STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PROGRAM AUDIT

OFFICE OF THE INSPECTOR GENERAL

DEPARTMENT OF HUMAN SERVICES

DECEMBER 1998

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OFFICE OF THE AUDITOR GENERAL
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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
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December 1998

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REPORT DIGEST

ILLINOIS DEPARTMENT OF HUMAN SERVICES

PROGRAM AUDIT: OFFICE OF THE INSPECTOR GENERAL

Release Date:

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State of Illinois
Office of the Auditor General

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SYNOPSIS

This is our fifth audit of the Office of the Inspector General's (OIG's) effectiveness in investigating allegations of abuse or neglect at facilities within the Department of Human Services (DHS). Overall the quality of OIG investigations has improved. Some findings have been repeated from our prior audits:

- Overall timeliness of the investigations has deteriorated since our December 1996 audit. Eighty-six percent of Fiscal Year 1998 investigations took longer than the 60 days allowed in DHS Policy. The number of cases taking more than 200 days to complete increased to 211 in Fiscal Year 1998 from 13 in Fiscal Year 1997.

- Case file documentation has improved since our last audit. We noted 18 percent of cases in our sample missing one or more required documents. In our prior audit, we reported that 44 percent were missing documentation.

- Supervisory review of case files needs to be improved. Of 186 OIG investigations requiring a supervisory review form, 30 (16%) did not have the form. Supervisory review also needs to be improved in investigations conducted by community agencies and facilities. Eighty-nine percent (77 of 87) of community and 32 percent (6 of 19) of facility investigations did not contain the appropriate case review documentation.

- Although the number of investigators who received all required training has improved, 12 of 30 investigators were lacking one or more of the 15 required courses. In addition, the OIG has not monitored the training received by facility investigators who conduct investigations and the initial steps in OIG investigations.

- The OIG has also not imposed or defined sanctions against facilities although the OIG has had statutory authority since January 1990.

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

REPORT CONCLUSIONS

The Office of the Inspector General closed 1,466 investigations of alleged employee abuse or neglect of DHS facility residents and community agency residents in Fiscal Year 1998 and 1,116 in Fiscal Year 1997.

Of these investigations closed in Fiscal Year 1998, 276 abuse or neglect allegations were substantiated. This increased the allegation substantiation rate from 16 percent in Fiscal Year 1997 to 19 percent in Fiscal Year 1998. The OIG also substantiated abuse or neglect in an additional 29 other incidents which were not alleged to be abuse or neglect at intake, for a total of 305 substantiated cases.

Overall the quality of OIG investigations has improved since our last audit. Case file documentation is more thorough, and final case reports are generally comprehensive, follow Investigation Guidelines, and address the allegation of abuse or neglect. There are, however, still areas for improvement.

Timeliness of cases closed has deteriorated in Fiscal Year 1998 with 86 percent of cases not completed within the 60 days allowed by DHS Policy. In Fiscal Year 1996 and 1997, 50 percent and 59 percent of cases respectively were not completed timely.

There was also a significant increase in the number of cases not completed within 200 days of being reported—211 in Fiscal Year 1998 and 13 in Fiscal Year 1997. Many of these cases in our sample lacked documentation of substantive reasons for delay.

Further, OIG Investigation Guidelines in effect during this audit eliminated many of the incremental case investigation timeliness requirements applicable in the last audit. For example, our sample of cases noted a median of 33 days for case review. Previous requirements allowed 3 days for case review.

Case file documentation has improved since the last audit. However, we found that 18 percent (34 of 186) of OIG investigations were missing one or more required documents. In our prior audit, 44 percent of case files were missing required case file documentation.

We continued to find problems with documentation of supervisory review. Of the cases requiring a supervisory case review form and status reports in our sample, 16 percent (30 of 186) did not have the review form and 48 percent (51 of 106) did not contain status reports.

New requirements established in statutes have not been fully implemented by the OIG. Statutes now require facilities and community agencies to submit a written response to the OIG in substantiated cases. In addition, the OIG is required to establish an appeals process to resolve differences between the OIG and the facilities and community agencies, and to report all substantiated cases to the Secretary of the Department of Human Services within ten days of a case becoming final.

