | 22 | 19 |
| Petitioner Lost Appeal | 6 | 13 |
| Decision Pending | 0 | 4 |
| **Total** | **28** | **36** |

Source: OIG data summarized by the OAG.

**Review of Nurse Aide Registry Appeals Won**

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

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

We reviewed all 11 substantiated cases referred to the Nurse Aide Registry that were rejected by the DHS administrative law judge (ALJ) in FY06. These 11 cases were investigated by the OIG during our audit period (FY05 or FY06). In the 11 referrals that were rejected, the ALJ found that the Department had not demonstrated by a preponderance of the evidence that the finding of abuse against the petitioner warranted reporting to the Nurse Aide Registry. In 4 of the 11 referrals (36%), the ALJ concluded that the evidence presented at the hearing was conflicting or insufficient to determine that the Petitioner committed the act.

Exhibit 4-7
**SUMMARY OF DHS ADMINISTRATIVE LAW JUDGE'S FY06 RULINGS ON PETITIONER'S NURSE AIDE REGISTRY APPEALS WON BY PETITIONER**
For Cases Investigated during FY05 or FY06

| | |
|---|---|
| 1 | Administrative Law Judge's Ruling: Use of improper redirection technique to prevent injury does not warrant reporting a finding of abuse to the Nurse Aide Registry. |
| 2 | Administrative Law Judge's Ruling: Evidence presented was insufficient to determine Petitioner committed an act that should prevent her from working with disabled persons. Evidence demonstrated only that Petitioner successfully redirected the client. |
| 3 | Administrative Law Judge's Ruling: Impossible to conclude on basis of conflicting hearsay evidence presented that Petitioner be reported to Nurse Aide Registry. |
| 4 | Administrative Law Judge's Ruling: Petitioner reacted to client's inappropriate act in an instinctive way. No injury to client was reported. Petitioner immediately realized her mistake and reported it herself to the program director. |
| 5 | Administrative Law Judge's Ruling: No evidence was disputed. The witness testimony was consistent with OIG and Petitioner agreed that the incident occurred. Petitioner testified that he acted without anger and with good intention. Petitioner believed he was complying with his director's instruction to be stricter with clients. |
| 6 | Administrative Law Judge's Ruling: The Petitioner and staff members testified credibly. The staff member did not have motive to lie, while the other witness did. The client changed his story several times and no injury was found when he was examined. |
| 7 | Administrative Law Judge's Ruling: Evidence presented at the hearing was insufficient to determine that Petitioner, who has worked with the disabled for twenty years without incident, committed an act that should prevent her from working with disabled persons. Witness testimony was problematic due to her failure to report the incident for five days. |
| 8 | Administrative Law Judge's Ruling: If the Petitioner did involuntarily push the resident away after being struck in her eye, which Petitioner denies, the action would not warrant reporting to the Nurse Aide Registry. Petitioner testimony was very credible, as were her "admiring" coworkers. |
| 9 | Administrative Law Judge's Ruling: Petitioner acted instinctively to prevent resident from eating something from dirty dishes. Evidence concerning amount of force used by the Petitioner was conflicting. No one contends Petitioner intended to harm recipient. |
| 10 | Administrative Law Judge's Ruling: The only introduced evidence of abuse was Petitioner's admission that he "swatted" the recipient. It seems clear the Petitioner did nothing to warrant placement on the Nurse Aide Registry. The decision by the Agency to terminate the Petitioner based on OIG's determination that the Petitioner committed physical abuse constitutes an unfair decision. |
| 11 | Administrative Law Judge's Ruling: Petitioner had dedicated herself, at the expense of her personal life, to the care of disabled persons. Petitioner has provided evidence that, with the exception of one moment, which she regrets and for which she had taken responsibility even before the incident was reported, she has done an exemplary job. Petitioner has been amply punished for that moment. |

Source: OAG summary of DHS Administrative Law Judge Rulings.

### Inconsistency in Findings Reported to the Nurse Aide Registry

During fieldwork, we reviewed numerous case files at the OIG. Our review included looking at the ALJ rulings for cases reported to the Nurse Aide Registry. During our review, we questioned the adequacy and consistency of findings being reported to the Nurse Aide Registry. As seen in Exhibit 4-8, we identified two substantiated cases of physical abuse that were referred to the Nurse Aide Registry where the ALJ found that the two staff members acted instinctively toward a client after the client either inappropriately touched or punched the staff.

In comparison, we found a case where a recipient was physically injured as a result of a community agency employee's actions. Based on the actions by the employee, the allegation appears to meet the definition of physical injury as defined by the OIG. A "wrong or injustice" to the recipient is the standard used by the OIG to substantiate physical injury in an abuse case. The case was categorized by the OIG as neglect, not abuse, and was therefore not reported to the Nurse Aide Registry.

The OIG determined that the neglect was not egregious based on its definition as defined in its administrative rule. Rule 50 defines egregious neglect as:

> *The substantive failure by an employee to provide adequate medical or personal care or maintenance that results in the death, serious medical condition, or serious deterioration of an individual's physical or mental condition, as determined by the Inspector General.*

However, a separate investigative report written by the community agency's investigator stated, "In my judgment, this would constitute egregious neglect due to the serious injury (client's name) received, and to the insensitive nature of the action." OIG's definition of egregious did not allow the OIG to consider the injury (which needed stitches), cold temperature, or insensitive nature of the allegation to factor into the decision as to whether or not the neglect was egregious. As a result, this case was not referred to the Nurse Aide Registry. The OIG's definition of egregious may be the primary factor why only 2 of 128 (1.6%) cases referred to the Nurse Aide Registry during FY05 and FY06 were for neglect.

In one case, a staff member allegedly pushed a client in self-defense after being punched in the face. Using OIG's current definitions, the staff member received a substantiated finding of abuse by the OIG and the finding was referred to the Nurse Aide Registry. In another case, a staff member pushed a client in a wheelchair outside in 10-degree weather and locked the door. The client became agitated and broke a window resulting in an injury to his hand requiring three stitches at the emergency room. The staff member received a finding of substantiated neglect and the finding was not reported to the Nurse Aide Registry.

