REPORT DIGEST

PROGRAM AUDIT OF

THE DEPARTMENT OF HUMAN SERVICES

OFFICE OF THE INSPECTOR GENERAL

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Office of the Auditor General

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SYNOPSIS

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

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

In this audit we also reported that:

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

REPORT CONCLUSIONS

The Abused and Neglected Long Term Care Facility Residents Reporting Act (Act) requires the Office of the Inspector General (OIG) to investigate allegations of abuse and neglect that occur in facilities operated by the Department of Human Services (DHS), as well as community agencies licensed, certified, or funded by DHS. In Fiscal Year 2004, DHS operated 17 State facilities and licensed, certified, or funded approximately 400 community agencies. Additionally, the Act requires the Office of the Auditor General to conduct a biennial program audit of the Inspector General's compliance with the Act. This is the eighth audit conducted of the OIG since 1990.

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

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

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

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

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

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

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

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

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

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

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

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

Alleged incidents of abuse and neglect are not being reported to the OIG by facilities and community agencies in the time frames required by OIG administrative rules. Although there was improvement since our last audit in 2002, we found that in Fiscal Year 2004, 10 percent of facility incidents and 42 percent of community agency incidents were not reported within the required four-hour time frame.

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

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

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

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

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

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

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

BACKGROUND

The Office of the Inspector General (OIG) was established by Public Act 85-223 in 1987 which amended the Abused and Neglected

Long Term Care Facility Residents Reporting Act (210 ILCS 30/1 *et seq*.). The Act required the Inspector General to investigate allegations of abuse and neglect within State-operated facilities serving the mentally ill and developmentally disabled. In 1995, the role of the Office of the Inspector General was expanded to include the authority to investigate reports of abuse or neglect at facilities or programs not only operated by the Department of Human Services (facilities), but also those licensed, certified, or funded by DHS (community agencies).

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

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

In the past, the Office of the Auditor General has conducted seven audits of the OIG to assess the effectiveness of its investigations into allegations of abuse and neglect, as directed under 210 ILCS 30/6.8. These audits were released in 1990, 1993, 1994, 1996, 1998, 2000, and 2002. (pages 4-8, 20)

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

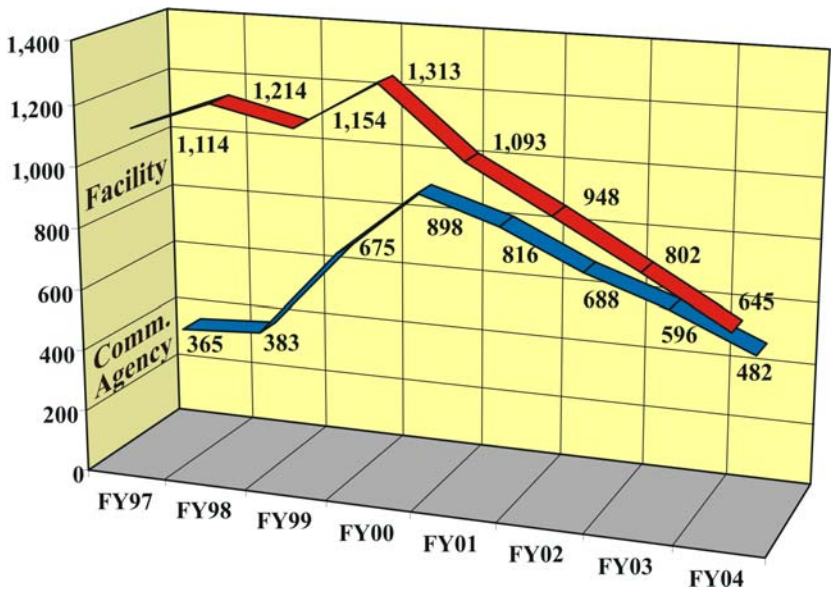
REPORTING OF ALLEGATIONS

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

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

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

Digest Exhibit 1
TOTAL ABUSE OR NEGLECT ALLEGATIONS REPORTED TO OIG



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

Source: OAG analysis of OIG data.

As a result of these changes:

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

OIG INVESTIGATIONS

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

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

OTHER STATE AGENCIES

Neither the OIG nor State Police are fulfilling statutory responsibilities established under the Abused and Neglected Long Term Care Facility Residents Reporting Act. The OIG and the Illinois State Police signed an interagency agreement in January 2003. The agreement, however, does not meet the statutory requirement established by the Act. The agreement provides guidance related to allegations involving State employees but not allegations against non-State employees (such as employees at community agencies) where evidence indicates a possible criminal act. (pages 17-19)

INVESTIGATION TIMELINESS

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

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

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

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

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

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

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

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

Source: OAG analysis of OIG data.

Illinois State Police

The OIG does not maintain documentation to record when cases are referred to the Illinois State Police. Statutes require that the OIG notify State Police within 24 hours of all allegations where a possible criminal act has been committed or where special expertise is required in the investigation. State Police must then investigate any report indicating a possible murder, rape, or other felony.