Again in Fiscal Year 1998, the OIG has not imposed or defined sanctions against facilities although the OIG has had statutory authority since January 1990.

The number of OIG investigators who received all required training has improved. However, 12 of the 30 investigators (40%) were still lacking one or more of the 15 required courses. Our prior audit noted that 17 of 19 (89%) investigators were lacking one or more courses. In addition, the OIG has not monitored the training received by facility investigators who conduct facility investigations and the preliminary investigative steps in OIG investigations. Facility staff training should be monitored to ensure thorough and effective investigations.

OIG and other DHS employees are not reporting to the Department of Professional Regulation (DPR) as required in statutes. We found one instance in our sample of community cases where a private physician misdiagnosed a patient's condition, but we found no evidence that the instance was ever reported to DPR as required.

The OIG closed investigations conducted by facilities and community agencies which did not meet the standards the OIG uses in their investigations. OIG Investigation Guidelines contain criteria for approving community agency investigation protocols. OIG will begin approving community agency protocols when draft administrative rules are adopted.

Of the 15 audit recommendations made in the last audit, the OIG has either corrected the problem (4), not addressed the problem (3), eliminated requirements in procedures (2), or improved their performance (6). The following report addresses these issues and others that affect the thoroughness and effectiveness of OIG investigations of abuse and neglect.

BACKGROUND

The Inspector General's Office became part of DHS July 1, 1997.

The Office of the Inspector General was initially created by Public Act 85-223 within the Department of Mental Health and Developmental Disabilities (DMHDD). The Inspector General is appointed by the Governor and confirmed by the Senate for a four-year term. The current Inspector General was appointed in October 1995.

The OIG continued to operate as part of DMHDD through Fiscal Year 1997. Effective July 1, 1997 the Departments of Mental Health and Developmental Disabilities, Alcoholism and Substance Abuse, and Rehabilitation Services were merged into the newly formed Department of Human Services.

In Fiscal Year 1998, the Department of Human Services (as successor to DMHDD) operated 19 facilities Statewide. In addition, DHS licenses, certifies, or provides funding for over 350 separate organizations that provide services to the developmentally disabled and the mentally ill in community settings within Illinois.

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

In the past, the Office of the Auditor General has conducted four audits of the OIG to assess the effectiveness of their investigations into allegations of abuse and neglect, as directed under 210 ILCS 30/6.8. These audits were released in 1990, 1993, 1994, 1996 and this audit in 1998. Digest Exhibit 1 indicates the categories that findings fell into for each of these audits.

Digest Exhibit 1
AUDITOR GENERAL FINDINGS
CONCERNING THE OIG

Recommended Area for Improvement	May 1990	April 1993	December 1994	December 1996	December 1998
Duplicate Investigation				X (1)	X (1)
Timeliness	X (1)	X (1)	X (1)	X (2)	X (2)
Review		X (1)	X (1)	X (1)	X (1)
Documentation	X (3)	X (1)	X (2)	X (2)	
Monitoring	X (1)			X (1)	X (1)
Sanctions				X (1)	X (1)
Training	X (1)	X (1)		X (3)	X (2)
Investigations				X (1)	
Community Investigations				X (1)	X (1)
Investigative Logs/ Data Accuracy			X (1)	X (2)	
Site Visits	X (1)		X (1)		
Annual Report		X (1)	X (1)		
Staff			X (1)		
Year 2000 Compliance					X (1)
Reporting to DPR					X (1)
Matter for Consideration				X (1)	
Total Findings	7	5	9	15	11

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

Source: 1998 DHS Program Audit; 1993, 1994, 1996 DMHDD Program Audits; and 1990 Abuse and Neglect Program Audit.

In 1995, statutes clarified the role of the Office of the Inspector General expanding it to include the authority to investigate reports of abuse or neglect at facilities or programs not only operated by DHS, but also those licensed, certified or funded by DHS. This gives the OIG the authority to conduct investigations at community

agencies. The amendment does not require the community agencies to report all allegations of abuse and neglect to the OIG; therefore, there are likely incidents that go unreported.

During our audit, the OIG formally established a mission statement and goals. OIG administrative rules that were in draft form during this audit were finalized in October.