Exhibit 4-8
**CASE COMPARISONS: INCONSISTENCY IN FINDINGS REPORTED TO THE NURSE AIDE REGISTRY**

| Case | Case Description | Agency/ Facility | OIG Bureau |
|---|---|---|---|
| **Case 1 (Not Reported to NAR)** | *Evidence:* A client was showing signs of agitation and anger. In response, a staff member pushed the client's wheelchair outside, and the client fell out on the deck. The staff member did not help the client back into the chair, left the client outside (in 10 degree weather), and came back inside and locked the door to prevent the client from coming back inside. The client had no coat, hat or gloves. The client then broke a window that **resulted in an injury** to his hand requiring three stitches at the emergency room.<br>*OIG Finding:* Abuse **unsubstantiated**. Allegation of Neglect **substantiated.**<br>*Action Taken by Agency:* Unpaid **suspension** for 5 days and required to attend training.<br>*ALJ Ruling:* N/A<br>*Note:* Since the OIG concluded that the case did not meet the definition of **egregious neglect,** the finding was not reported to the Nurse Aide Registry. | Comm. Agency | Central |
| **Case 2 (Reported to NAR)** | *Evidence:* A community agency staff member struck a client with an open hand on the chest after the client had grabbed her buttocks. The staff member realized her mistake and immediately reported the inappropriate act to the program director. The client had **no visible injury**. Staff member testified that her reaction was unintentional and instinctive.<br>*OIG Finding:* Abuse **substantiated.**<br>*Action Taken by Agency:* **Employee Terminated**<br>*ALJ Ruling:* The Department did not demonstrate by a preponderance of the evidence that the finding warrants reporting to the Nurse Aide Registry. | Comm. Agency | Central |
| **Case 3 (Reported to NAR)** | *Evidence:* A community agency staff member thrust her hand out in front of her to protect herself after a client punched her in the eye, giving the staff member a black eye. The client had **no visible injury** when examined. The staff member sought medical treatment for her injury.<br>*OIG Finding:* Abuse **substantiated**.<br>*Action Taken by Agency:* **Employee Terminated**<br>*ALJ Ruling:* The Department did not demonstrate by a preponderance of the evidence that the finding warrants reporting to the Nurse Aide Registry. | Comm. Agency | Central |

Source: OAG summary of OIG files and DHS Administrative Law Judge Rulings.

| NURSE AIDE REGISTRY | |
|---|---|
| **RECOMMENDATION 12** | ***The Office of the Inspector General should:***<br>• ***review ALJ rulings to determine the reasons why referrals to the Nurse Aide Registry are rejected by the ALJ and whether changes to the investigative process are warranted; and***<br>• ***ensure the safety of individuals with mental or physical disabilities receiving services in the State of Illinois by making appropriate revisions to its administrative rules, policies or procedures (which may include revising the definition of egregious) to ensure that all cases with findings that warrant reporting to the Nurse Aide Registry are reported.*** |
| **OFFICE OF THE INSPECTOR GENERAL RESPONSE** | OIG agrees and, since FY 2005, has been reviewing every decision in Registry referral appeals. No problems with the investigator process have been found.<br>The statute mandates that OIG refer the names of all persons substantiated to have committed physical abuse, sexual abuse, or egregious neglect, regardless of the severity of the act. However, the statute provides for an appeals process, granting the ALJ the discretion to determine that the act was not severe enough to warrant referral to the Registry. That is, the appeal is to address the referral, not the finding.<br>After reviewing several decisions by the ALJ upholding appeals, OIG initiated a dialog with the department's Legal Services to develop some constructive approaches to the appeals process. These discussions culminated in the following three specific actions:<br>· OIG completed development of an in-house training on testifying at court hearings.<br>· OIG designated a legal liaison to help prepare the department attorney who is assigned to represent OIG at a Registry appeals hearing.<br>· DHS Legal and OIG established a process authorized by the code governing these hearings for stipulating that certain physical abuse cases, while meeting the broad definition of physical abuse, did not deserve placement on the Registry. This new process was approved by the department on September 11, 2006. It is triggered by a 50.90 petition and includes input from the petitioner, OIG and DHS Legal while leaving the final decision with the ALJ and the Secretary of DHS.<br>Ensuring the safety of individuals remains OIG's highest priority. OIG agrees with the auditors that Registry referrals have been consistent with the current Rule 50 definitions. If OIG has the opportunity to propose changes to the statute, the definitions would be a focal point. Revisions to Rule 50 and the Directives would follow. By ensuring appropriate referrals, this would help prevent abuse/neglect. |

## SANCTIONS

Over the past 13 fiscal years (1994 to 2006) 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 by closing a facility, transferring or relocating residents, or appointing on-site monitors. In our 1996 and 1998 audits, 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. At the end of this audit, there were no changes to the Directives regarding sanctions.

**Chapter Five**

# OTHER ISSUES

## CHAPTER CONCLUSIONS

During FY05 and FY06, the Quality Care Board (Board) did not have seven members as required by statute. Even after Board member appointments from the Governor in June and July of 2005, the Board still had only five members and two vacancies at the end of this audit period. However, the two vacant positions were filled in September 2006. In addition, the Board did not meet statutory requirements regarding quarterly meetings. The Board did not meet at all during FY05, and it did not meet during the first quarter of FY06. The Board did meet twice in the second quarter, and had meetings in each of the other quarters of the fiscal year, but the last meeting failed to have a quorum.

During FY05 and FY06, the OIG conducted unannounced site visits at all of the mental health and developmental centers as required by 210 ILCS 30/6.2. However, the OIG did not always comply with its established timeline for submitting site visit reports to facility directors or hospital administrators. According to a OIG Directive, site visit reports should be submitted to facility directors or hospital administrators within 60 days of the completion of the site visit. In FY05, 10 of the 18 (56%) mental health and developmental centers received a site visit report after the 60-working day timeline. In FY06, 6 of the 18 (33%) centers received a site visit report after the timeline.

## QUALITY CARE BOARD

During FY05 and FY06, the Quality Care Board (Board) did not have seven members as required by statute. 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. Section 6.3 of the Act states that the Board should be comprised of seven members who are appointed by the Governor with the advice and consent of the Senate. It also states that the Board is to meet quarterly and that four Board members constitute a quorum.

During our last audit, we noted that there had only been four members serving on the Board since September 2002. In June 2004, Board membership decreased to three when one of the remaining Board members resigned. In September 2004, the three remaining Board members' terms expired, leaving the Board without any members.

In June and July of 2005, the Governor appointed 5 members to the Board: four new appointments and one reappointment. By the end of this audit period, June 30, 2006, there were

still only 5 members serving on the Board, with two vacancies. However, the two vacant positions were filled in September 2006.

