STATE OF ILLINOIS

OFFICE OF THE

AUDITOR GENERAL

William G. Holland, Auditor General

SUMMARY REPORT DIGEST

DEPARTMENT OF HUMAN SERVICES OFFICE OF THE INSPECTOR GENERAL

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

Release Date: December 2010

Summary of Findings:

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

SYNOPSIS

The Department of Human Services Act (Act) requires the Office of the Inspector General (OIG) to investigate allegations of abuse and neglect that occur in mental health and developmental disability facilities operated by the Department of Human Services (DHS). The Act also authorizes the OIG to conduct investigations in community agencies.

In this audit we reported that:

- Total allegations of abuse and neglect reported to the OIG increased 22 percent over the last two years. In FY10, 2,468 allegations were reported. This compares to 2,026 in FY08.
- The timeliness of OIG investigations continued to improve since our last audit. In FY10, 69 percent of investigations were completed within 60 calendar days. Using the more lenient working days standard, the OIG's timeliness of case completion reached its highest percent ever at 85 percent for FY10.
- Although there has been continued improvement in the overall timeliness of investigations, the timeliness of cases assigned to clinical coordinators (involving death or other medical issues) continues to be a problem. Of the 327 cases closed in FY10 that took more than 60 working days to complete, 98 were clinical.
- The timeliness of reporting allegations of abuse and neglect by community agencies improved substantially. For FY10, 13 percent of allegations were not reported within the required four hours, as compared to 25 percent in FY08. In FY10, 10 percent of State-operated facility incidents were not reported within the four-hour time requirement.
- In 18 percent (5 of 28) of the cases sampled, more than six months passed from the date the case was completed to the date when a written response delineating the corrective actions taken was submitted by the State facility or community agency and approved by DHS.
- Two facilities remained decertified from participation in Medicare and Medicaid (Howe Developmental Center and Tinley Park Mental Health Center). The U.S. Department of Justice released reports in 2009 with serious concerns about two facilities (Howe Developmental Center and Choate Developmental Center). Howe Developmental Center closed effective June 21, 2010.
- The Quality Care Board did not maintain the seven members that are required by statute. From November 2009, to May 2010, all of the members of the Board were serving under terms that had expired.

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FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

BACKGROUND

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

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

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

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

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

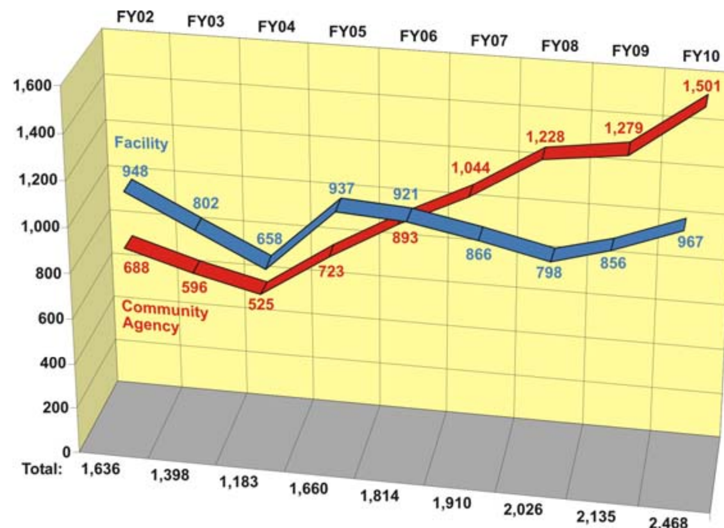
SERIOUS INJURIES

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

Digest Exhibit 1

TOTAL ABUSE OR NEGLECT ALLEGATIONS REPORTED TO OIG

Fiscal Years 2002 to 2010



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

Source: OIG data summarized by OAG.

INTERAGENCY AGREEMENTS

While the Department of Human Services Act requires the OIG to investigate abuse and neglect, other State agencies, including the Illinois State Police, the Department of Children and Family Services, and the Department of Public Health, also have statutory responsibility to investigate potential instances of abuse and neglect. Although the Inspector General has clarified the investigatory role of each agency through signed interagency agreements, several of the agreements now contain outdated statutory cites and definitions that need updated. (pages 17-20)