The OIG closed 1,466 investigations of alleged employee abuse or neglect of the Department of Human Services facility residents and community agency residents in Fiscal Year 1998 and 1,116 in Fiscal Year 1997. Of these investigations closed in Fiscal Year 1998, 276 abuse or neglect allegations were substantiated. The OIG also substantiated abuse or neglect in an additional 29 other incidents which were not alleged to be abuse or neglect at intake, for a total of 305 substantiated cases. (pp.1-5)

There are certain important components of an investigation into abuse and neglect. They include: whether the investigation is timely, whether the investigation is thorough, and whether corrective action is taken.

INVESTIGATION TIMELINESS

Overall timeliness of case completion deteriorated in FY 98.

The effectiveness of an investigation is diminished if it is not conducted in a timely manner. Timely completion of investigations is critical for an effective investigation, because as time passes, injuries heal, memories fade, or witnesses may not be located. DHS policy requires that investigations be completed as expeditiously as possible and should not exceed 60 days absent exceptional circumstances.

In Fiscal Year 1998, the overall timeliness of case completion deteriorated. Approximately 86 percent of cases closed in Fiscal Year 1998 took more than the 60 days allowed in DHS Policy to complete. In Fiscal Year 1997, 59 percent of cases exceeded the 60 day time requirement.

The number of cases taking more than 200 days to complete increased from 13 in FY 97 to 211 in FY 98.

In addition, the number of cases taking more than 200 days to complete increased to 211 (16%) in Fiscal Year 1998 from 13 (1%) cases in Fiscal Year 1997. Our measurement of the time to complete an investigation was taken from the time an incident was reported to the OIG until the OIG completion date. Overall it took an average of 130 days to complete an investigation of employee abuse or neglect in Fiscal Year 1998 and an average of 76 days in Fiscal Year 1997. Digest Exhibit 2 shows the number of days to investigate cases.

OIG Investigation Guidelines in effect during our audit eliminated many of the incremental case investigation timeliness requirements applicable in the last audit. One requirement involved supervisory review.

Digest Exhibit 2
NUMBER OF DAYS TO COMPLETE INVESTIGATIONS
Cases Closed During FY97 and FY98

	FY 97	%	FY 98	%
0-60	396	41%	187	14%
61-90	262	27%	242	19%
91-120	161	17%	212	16%
121-180	115	12%	384	29%
181-200	17	2%	72	6%
> 200	13	1%	211	16%
TOTAL	**964**		**1,308**	

Note: Data excludes cases investigated by State Police.

Source: 1997 and 1998 Investigations Log

We recommend that the OIG develop a process to ensure the timeliness in investigations and to ensure that case reports are reviewed in a timely manner. (pp.15-19)

INVESTIGATION THOROUGHNESS

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. The investigator's primary responsibility is to collect facts and information in order to accurately determine the manner in which the incident occurred.

Documentary evidence collection in OIG investigations has improved since the last audit.

Documentary evidence collection has improved since the last audit. However, improvement in overall case file thoroughness is still needed as was also cited in our four previous audits. In our sample of Fiscal Year 1998 cases, we found that 18 percent (34 of 186) of investigations conducted by OIG were missing one or more required documents. In our prior audit, 44 percent of case files were missing required case file documentation. Digest Exhibit 3 shows the percent of documents missing in Fiscal Year 1996 and Fiscal Year 1998. The OIG has improved in many areas.

Digest Exhibit 3
EXAMPLES OF MISSING DOCUMENTATION
FY 96 and FY 98

	Percent Missing	
Document	**FY 96**	**FY 98**
Injury Report	9%	7%
Photos	46%	26%
Diagrams	12%	9%
Shift Log	13%	9%
Visitor's Log	15%	26%
Progress Notes	7%	3%
Restraint/Seclusion Monitoring Record	7%	20%

Source: OAG analysis of 148 FY 98 and 278 FY 96 closed OIG abuse or neglect investigations.

The Abused and Neglected Long Term Care Facility Residents Reporting Act (Act) requires the OIG to investigate all allegations of abuse and neglect at State-operated facilities and complaints of abuse and neglect at community agencies. Other incidents and self-reported allegations of abuse and neglect at community agencies are investigated by the community agency.