In addition, the Quality Care Board did not meet statutory requirements regarding quarterly meetings. The Board did not meet at all during FY05, and it did not meet during the first quarter of FY06. According to an OIG official, there was not a Quality Care Board in FY05 because all of the members' terms had expired. However, after the Governor appointed five members to the Board, it met twice in the second quarter of FY06: October 2005 and December 2005. The Board also held a meeting in February 2006 and May 2006, but the May meeting failed to have a quorum.

The statute 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 the Board's meeting minutes for FY06, and a discussion of the role of the Board with OIG officials, it appears that the Quality Care Board is attempting to meet its statutory requirements.

| **QUALITY CARE BOARD** | |
|---|---|
| **RECOMMENDATION 13** | ***The Office of the Inspector General should continue to work with the Quality Care Board to assure that the Board meets quarterly as required by statute (210 ILCS 30/6.3).*** |
| **OFFICE OF THE INSPECTOR GENERAL RESPONSE** | OIG agrees. The Quality Care Board has full membership as of September 2006 and is meeting quarterly as required. As noted by the auditors, the Board is fulfilling its statutory requirements to monitor and oversee the operations, policies and procedures of OIG to ensure the thorough and prompt investigation of abuse/neglect allegations. |

## SITE VISITS

During Fiscal Years 2005 and 2006, the OIG conducted unannounced site visits at all of the mental health and developmental centers as required by 210 ILCS 30/6.2. However, the OIG did not always comply with the established timeline for submitting site visit reports to facility directors or hospital administrators. According to a OIG Directive, site visit reports should be submitted to facility directors or hospital administrators within 60 days of the completion of the site visit. During the prior audit, the OIG had made substantial improvements in meetings its established timeline for submitting site visit reports to facilities.

The OIG developed a new site visit protocol for FY05 unannounced site visits that was implemented in August 2004. They also developed a plan for FY06 site visits that was implemented in July 2005. In addition, the OIG has a Directive for unannounced site visits that became effective in June 2002, which was revised in April and November 2003, and August 2005. The protocol, site visit plan, and Directive provide procedures for site visitors to follow while conducting site visits.

The OIG staff from the Bureau of Compliance and Evaluation and from Clinical Coordination were responsible for conducting site visits. The OIG does not conduct site visits at community agencies because it does not have the specific statutory authority to do them.

The OIG provided us with site visit reports and other documentation for FY05 and FY06 site visits. Based on a review of the site visit reports, the site visitors appeared to have effectively applied procedures as outlined in the protocol, site visit plan, and Directive. Also, the site visit reports focused on relevant issues and provided useful information to the mental health and developmental centers. Site visits generally lasted 1-2 days.

During FY05, the site visitors reviewed cases and written responses, non reportable incidents to check facility follow-up, and policies and procedures relating to individual safety that were changed since the last site visit. The cases with written responses were reviewed to evaluate the implementation of remedial plans. Site visitors also reviewed recent survey findings since the last audit, and the facility's process of responding to individual injuries. During most of the site visits, visitors reviewed initiatives and policies relating to reducing violence and/or episodes of restraint; and a registered nurse accompanied the site visitor to review facility practices concerning its medication administration policy, error reduction, and quality control. Recommendations from the previous site visit were also checked for compliance.

During FY06, site visitors continued to review non-reportable complaints, patient safety, and injury reporting. However, unlike FY05, the site visit process included focused reviews of particular issues. For example, site visitors reviewed communication between nurses and the facility's use of overtime for nursing coverage, which focused on detailing and mandated double-shifts. Site visitors reviewed the training of facility employees and the policies and practices relative to contraband on the unit. They also reviewed how the internal patient safety and human rights committees received, analyzed, and recorded reports of complaints/allegations and outcomes of recommendations. In addition, site visitors reviewed results of patient surveys on violence and patient care.

During Fiscal Years 2005 and 2006, the OIG did not always comply with its established timeline for submitting site visit reports to facility directors or hospital administrators. OIG Directives state that site visit reports should be submitted to facility directors or hospital administrators within 60 days of the completion of the site visit. In FY04, all of the site visit reports were completed and sent to the facility directors or hospital administrators within the required timeline. In FY05, 10 of the 18 (56%) mental health and developmental centers received a site visit report after the 60-working day timeline. In FY06, 6 of the 18 (33%) centers received a site visit report after the timeline. According to an OIG official, at the end of October 2004, one of the two regular site visitors resigned and the remaining site visitor had several other time-sensitive duties, which resulted in a delay in completing site visit reports. The official also stated that during FY06, some site visit reports were delayed due to high priorities such as completing case reports, death reviews and other statutory requirements.

| OIG SITE VISITS | |
|---|---|
| **RECOMMENDATION 14** | ***The Office of the Inspector General should ensure that established timelines are met for submitting site visit reports to facility directors or hospital administrators.*** |
| **OFFICE OF THE INSPECTOR GENERAL RESPONSE** | OIG agrees and notes that the auditors found that OIG's site visitors focused on relevant issues, effectively applied standard procedures, and provided useful information to the facilities. Since OIG's site visitors discuss the findings with the facility administrators at an exit conference when the site visit concludes, corrective actions are not prevented by a delay in the written report.<br><br>During FY 2005, one of the two administrative site visitors resigned and that position has not been filled; then, during FY 2006, the administrative site visitor covering the other half of the state also resigned. Still, OIG has completed all the required site visits using existing staff who have other responsibilities. During FY 2005, OIG mailed 8 of the 18 site visit reports (*44%*) on time; during FY 2006, OIG mailed 14 of the 18 site visit reports (*78%*) on time. |

# APPENDICES

# APPENDIX A
# (210 ILCS 30/6.8)

**Appendix A**

# ILLINOIS COMPILED STATUTES

## Chapter 210 Health Facilities Act 30. Abused and Neglected Long Term Care Facility Residents Reporting Act

**Sec. 6.8. Program audit.** The Auditor General shall conduct a biennial program audit of the office of the Inspector General in relation to the Inspector General's compliance with this Act. The audit shall specifically include the Inspector General's effectiveness in investigating reports of alleged neglect or abuse of residents in any facility operated by the Department 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;
- Testing investigative files to determine the adequacy of investigations; and
- Reviewing several compliance issues including investigator training, conducting site visits and Quality Care Board meetings.