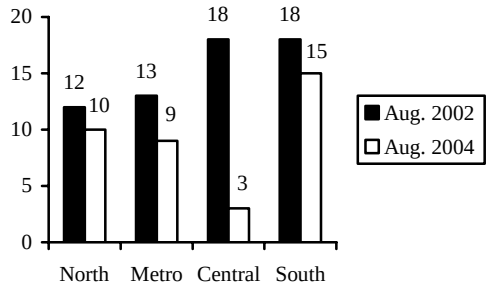
In our testing of Fiscal Year 2004 cases, we had five cases which were referred to State Police. The OIG refers these cases to the State Police by telephone and does not keep a record of these calls in the case files. However, the OIG was able to provide us with dates of the referrals for the five cases.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

Investigator Caseloads

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

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

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



Source: OIG data summarized by the OAG.

Timeliness of Investigative Interviews

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

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

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

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

Timeliness of Case File Reviews

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

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

Case Management System for Timeliness

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

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

TIMELY REPORTING OF ALLEGATIONS

Alleged incidents of abuse and neglect are not being reported to the OIG by facilities and community agencies in the time frames required by OIG administrative rules. The current administrative rules require that

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

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

Source: OAG analysis of OIG data.

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

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

INVESTIGATION THOROUGHNESS

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

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

Community Agency Investigations

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

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

- Community agencies now must accept the community agency protocol developed by the OIG and be properly trained or they will not be allowed to conduct <u>any</u> investigations for the OIG.
- As of January 1, 2002, OIG administrative rules were changed so that community agencies can investigate only abuse cases that allege mental injury.

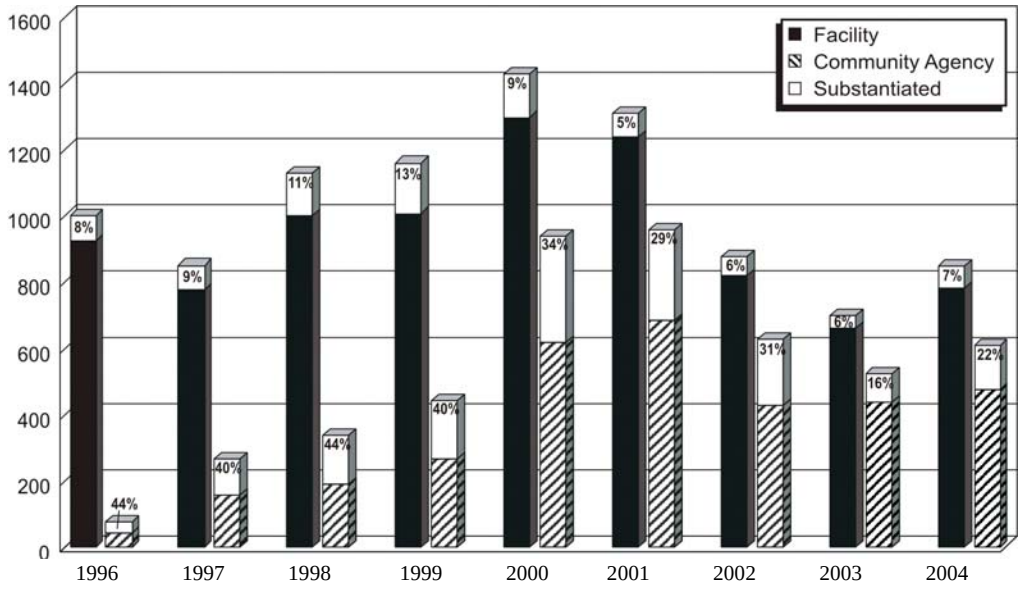
Community agencies are not being properly trained in basic investigative skills. Without proper training, investigative steps may not be completed properly and may hinder the investigation. Community agencies may take initial statements and collect evidence. In addition, the community agencies may not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

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

SUBSTANTIATED ABUSE AND NEGLECT CASES

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

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



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

Source: OAG analysis of OIG data.

OIG INVESTIGATOR TRAINING

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

The OIG did not comply with the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6.5) to provide continuing education to its investigators. The Act requires the OIG to establish a comprehensive program to ensure that every person employed or newly hired to conduct investigations shall receive training on an on-going basis. This training should be in the areas of investigative techniques, communication skills, and the appropriate means of contact with persons admitted or committed to the mental health or developmental disabilities facilities under the jurisdiction of DHS.

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

QUALITY CARE BOARD

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

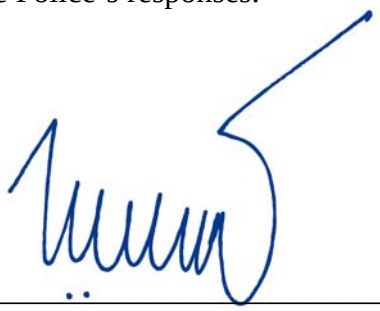
The Board minutes indicated that it had difficulty maintaining membership during this audit period. According to a Board official, the Board has not received the needed appointments for successors to fill vacant positions, nor has it received reappointments for members whose terms have expired. In June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

ANNUAL REPORT

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

RECOMMENDATIONS

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



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December 2004