Documentary evidence collection in investigations conducted by facilities and community agencies needs improvement.

We sampled incidents that were delegated to State operated facilities and community agencies. In our sample, we noted a significant difference in the documentation in these case files to those investigations conducted by the OIG. Eleven percent (2 of 19) of the facility investigations and 22 percent (19 of 87) of the community agency investigations in our sample were missing at least one of the documents the OIG requires in their investigations.

Supervisory Review

The second element of an effective investigation is case review and monitoring. We continued to find problems with supervisory review of case files and monitoring of open investigations similar to those noted in our prior audits. In our sample of allegations investigated by OIG, 16 percent (30 of 186) did not contain the required review form.

We continue to find problems with supervisory review in both OIG and facility and community agency investigated cases.

In addition, there was not any evidence of review in some of the facility and community agency investigated cases because they did not contain any of the review forms required in OIG case files. Eighty-nine percent (77 of 87) of community and 32 percent (6 of 19) of facility cases did not contain the appropriate case review documentation.

Case Reports

A third element of an effective investigation is a clear and convincing case report. In our sample of OIG cases closed in Fiscal Year 1998, we noted that all of the cases contained a case report of some kind.

Case reports in our sample of non-OIG investigated cases were significantly different from those conducted by the OIG investigators. Community agency case reports of abuse and neglect were missing in 4 of 26 cases (15%) in our sample and only 2 of 26 contained all elements of an OIG case report.

Only 11 of 19 facility and 14 of 61 community agency investigations of other incidents in our sample contained case reports. None of these reports from facilities and

community agencies included all of the elements required in OIG case reports**.** (pp. 4,7, 23-31)

ACTIONS, SANCTIONS, AND RECOMMENDATIONS

The facilities and community agencies took some kind of action in 95 percent of FY 98 cases substantiated by the OIG.

Of the 1,466 abuse and neglect cases closed in Fiscal Year 1998, the OIG substantiated abuse or neglect in 276 cases. The OIG also substantiated abuse or neglect in an additional 29 other incidents which were not alleged to be abuse or neglect at intake, for a total of 305 substantiated cases. In Fiscal Year 1998, facilities or agencies took some kind of action in 95 percent of cases substantiated by the OIG.

Administrative action, such as suspension or termination, against employees was used in 251 (82%) of these cases. Digest Exhibit 4 shows actions taken in cases substantiated by the OIG and who investigated the case.

Digest Exhibit 4
ACTIONS TAKEN ON SUBSTANTIATED CASES
Fiscal Year 1998

Action	Investigated by OIG	Investigated by Community Agency
Administrative Action	149	102
General Retraining	2	4
Policy Creation/Revision	6	3
Procedure Clarified	5	3
Specific Staff Retraining	6	5
Facility Structure Change	1	0
Treatment/Program Change	3	0
No Action	10	6
Total Substantiated	182	123

Source: OAG analysis of OIG 1998 Investigation Log

Amendments to the Act established new requirements for the OIG which have not been fully implemented. Statutes now:

- Require facilities and community agencies to submit a written response in substantiated cases,

- Require an appeals process to resolve differences between the OIG and the facilities and community agencies, and

- Require the OIG to report all substantiated cases to the Secretary of the Department of Human Services within ten days of completion (210 ILCS 30/6.2).

Written response had been submitted in 56 of 182 substantiated cases investigated by OIG. Of the 56 substantiated cases with written responses, 45 were facility cases and 11 were community agency cases. Only 3 of 123 substantiated cases investigated by community agencies had written responses.

In Fiscal Year 1998, there were 3 of the 305 cases where the allegation of abuse or neglect was substantiated but the facility/agency did not accept the recommendation of the OIG. However, there were no cases where the facility or community agency used either the new formal appeals process required in statutes or reported to the Secretary of the Department of Human Services to reconcile the difference of opinion.

Sanctions

The OIG has not recommended sanctions against facilities nor have they developed criteria for when a recommendation should be made.

The OIG enabling statute (210 ILCS 30/6.2) allows the OIG to recommend sanctions to be imposed against the facilities for the protection of residents including appointment of on-site monitors, transfers or relocation of residents, and closure of units.