We interviewed representatives and obtained information and documentation from the Inspector General's Office, the Department of Human Services, the Department of Public Health, Department of State Police, and the Department of Children and Family Services. We analyzed OIG's electronic database from Fiscal Years 2005 and 2006. We examined the current OIG organizational structure, policies and procedures, investigations process, case review process, documentation requirements and changes to Directives. We reviewed backgrounds of investigators hired since our last OIG audit and reviewed investigators' training records.

We assessed risk by reviewing recommendations from previous OIG audits, OIG internal documents, policies and procedures, management controls, and the OIG's administrative rule. We reviewed management controls relating to the audit objectives that are 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 2006 and fieldwork was concluded in September 2006. In order to test case files for thoroughness of investigation methods, we selected a sample of cases closed in FY06. 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 FY06. We took a systematic random sample of 126 cases with a confidence level of at least 90 percent and an acceptable error rate of 10 percent. Our random sample was stratified into the two following case classifications:

- 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 2005 and 2006 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

## FY04, FY05 and FY06

Appendix C

**RATE OF SUBSTANTIATED ABUSE OR NEGLECT CASES BY FACILITY**

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

FY04, FY05 and FY06

| | **Fiscal Year 2004** | | | **Fiscal Year 2005** | | | **Fiscal Year 2006** | | |
|---|---|---|---|---|---|---|---|---|---|
| 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 | 56 | 2 | 4% | 83 | 4 | 5% | 103 | 4 | 4% |
| Chester | 126 | 2 | 2% | 136 | 1 | 1% | 107 | 1 | 1% |
| Chicago-Read | 34 | 1 | 3% | 31 | 1 | 3% | 28 | 0 | 0% |
| Choate | 168 | 5 | 3% | 275 | 7 | 3% | 201 | 6 | 3% |
| Elgin | 37 | 2 | 5% | 31 | 0 | 0% | 27 | 1 | 4% |
| Fox | 9 | 2 | 22% | 11 | 4 | 36% | 7 | 1 | 14% |
| Howe | 119 | 8 | 7% | 85 | 3 | 4% | 79 | 4 | 5% |
| Jacksonville | 78 | 6 | 8% | 89 | 3 | 3% | 104 | 6 | 6% |
| Kiley | 46 | 10 | 22% | 24 | 5 | 21% | 47 | 11 | 23% |
| Ludeman | 41 | 5 | 12% | 23 | 1 | 4% | 22 | 1 | 5% |
| Mabley | 14 | 6 | 43% | 18 | 3 | 17% | 12 | 1 | 8% |
| Madden | 25 | 0 | 0% | 26 | 0 | 0% | 15 | 0 | 0% |
| McFarland | 22 | 0 | 0% | 29 | 2 | 7% | 33 | 2 | 6% |
| Murray | 24 | 7 | 29% | 24 | 5 | 21% | 27 | 7 | 26% |
| Shapiro | 60 | 6 | 10% | 30 | 1 | 3% | 58 | 10 | 17% |
| Singer | 31 | 3 | 10% | 25 | 2 | 8% | 45 | 3 | 7% |
| Tinley Park | 25 | 1 | 4% | 15 | 1 | 7% | 6 | 0 | 0% |
| Community Agencies [1] | 724 | 138 | 19% | 798 | 147 | 18% | 878 | 154 | 18% |
| **Totals** | **1,639** | **204** | **12%** | **1,753** | **190** | **11%** | **1,799** | **212** | **12%** |

[1] Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

# APPENDIX D

## Allegations by Facility
## FY04 through FY06

## CATEGORIES FOR ALLEGATIONS AND OTHER INCIDENTS

Allegations of **Abuse**

**A1 --** Physical abuse with imminent danger alleged

**A2 --** Physical abuse with serious harm alleged

**A3 --** Physical abuse without serious harm alleged

**A4 --** Sexual abuse alleged

**A5 --** Mental injury (verbal) alleged

**A6 --** Mental injury (psychological) alleged

Allegations of **Neglect**

**N1 --** Neglect with imminent danger alleged

**N2 --** Neglect in any serious injury

**N3 --** Neglect in any non-serious injury

**N4 --** Neglect in an individual's absence

**N5 --** Neglect in sexual activity between recipients

**N7 --** Neglect with risk of harm or injury

Recipient **Deaths**

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

**D2 --** Suicide within 14 days after discharge

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

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

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

**D7 --** Death - any other reportable death

Appendix D
**ALLEGATIONS BY FACILITY**
FY04 through FY06

| Location | Abuse Allegations | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **A1 physical abuse - imminent danger** | | | **A2 physical abuse - serious injury** | | | **A3 other physical abuse** | | |
| | **FY04** | **FY05** | **FY06** | **FY04** | **FY05** | **FY06** | **FY04** | **FY05** | **FY06** |
| **DD Facilities** | | | | | | | | | |
| Fox | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 |
| Howe | 0 | 0 | 0 | 2 | 3 | 1 | 41 | 66 | 57 |
| Jacksonville | 1 | 0 | 0 | 1 | 2 | 2 | 43 | 67 | 92 |
| Kiley | 0 | 0 | 0 | 0 | 1 | 1 | 20 | 17 | 20 |
| Ludeman | 0 | 0 | 0 | 0 | 4 | 0 | 18 | 13 | 16 |
| Mabley | 0 | 1 | 0 | 0 | 0 | 0 | 5 | 8 | 6 |
| Murray | 1 | 0 | 0 | 0 | 1 | 0 | 8 | 14 | 24 |
| Shapiro | 0 | 1 | 0 | 1 | 0 | 1 | 20 | 24 | 37 |
| **MH Facilities** | | | | | | | | | |
| Alton | 0 | 0 | 0 | 0 | 2 | 0 | 31 | 48 | 39 |
| Chester | 1 | 0 | 0 | 3 | 2 | 1 | 90 | 88 | 92 |
| Chicago-Read | 0 | 0 | 0 | 0 | 2 | 1 | 7 | 13 | 12 |
| Elgin | 0 | 0 | 0 | 0 | 0 | 0 | 7 | 10 | 15 |
| Madden | 0 | 0 | 0 | 0 | 1 | 0 | 10 | 12 | 8 |
| McFarland | 0 | 0 | 0 | 1 | 1 | 0 | 9 | 15 | 21 |
| Singer | 0 | 0 | 0 | 0 | 0 | 1 | 16 | 9 | 18 |
| Tinley Park | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 4 | 8 |
| **Dual Facility** | | | | | | | | | |
| Choate | 1 | 0 | 0 | 0 | 3 | 1 | 104 | 192 | 130 |
| | | | | | | | | | |
| **Community Agencies** [1] | 6 | 3 | 0 | 8 | 11 | 6 | 242 | 349 | 418 |
| **Totals** | **10** | **5** | **0** | **16** | **33** | **15** | **677** | **951** | **1,015** |