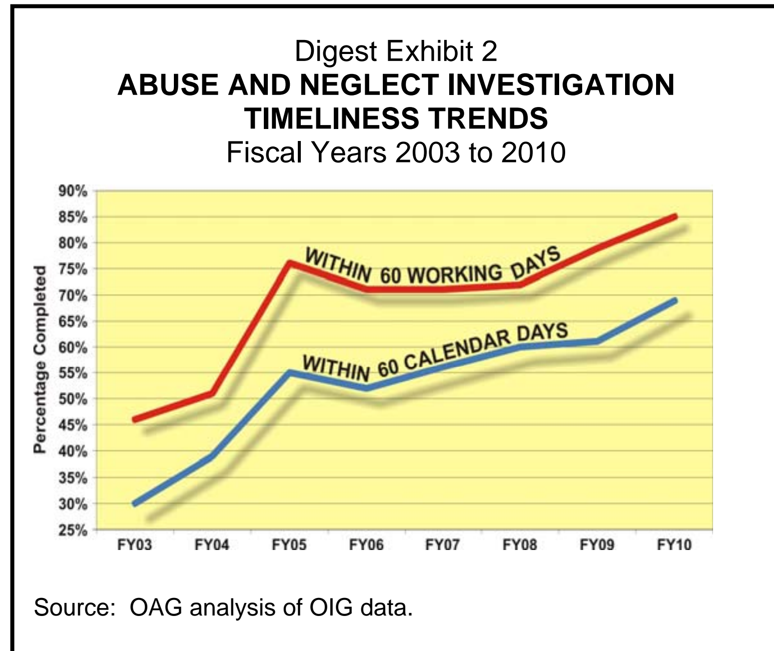
The timeliness of OIG investigations continued to improve in FY09 and FY10.

INVESTIGATION TIMELINESS

The timeliness of OIG investigations continued to improve in FY09 and FY10. In FY08, 60 percent of OIG investigations were completed in 60 calendar days. Timeliness improved in FY09 with 61 percent and in FY10 with 69 percent completed within 60 calendar days. In January 2002, the OIG amended its administrative rules to require investigations be completed within 60 working days. Using the more lenient working days standard, the OIG's timeliness of case completion reached its highest percent ever at 85 percent for FY10 (see Digest Exhibit 2).

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

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



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

Source: OAG analysis of OIG data.

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

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

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

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

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

The OIG needs to improve the timeliness of investigator assignment and completion of investigative plans.

The OIG needs to improve the timeliness of investigator assignment and completion of investigative plans. OIG directives require that investigations be assigned to an investigator within one working day of the OIG assuming responsibility for the investigation. For 24 of the 123 (20%) cases we sampled and could determine an assignment date, the assignment was not made within one working day.

OIG directives also require assigned investigators to complete an investigative plan within three working days of assignment, except if the case is closed at intake or is a death investigation. For 9 of the 128 (7%) cases we sampled, we could not determine whether the plan was completed in a timely manner because there was no investigative plan in the file, there was no date on the investigative plan, or we could not determine the date assigned. For 10 cases, a plan was not required. Of the remaining 109 cases, 6 (6%) were not completed and approved within the required three working days.

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

Digest Exhibit 3

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

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

Source: OAG analysis of OIG data.

INVESTIGATION THOUROUGHNESS

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

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

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

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

ACTIONS, RECOMMENDATIONS, AND SANCTIONS

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

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

State facilities and community agencies are required to submit a written response to DHS for all substantiated cases of abuse or neglect, or cases with other administrative issues. We found that

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

According to 59 Ill. Adm. Code 50.90, an employee may request a hearing with DHS and present evidence supporting why his or her finding does not warrant reporting to the Health Care Worker Registry. The percentage of cases appealed in which the Administrative Law Judge's (ALJ) decision found in favor of the petitioner, and therefore the employee was not referred to the Health Care Worker Registry, increased in FY10. The ALJ decision resulted in the employee not being referred to the registry in 23 percent of the appeal decisions in FY09 (7 of 30). For FY10 appeal decisions, this increased to 51 percent (18 of 35).

During FY09 and FY10, the OIG conducted annual unannounced site visits at all of the mental health and developmental centers as required by statute (20 ILCS 1305/1-17(i)). Also, during FY09 and FY10, the OIG met its established timeline for submitting site visit reports to facility directors or hospital administrators. The goal of these visits is to review systemic issues that may be related to the prevention of abuse or neglect of individuals receiving services in the facilities.

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

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

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

45-62)

OTHER ISSUES

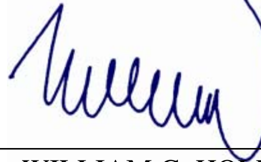
The Quality Care Board held all required quarterly meetings during FY09-10. However, the Board did not maintain the seven members that are required by statute.

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

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

RECOMMENDATIONS

The audit report contains nine recommendations; seven to the Office of the Inspector General, one to DHS, and one to both OIG and DHS. The Inspector General and DHS generally agreed with all nine of the recommendations. Appendix E to the audit report contains the Department of Human Services' and the Inspector General's responses.



WILLIAM G. HOLLAND
Auditor General

WGH:MSP

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