The OIG has not issued sanctions against any facility during the last three years. The OIG has also not developed formal written criteria to determine when sanctions should be recommended.

In Fiscal Year 1998, the OIG did, however, conduct annual unannounced site visits of all State operated facilities as required by 210 ILCS 30/6.2. The OIG developed a site visit protocol using input from consumers, advocates, family members, facility and Department administrators, other Department staff, and OIG investigators. (pp. 33-39)

OTHER ISSUES

During the course of our audit we identified other issues that may affect the conduct and effectiveness of investigations at the OIG.

To conduct an effective investigation, OIG investigators must be adequately trained. The criteria for OIG investigator training are clearly defined in OIG's policies and procedures.

Not all OIG investigators have received required training.

Training has improved since the last audit, however, not all OIG investigators are receiving the training that is required by OIG policy and the Act. Of the 30 investigators, 12 (40%) were lacking one or more of the 15 required courses. Digest Exhibit 5 shows the number of missing courses by investigator.

Digest Exhibit 5
NUMBER OF INVESTIGATORY COURSE DEFICIENCIES BY OIG INVESTIGATORS

Number of Courses Needed	Number of Investigators
None	18
1-4 courses needed	7
5-9 courses needed	2*
10 or more courses needed	3**

* One person was employed for 1 month at the start of Fiscal Year 1998.
**These individuals were employed in February, March and June of 1998.

Source: OAG analysis of OIG data.

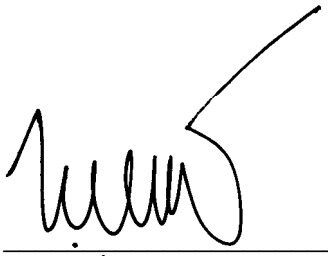
The OIG does not monitor the training of facility staff who conduct investigations and conduct the initial steps in OIG investigations.

The OIG does not monitor the training received by staff that conduct investigations at the facilities unless training is provided or sponsored by the OIG. Facility staff should also receive appropriate training since they routinely conduct the initial steps of the investigation such as taking initial statements. Facility staff may also conduct investigations of other incidents at the facilities.

Another issue that may affect OIG operations concerns the OIG Investigations Log. The OIG has not yet ensured that the Investigations Log is Year 2000 compliant.

Finally, the OIG and DHS employees have not been reporting to the Department of Professional Regulation (DPR) as required in statute. We found one instance in our sample of community agency cases where a private physician misdiagnosed a patient's condition but we could find no evidence that the instance was ever reported to DPR as required. (pp. 41-46)

The audit report contains 11 recommendations related to the Office of the Inspector General. The OIG agreed with all of the recommendations. Appendix E to the audit report contains the Inspector General's complete responses.



WILLIAM G. HOLLAND
Auditor General

WGH:KJM

December 1998

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Chapter One

REPORT CONCLUSIONS

The Office of the Inspector General (OIG) closed 1,466 abuse or neglect investigations of the Department of Human Services (DHS) facility residents and community agency residents in Fiscal Year 1998 and 1,116 in Fiscal Year 1997.

Of these investigations closed in Fiscal Year 1998, 276 abuse or neglect allegations were substantiated. This increased the allegation substantiation rate from 16 percent in Fiscal Year 1997 to 19 percent in Fiscal Year 1998. The OIG also substantiated abuse or neglect in an additional 29 other incidents which were not alleged abuse or neglect at intake, for a total of 305 substantiated cases.

Overall the quality of OIG investigations has improved since our last audit. Case file documentation is more thorough, and final case reports are generally comprehensive, follow Investigation Guidelines, and address the allegation of abuse or neglect. There are, however, still areas for improvement.

Timeliness of cases closed has deteriorated in Fiscal Year 1998 with 86 percent of cases not completed within the 60 days allowed by DHS Policy. In Fiscal Years 1996 and 1997, 50 percent and 59 percent of cases respectively were not completed timely.

There was also a significant increase in the number of cases not completed within 200 days of being reported - 211 in Fiscal Year 1998 and 13 in Fiscal Year 1997. Many of these cases in our sample lacked documentation of substantive reasons for delay.