[1] Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

Appendix D
**ALLEGATIONS BY FACILITY**
FY04 through FY06

| Abuse Allegations | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **A4 sexual abuse** | | | **A5 verbal abuse** | | | **A6 psychological abuse** | | |
| **FY04** | **FY05** | **FY06** | **FY04** | **FY05** | **FY06** | **FY04** | **FY05** | **FY06** |
| | | | | | | | | |
| 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 1 | 2 | 0 | 6 | 8 | 16 | 7 | 4 | 15 |
| 5 | 1 | 4 | 3 | 4 | 7 | 4 | 3 | 4 |
| 1 | 0 | 2 | 1 | 3 | 0 | 1 | 1 | 2 |
| 1 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 1 |
| 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| 1 | 0 | 0 | 0 | 2 | 0 | 0 | 1 | 0 |
| 0 | 1 | 0 | 0 | 2 | 2 | 0 | 0 | 6 |
| | | | | | | | | |
| 6 | 11 | 9 | 4 | 20 | 27 | 2 | 14 | 16 |
| 3 | 4 | 1 | 3 | 8 | 6 | 9 | 4 | 10 |
| 3 | 5 | 4 | 4 | 3 | 2 | 1 | 2 | 2 |
| 5 | 4 | 5 | 4 | 5 | 6 | 7 | 5 | 7 |
| 2 | 0 | 0 | 1 | 4 | 4 | 5 | 2 | 2 |
| 1 | 3 | 3 | 2 | 4 | 3 | 2 | 5 | 1 |
| 2 | 9 | 4 | 0 | 4 | 7 | 1 | 0 | 7 |
| 3 | 0 | 0 | 2 | 2 | 2 | 1 | 0 | 1 |
| | | | | | | | | |
| 13 | 12 | 6 | 4 | 31 | 5 | 7 | 28 | 12 |
| | | | | | | | | |
| 46 | 58 | 59 | 23 | 34 | 83 | 31 | 35 | 100 |
| **94** | **111** | **97** | **57** | **134** | **171** | **79** | **104** | **187** |

Appendix D
**ALLEGATIONS BY FACILITY**
FY04 through FY06

| Location | Neglect Allegations | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | N1 neglect- imminent danger | | | N2 neglect- serious injury | | | N3 neglect- non-serious injury | | |
| | FY04 | FY05 | FY06 | FY04 | FY05 | FY06 | FY04 | FY05 | FY06 |
| **DD Facilities** | | | | | | | | | |
| Fox | 0 | 0 | 0 | 2 | 1 | 0 | 1 | 1 | 4 |
| Howe | 0 | 0 | 0 | 1 | 5 | 3 | 4 | 2 | 7 |
| Jacksonville | 0 | 0 | 0 | 1 | 0 | 1 | 4 | 2 | 10 |
| Kiley | 1 | 0 | 0 | 1 | 4 | 6 | 2 | 2 | 4 |
| Ludeman | 0 | 0 | 0 | 1 | 0 | 2 | 3 | 1 | 2 |
| Mabley | 0 | 1 | 0 | 0 | 0 | 0 | 2 | 3 | 5 |
| Murray | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 2 | 2 |
| Shapiro | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 0 | 0 |
| **MH Facilities** | | | | | | | | | |
| Alton | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 0 | 0 |
| Chester | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 3 | 0 |
| Chicago-Read | 0 | 0 | 0 | 2 | 4 | 2 | 3 | 1 | 3 |
| Elgin | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 2 | 1 |
| Madden | 0 | 0 | 0 | 0 | 3 | 0 | 1 | 1 | 0 |
| McFarland | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 1 | 1 |
| Singer | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 4 |
| Tinley Park | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 3 |
| **Dual Facility** | | | | | | | | | |
| Choate | 0 | 0 | 0 | 3 | 3 | 1 | 2 | 9 | 6 |
| | | | | | | | | | |
| **Community Agencies** [1] | 3 | 2 | 3 | 21 | 37 | 44 | 56 | 76 | 123 |
| **Totals** | **4** | **3** | **3** | **33** | **58** | **65** | **91** | **107** | **175** |

[1] Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

Appendix D
**ALLEGATIONS BY FACILITY**
FY04 through FY06

**Neglect Allegations**

| **N4 neglect in individual absence** | | | **N5 neglect in recipient sexual activity** | | | **N7 Neglect with risk of harm or injury** | | |
|---|---|---|---|---|---|---|---|---|
| **FY04** | **FY05** | **FY06** | **FY04** | **FY05** | **FY06** | **FY04** | **FY05** | **FY06** |
| | | | | | | | | |
| 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| 0 | 0 | 0 | 0 | 2 | 0 | 1 | 4 | 5 |
| 1 | 0 | 1 | 1 | 0 | 0 | 0 | 2 | 2 |
| 0 | 0 | 0 | 0 | 0 | 0 | 3 | 6 | 5 |
| 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| 0 | 1 | 0 | 0 | 0 | 0 | 2 | 2 | 2 |
| 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 |
| 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| | | | | | | | | |
| 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 |
| 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| 0 | 0 | 1 | 1 | 0 | 0 | 1 | 3 | 1 |
| 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| 0 | 0 | 0 | 0 | 0 | 1 | 0 | 2 | 2 |
| 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| 0 | 0 | 0 | 0 | 0 | 2 | 0 | 1 | 0 |
| 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| | | | | | | | | |
| 1 | 0 | 1 | 2 | 0 | 0 | 3 | 2 | 1 |
| | | | | | | | | |
| 6 | 0 | 2 | 2 | 6 | 4 | 38 | 29 | 51 |
| **8** | **2** | **5** | **6** | **10** | **7** | **51** | **54** | **74** |

