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 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)

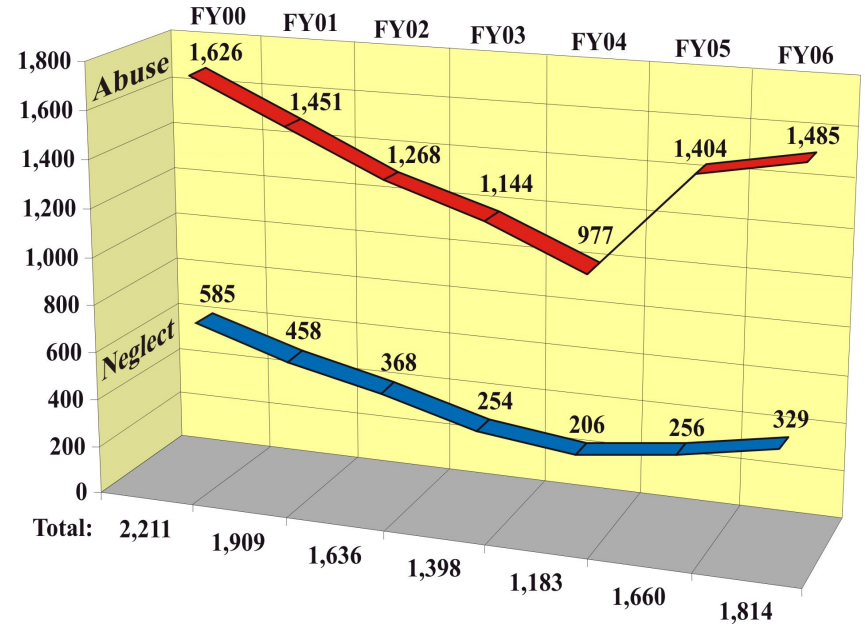
REPORTING OF ALLEGATIONS

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

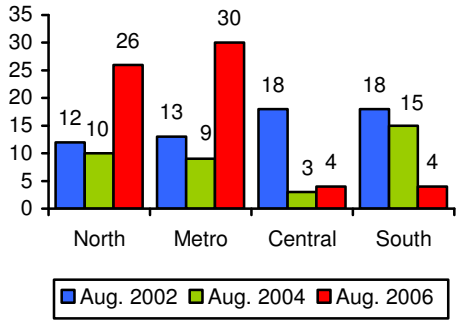
allegation was reported within the 24-hour reporting requirement found in the Act. (pages 28, 29)

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

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December 2006