Further, OIG Investigation Guidelines in effect during this audit eliminated many of the incremental case investigation timeliness requirements applicable in the last audit. For example, case review took a median of 33 days. Previous requirements allowed 3 days for case review.

Case file documentation has improved since the last audit. However, we found that 18 percent (34 of 186) of OIG investigations were missing one or more required documents. In our prior audit, 44 percent of case files were missing required case file documentation.

We continued to find problems was with documentation of supervisory review. Of the cases requiring a supervisory case review form and status reports in our sample, 16 percent (30 of 186) did not have the review form and 48 percent (51 of 106) did not contain status reports. However, when review forms were available, they contained substantive comments.

New requirements established in statutes have not been fully implemented by the OIG. Statutes now require facilities and community agencies to submit a written response to the OIG in substantiated cases. In addition, the OIG is required to establish an appeals process to resolve differences between the OIG and the facilities and community agencies, and to report all substantiated cases to the Secretary of the Department of Human Services within ten days of a case becoming final.

Again in Fiscal Year 1998, the OIG has not imposed or defined sanctions against facilities for which they have had statutory authority. Since January 1990, statutes have authorized the OIG to recommend to the Department of Public Health (DPH) and the Department of Human Services (DHS) that sanctions be imposed against facilities operated by DHS for the protection of the residents.

In Fiscal Year 1998 the OIG conducted unannounced site visits at all of the State operated facilities using a site visit protocol developed during 1996 and adopted in January 1997.

The number of OIG investigators who received all required training has improved. However, 12 of the 30 investigators (40%) were still lacking one or more of the 15 required courses. Our prior audit noted that 17 of 19 (89%) investigators were lacking one or more courses. In addition, the OIG has not monitored the training received by facility investigators who conduct facility investigations and the preliminary investigative steps in OIG investigations. Facility staff training should be monitored to ensure thorough and effective investigations.

OIG and other DHS employees are not reporting to the Department of Professional Regulation (DPR) as required in statutes. We found one instance in our sample of community cases where a private physician misdiagnosed a patient's condition but we found no evidence that the instance was ever reported to DPR as required.

We also found problems with investigations conducted by facilities and community agencies. OIG investigates only those allegations of abuse or neglect involving staff, or those with the potential for abuse or neglect by staff. OIG delegates the investigations of other incidents to the facilities or community agencies. OIG then reviews and accepts these other investigations to fulfill its statutory responsibility to investigate all abuse or neglect allegations.

The OIG closed investigations conducted by facilities and community agencies which did not meet the standards the OIG uses in their investigations. OIG Investigation Guidelines contain criteria for approving community agency investigation protocols. OIG will begin approving community agency protocols when draft administrative rules are adopted.

Because facility and community agency conducted investigative case files did not follow OIG guidelines for content, review documentation and organization, we were unable to determine whether the investigation was thorough and effective.

Of the 15 audit recommendations made in the last audit, the OIG has either corrected the problem (4), not addressed the problem (3), eliminated requirements in procedures (2), or improved their performance (6). The following report addresses these issues and others that affect the thoroughness and effectiveness of OIG investigations of abuse or neglect.

BACKGROUND

The Office of the Inspector General (OIG) was initially created by Public Act 85-223 within the Department of Mental Health and Developmental Disabilities (DMHDD). The Inspector General is appointed by the Governor and confirmed by the Senate for a four-year term. The current Inspector General was appointed in October 1995. Prior to 1987, all cases of abuse or neglect were reported to the Department of State Police, Division of Internal Investigations (DII). If DII elected not to investigate, it was the facility director's responsibility to investigate the case. Facility investigations were then reviewed by the DMHDD Office of Internal Review.

The OIG continued to operate as part of DMHDD through Fiscal Year 1997. Effective July 1, 1997 the Departments of Mental Health and Developmental Disabilities, Alcoholism and Substance Abuse, and Rehabilitation Services were merged into the newly formed Department of Human Services (DHS). In addition, parts of the Department of Public Aid, Department of Public Health, and the Department of Children and Family Services (DCFS) were also incorporated into DHS.