Appendix D
**ALLEGATIONS BY FACILITY**
FY04 through FY06

| Location | Death Allegations | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **D1 suicide in program** | | | **D2 suicide within 14 days after discharge** | | | **D4 death in residential program** | | |
| | **FY04** | **FY05** | **FY06** | **FY04** | **FY05** | **FY06** | **FY04** | **FY05** | **FY06** |
| **DD Facilities** | | | | | | | | | |
| Fox | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 2 |
| Howe | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 2 |
| Jacksonville | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Kiley | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Ludeman | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Mabley | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Murray | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 |
| Shapiro | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 3 |
| **MH Facilities** | | | | | | | | | |
| Alton | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Chester | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 0 |
| Chicago-Read | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 |
| Elgin | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Madden | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 |
| McFarland | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Singer | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 0 |
| Tinley Park | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 |
| **Dual Facility** | | | | | | | | | |
| Choate | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 |
| | | | | | | | | | |
| **Community Agencies** [1] | 2 | 1 | 1 | 0 | 2 | 0 | 22 | 20 | 35 |
| **Totals** | **3** | **1** | **2** | **3** | **4** | **1** | **32** | **26** | **47** |

[1] Aggregate numbers from all Community Agencies.

Source: OAG analysis of OIG data.

Appendix D
**ALLEGATIONS BY FACILITY**
FY04 through FY06

**Death Allegations**

| **D5 death not in residential program** | | | **D6 death due to natural causes in a program** | | | **D7 any other reportable deaths** | | |
|---|---|---|---|---|---|---|---|---|
| **FY04** | **FY05** | **FY06** | **FY04** | **FY05** | **FY06** | **FY04** | **FY05** | **FY06** |
| | | | | | | | | |
| 0 | 0 | 0 | 4 | 4 | 0 | 0 | 0 | 0 |
| 0 | 1 | 2 | 0 | 3 | 4 | 0 | 1 | 1 |
| 0 | 1 | 0 | 1 | 0 | 1 | 0 | 0 | 0 |
| 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 |
| 1 | 0 | 3 | 4 | 2 | 1 | 0 | 0 | 0 |
| 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| 0 | 1 | 1 | 3 | 1 | 2 | 0 | 0 | 0 |
| 1 | 2 | 2 | 9 | 2 | 6 | 0 | 0 | 0 |
| | | | | | | | | |
| 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 0 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 2 |
| 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| 0 | 0 | 0 | 1 | 1 | 1 | 2 | 0 | 1 |
| 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| 0 | 0 | 0 | 1 | 1 | 1 | 1 | 0 | 1 |
| 0 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 0 |
| 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 |
| | | | | | | | | |
| 1 | 0 | 1 | 1 | 3 | 2 | 0 | 2 | 0 |
| | | | | | | | | |
| 2 | 9 | 20 | 56 | 41 | 42 | 3 | 3 | 7 |
| **5** | **16** | **31** | **84** | **60** | **61** | **7** | **7** | **13** |

# APPENDIX E

## Agency Responses

**Note:** Appendix E contains the written responses of the Office of the Inspector General. Following the OIG Responses are 4 numbered Auditor Comments. The number for the comment appears in the margin of the OIG Response.

Rod R. Blagojevich, *Governor*

Illinois Department of Human Services

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

**Office of the Inspector General**
100 W. Randolph, Suite 4-750
Chicago, IL 60601

November 20, 2006

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

Dear Auditor General Holland:

Thank you for the opportunity to respond to the recommendations in your draft audit report and for your willingness to include them in the body of the report. Our responses are attached.

I appreciate the efforts that Audit Manager Scott Wahlbrink and his staff made to understand and present information about our ongoing efforts to investigate and prevent the abuse and neglect of some of Illinois' most vulnerable citizens.

I am also sending a copy of this letter and the responses by email in MS Word format. If you have any questions, please feel free to call me at (312) 814-2718.

Sincerely,

William M. Davis
Inspector General

cc: Carol L. Adams, PhD, DHS Secretary

## Response to Recommendations in the FY 2005-2006 Audit of OIG

**Recommendation 1**

*The Office of the Inspector General should ensure that all allegations reported to the Hotline are investigated appropriately as required by 59 Ill. Adm. Code 50. Additionally, the OIG should consider revising its Investigative Directives and Administrative Rule to ensure that all potential allegations of abuse and neglect are investigated.*

**OIG's Response**

OIG agrees. As the auditors noted, OIG is in compliance with its statutory mandate to investigate abuse and neglect as defined in Rule 50. OIG's statutory jurisdiction covers alleged or suspected abuse/neglect, not *potential* abuse/neglect. OIG's Bureau of Hotline and Intake assesses every call for an allegation or suspicion of abuse or neglect. **1**

Following the FY 2004 audit, OIG began the process of amending Rule 50, including revising some definitions. However, on June 5, 2006, the department's Legal Services recommended suspending the process, since some revisions would require statutory changes. Any revision to Rule 50 or to OIG's Investigative Directives must follow statutory changes.

However, a cross-bureau team in OIG is currently reviewing its Investigative Directives for needed clarifications or improvements. While some directives can be revised to improve operations without statutory changes, all revisions must be consistent with the current statute and Rule 50.

**Recommendation 2**

*The Office of the Inspector General should ensure that all allegations of suspected abuse or neglect that indicate any possible criminal act has been committed are reported to the Illinois State Police as required by 210 ILCS 30/6.2(b).*

**OIG's Response**

OIG agrees. The statute requires that, if OIG determines that a criminal act may have been committed, the incident is to be reported to the Illinois State Police or to an appropriate local law enforcement entity. In the only incident cited by the auditors, the facility reported that the female resident had been taken to the hospital for a rape kit, which involves automatic reporting to local law enforcement. OIG confirmed that the Cook County Sheriff's office had responded to the report, and thus notification of the Illinois State Police was not also necessary. **2**

OIG Intake investigators will continue to ensure that non-reportable claims of rape, murder, or other felony are reported to the Illinois State Police or local law enforcement within 24 hours of determining credible evidence that a criminal act may have occurred. OIG will revise its directive to more clearly specify responsibility for this determination.

**Recommendation 3**
*The Office of the Inspector General should record data for non-reportable allegations and serious injuries in its investigative database.*

**OIG's Response**

OIG agrees that non-reportable complaints (which includes some serious injuries) should be recorded in the database when received; with the assistance of the department's Management Information Systems, OIG expects to complete development of that capability shortly. As noted by the auditors, out of the 128 calls they reviewed, they found only one *(0.8%)* that possibly met the current definitions in Rule 50. **3**

Rule 50 requires reporting of serious injuries only if alleged or suspected to have been the result of abuse or neglect by staff. Requiring agencies and facilities to report all other serious injuries to OIG would require a change in the statute.