In FY 98, the Department of Human Services (as successor to DMHDD) operated 19 facilities Statewide. Nine facilities served the developmentally disabled, eight facilities served the mentally ill, and two facilities served both. Prior to 1995 there were 21 facilities, but the Meyer Mental Health Center was closed in December 1996 and Chicago Metropolitan Child & Adolescent Center was closed in June 1997. Exhibit 1-2 shows the location of the 19 facilities and indicates whether the facilities are part of the OIG's Northern Bureau of Investigations or the Southern Bureau of Investigations. In addition, the Department licenses, certifies, or provides funding for over 350 separate community agency programs that provide services to the developmentally disabled and the mentally ill in community settings within Illinois. These community agency programs provide

transportation services, workshops, or community living arrangements, and are referred to as community agencies.

Past Audits

In the past, the Office of the Auditor General has conducted four audits of the OIG to assess the effectiveness of their investigations into allegations of abuse or neglect, as directed under 210 ILCS 30/6.8. These audits were released in 1990, 1993, 1994, 1996 and this audit to be released in 1998. Exhibit 1-1 indicates the categories that findings fell into for each of these audits.

Exhibit 1-1
AUDITOR GENERAL FINDINGS
CONCERNING THE OIG

Recommended Area for Improvement	May 1990	April 1993	December 1994	December 1996	December 1998
Duplicate Investigation				X (1)	X (1)
Timeliness	X (1)	X (1)	X (1)	X (2)	X (2)
Review		X (1)	X (1)	X (1)	X (1)
Documentation	X (3)	X (1)	X (2)	X (2)	
Monitoring	X (1)			X (1)	X (1)
Sanctions				X (1)	X (1)
Training	X (1)	X (1)		X (3)	X (2)
Investigations				X (1)	
Community Investigations				X (1)	X (1)
Investigative Logs/ Data Accuracy			X (1)	X (2)	
Site Visits	X (1)		X (1)		
Annual Report		X (1)	X (1)		
Staff			X (1)		
Year 2000 Compliance					X (1)
Reporting to DPR					X (1)
Matter for Consideration			X (1)		
Total Findings	**7**	**5**	**9**	**15**	**11**

Note: The number in parentheses indicates the number of recommendations in the report on that topic.
Source: 1998 DHS Program Audit to be released by January 1, 1999; 1993, 1994, 1996 DMHDD Program Audits; and 1990 Abuse or Neglect Program Audit.

There have been findings and recommendations concerning timeliness in all of our audits. Case file documentation and training issues have appeared as findings and recommendations in four of our five audits.

OIG Authority

Since August 1987, the Abused and Neglected Long Term Care Facility Residents Reporting Act (Act) (210 ILCS 30/*et seq*.) has been amended several times, most recently in July 1997. In 1995, the role of the Office of the Inspector General was clarified and expanded to include the authority to investigate reports of abuse or neglect at facilities or programs not only operated by DHS, but also those licensed, certified or funded by DHS. This gives the OIG the authority to conduct investigations at community agencies. The amendment does not require the community agencies to report all allegations of abuse or neglect to the OIG, therefore there are likely incidents that go unreported. The amendment also required the OIG to promulgate rules to establish guidelines and requirements for investigations and how the OIG would interact with the licensing unit of DHS. The Act did not specify a deadline for the rules. The draft rules were being finalized during our audit work but were adopted in October 1998, while the audit report was being finished.