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**Recommendation 4**
*The Inspector General should continue to work to improve the timeliness of investigations of abuse and neglect.*

**OIG's Response**

OIG agrees and reaffirms its commitment to completing investigations more quickly and efficiently without sacrificing quality. The auditors noted that, in this audit period, OIG made substantial improvements in timeliness. In addition, the average time it took OIG to complete its investigations fell from 74 days in FY 2004 to 50 days in FY 2006, a reduction of 32 %.

OIG notes that the auditors use *calendar* days when evaluating timeliness issues, even though Rule 50 has used *working* days since FY 2002. OIG maintains that audits should evaluate timeliness based on the legal measure governing its operation and that working days is a more accurate gauge of the actual time worked by salaried employees. OIG hopes that by the FY 2008 audit, six years of using working days will provide sufficient data for the auditors to evaluate trends.

The auditors also observed that the OIG now has significantly fewer investigators than in FY 2000. In addition, three investigator positions are currently vacant and three others have only recently been filled. Yet, since FY 2005, OIG has received 52% more allegations. Further, since OIG has only two clinical investigators, their involvement can slow an investigation, as the auditors noted. Adding a third clinical investigator would improve investigative timeliness. OIG is continuing to fill vacant positions as expeditiously as possible in a difficult fiscal climate.

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**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.*

**OIG's Response**

OIG agrees that the documentation should show whether notification to the Illinois State Police or appropriate local law enforcement was within 24 hours of determining credible evidence of a possible criminal act. OIG has modified its law enforcement notification form to include the date and time of that determination and is currently deciding the most appropriate way to monitor timely notification.

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**Recommendation 6**

*The Inspector General should take proactive measures to ensure that increased allegations, especially in the North and Metro Bureaus, do not negatively impact it's case completion timeliness.*

**OIG's Response**

OIG agrees that the North and Metro Bureaus have experienced higher caseloads and greater backlogs than the other bureaus. In addition, these two bureaus have each: lost an investigator position in the past three years; had an investigator on an extended leave of absence during the audited period; had a vacant investigator position for nearly a year; and been in the process of filling an investigator position.

To address this issue, OIG has taken the following actions:

- Established regular meetings of the investigative bureau chiefs to discuss issues and caseload;
- Assigns all investigations using a "task" function in email that alerts the supervisor when a case reaches 20 days old, so the supervisor can follow-up if it has not yet been completed;
- Revised OIG Directive INV 02-019 to further standardize a process of 30-day and over 45-day reviews for all active investigations;
- Directed that, to avoid duplicating investigative efforts, OIG investigators should, where appropriate, rely on interviews conducted by trained facility/agency investigators;
- Since June 2006, enabled the Bureau of Hotline and Intake to complete investigations when the alleged victim recants the allegation;

- Proposed allowing the Bureau of Hotline and Intake to assign and then monitor investigations of alleged mental injury to agencies that have an OIG-approved investigative protocol; and

- Is acquiring ten laptops for use by investigators, to facilitate their investigative efforts.

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**Recommendation 7**

*The Inspector General should define in the OIG Directives what is considered to be a critical interview to provide additional guidance and ensure investigative bureaus conduct investigations in a similar manner.*

**OIG's Response**

OIG has maintained that, since each investigation is unique and requires judgment based on investigative skill and experience, it is impossible to specify what interviews are necessary and in what order, based simply upon the intake information. Important leads often develop later during the course of the investigation.

In response to an FY 2004 audit recommendation, OIG attempted to create a "critical" interview time requirement. Establishing these blanket time requirements, however, has neither provided meaningful guidance in investigations nor resulted in faster case completion. For these reasons, OIG determined that this approach is not workable and has been examining other approaches. **4**

At the same time, OIG promulgated a standard Investigative Plan, where the investigator and supervisor identify specific leads to pursue at the outset of the investigation. OIG also mandated the use of the "task" function, to prompt an automatic 20-day review, and standardized 30-day and "over 45-day" reviews. These steps allowed for professional judgment, yet also addressed timeliness.

OIG agrees that the interview of the alleged perpetrator is vital. OIG responds that proper investigative practice often dictates this interview may take place after many, if not all, of the other interview statements and evidence have been gathered. This is another reason why adherence to a strict timetable is not applicable.

As the auditors noted, the timeliness of OIG's interviews improved greatly; the time to interview all alleged victims fell 67% from the previous audit period. OIG will continue to review this progress, building upon what has worked, in order to further improve investigative timeliness.

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**Recommendation 8**

*The Inspector General should improve its electronic case tracking system to help manage investigations and case file review timeliness.*

**OIG's Response**

OIG agrees. With the help of the department's Management Information Systems, OIG is developing a web-enabled version of the Investigative Case Actions form, which should significantly speed the entry of actions taken and allow for entry even when off-site.

OIG case reviewers have now begun entering review dates into the database to allow tracking and ensure case review timeliness.

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**Recommendation 9**

*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 OIG's administrative rule.*

**OIG's Response**

OIG agrees. Timeliness of self-reports to OIG has steadily improved, from 75% on time in FY 2003 to 83% on time in FY 2006. Since the last audit, OIG has accomplished the following:

- Wrote and sent to all facilities and agencies a handbook entitled, "Reporting and Investigating Abuse and Neglect of Adults with Disabilities," which emphasizes timeliness;
- Created and e-mailed to all facilities and agencies a self-contained training module on Rule 50;
- Placed two automated flags on the intake form, which appear when an intake is reported late;
- Routinely cites late reporting as an issue in the investigative case report when it has occurred, which requires a Written Response from the agency or facility listing corrective actions;
- Sends monthly reports to the program divisions listing late reporting by facilities and agencies;
- Discussed the issue with the program divisions at the quarterly OIG Coordination Committee for their follow-up; and
- Proposed a new law (P.A. 94-853, effective June 13, 2006) making intentional late reporting or non-reporting a Class A misdemeanor.

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**Recommendation 10**
*The Inspector General should develop criteria for documenting investigative interviews.*

**OIG's Response**

OIG agrees that investigative interviews should be documented, and OIG has both a directive requiring investigators to document interviews and a standard form for that purpose. Each interview is unique, however, and OIG relies on the skill and experience of the investigator and supervisor to determine the best approach to the interview and to documenting it.

Further, when reviewing the submitted case report, the supervisor ensures that all appropriate interviews were done and are accurately reflected in the report. In one instance of verbatim interview statements identified by the auditors, the witnesses had all said they were in the room and had not observed the alleged abuse. The interviews were thus short and identical. The bureau chiefs carefully review such verbatim statements to ensure that they properly record the particulars of the interviews.

The auditors highlight the training manual's guidance against asking leading questions. This sentence is under the description of the "Initial Interview." Two pages later, the manual states: "Follow-up interviews differ from initial interviews in that they are specific in nature." That is, after analyzing the initial statements, an interviewer may need to ask specific leading questions in a follow-up interview. Such questions may be appropriate in other interviews, such as with an expert or a hostile witness. Again, the interview and its documentation must rely on professional judgment.

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**Recommendation 11**
*To address investigative inconsistencies among the bureaus, the Inspector General should clearly define what constitutes physical injury and physical harm, and establish a centralized review process of substantiated, unsubstantiated, and unfounded investigations to help ensure consistency of its investigations.*

**OIG's Response**

OIG agrees and believes that the issue of definitions would be resolved by revisions to the statute. Until the statute is revised, however, such a change to Rule 50 would be premature. However, in the meantime, OIG will reinforce that physical "harm" is a physical " wrong or injustice."

Since one designee could not adequately review 2,000 cases/year nor spot every inconsistency, OIG will instead implement quarterly reviews conducted by the Deputy Inspector General and one investigative bureau chief selected on a rotating basis. The reviews will examine a sampling of unfounded and unsubstantiated cases to ensure consistency across bureaus. Findings will be discussed at OIG Leadership Team meetings and at investigative bureau chiefs' meetings.

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**Recommendation 12**

*The Inspector General should:*

- *review ALJ opinions to determine the reasons why referrals to the Nurse Aide Registry rejected by the ALJ and whether changes to the investigative process are warranted; and*

- *ensure the safety of individuals with mental or physical disabilities receiving services in the State of Illinois by making appropriate revisions to its administrative rules, policies or procedures (which may include revising the definition of egregious) to ensure that all cases with findings that warrant reporting to the Nurse Aide Registry are reported.*

**OIG's Response**

OIG agrees and, since FY 2005, has been reviewing every decision in Registry referral appeals. No problems with the investigator process have been found.

The statute mandates that OIG refer the names of all persons substantiated to have committed physical abuse, sexual abuse, or egregious neglect, regardless of the severity of the act. However, the statute provides for an appeals process, granting the ALJ the discretion to determine that the act was not severe enough to warrant referral to the Registry. That is, the appeal is to address the referral, not the finding.

After reviewing several decisions by the ALJ upholding appeals, OIG initiated a dialog with the department's Legal Services to develop some constructive approaches to the appeals process. These discussions culminated in the following three specific actions:

- OIG completed development of an in-house training on testifying at court hearings.

- OIG designated a legal liaison to help prepare the department attorney who is assigned to represent OIG at a Registry appeals hearing.

- DHS Legal and OIG established a process authorized by the code governing these hearings for stipulating that certain physical abuse cases, while meeting the broad definition of physical abuse, did not deserve placement on the Registry. This new process was approved by the department on September 11, 2006. It is triggered by a 50.90 petition and includes input from the petitioner, OIG and DHS Legal while leaving the final decision with the ALJ and the Secretary of DHS.

Ensuring the safety of individuals remains OIG's highest priority. OIG agrees with the auditors that Registry referrals have been consistent with the current Rule 50 definitions. If OIG has the opportunity to propose changes to the statute, the definitions would be a focal point. Revisions to Rule 50 and the Directives would follow. By ensuring appropriate referrals, this would help prevent abuse/neglect.

**Recommendation 13**

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

**OIG's Response**

OIG agrees. The Quality Care Board has full membership as of September 2006 and is meeting quarterly as required. As noted by the auditors, the Board is fulfilling its statutory requirements to monitor and oversee the operations, policies and procedures of OIG to ensure the thorough and prompt investigation of abuse/neglect allegations.

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**Recommendation 14**

*The Inspector General should ensure that established timelines are met for submitting site visit reports to facility directors or hospital administrators.*

**OIG's Response**

OIG agrees and notes that the auditors found that OIG's site visitors focused on relevant issues, effectively applied standard procedures, and provided useful information to the facilities. Since OIG's site visitors discuss the findings with the facility administrators at an exit conference when the site visit concludes, corrective actions are not prevented by a delay in the written report.

During FY 2005, one of the two administrative site visitors resigned and that position has not been filled; then, during FY 2006, the administrative site visitor covering the other half of the state also resigned. Still, OIG has completed all the required site visits using existing staff who have other responsibilities. During FY 2005, OIG mailed 8 of the 18 site visit reports (*44%*) on time; during FY 2006, OIG mailed 14 of the 18 site visit reports (*78%*) on time.

## AUDITOR COMMENTS

**1** The auditors' review of Hotline referrals closed without an investigation identified instances where non-verbal clients received unexplained injuries and instances where clients were left unsupervised. Based on the documentation provided, it was unclear whether the injuries or the lack of supervision was the result of abuse or neglect. The auditors are recommending that the OIG take the necessary steps, including possibly revising its Investigative Directive or Administrative Rule, to ensure that all allegations reported to the Hotline that involve the possible abuse or neglect of a client are appropriately investigated.

**2** Notification of the Illinois State Police, rather than a local law enforcement agency, **was** required by State law in this case. The Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6.2(b)) specifically requires that "the department of State Police shall investigate any report from a State-operated facility indicating a possible murder, rape, or other felony."

**3** As stated in the audit report, of the 128 allegations deemed "non-reportable" by Hotline staff from January 1, 2006 to March 31, 2006, auditors questioned the closing of 27 of these cases.

**4** The 2004 recommendation was that the OIG "should develop specific time requirements for conducting interviews of the alleged perpetrator, victim, and any witnesses." The OIG, not the OAG, established the 5-day "critical interview" requirement. The recommendation in the 2004 audit was made as a result of auditors determining that, on average, 37 days elapsed from the time the allegation was reported until the time when the alleged victim was interviewed. In many instances, auditors had found that when the alleged victim was eventually interviewed, the victim recanted the allegation.