OIG Mission

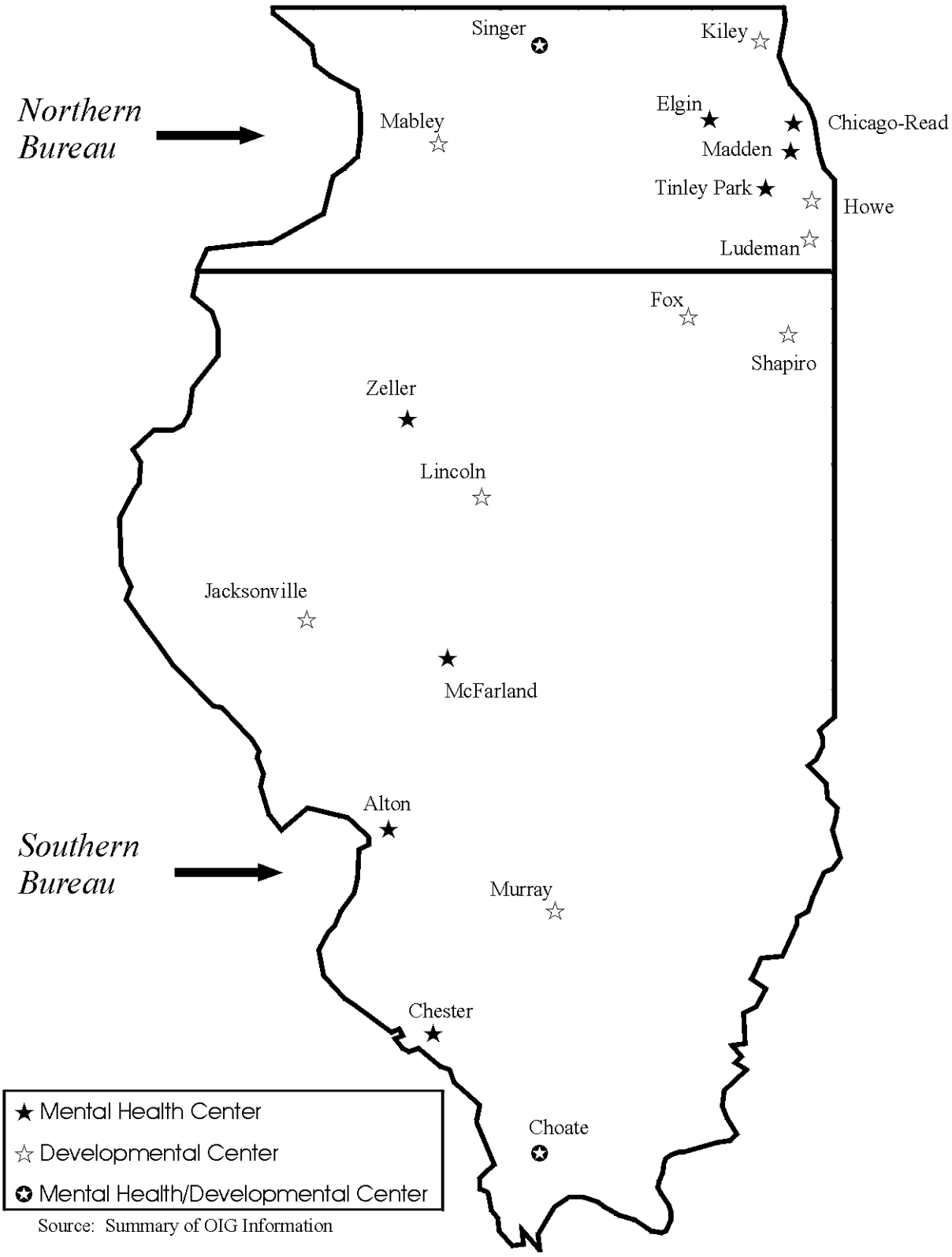
According to statutes, the primary purpose of the OIG is to investigate alleged incidents of abuse or neglect reported at facilities operated, licensed, certified, or funded by DHS. During our audit, the OIG developed a mission statement along with goals and objectives to guide future operations. The OIG's mission is " to identify, evaluate, and communicate the prevention of abuse or neglect." The OIG's goals and objectives include the following:

- defining clearly the responsibilities of the OIG in terms of which investigations are to be conducted by OIG investigators and those to be delegated to the facilities and community agencies.
- making the OIG organizationally independent from the facility staff to eliminate any perception of conflict of interest;
- improving the representation of recipients in the disciplinary arbitration process; and
- expanding the application of the zero tolerance policy for physical abuse cases.

Prior to the development of this mission and goals, the OIG stated that they used the statute to guide their operations. OIG officials stated that the mission and goals would be distributed to all staff. Although the OIG was established over 10 years ago, and the current Inspector General was appointed in October 1995, the OIG has only recently formalized their mission and goals.

Exhibit 1-2

DHS OPERATED RESIDENT FACILITIES



Source: Summary of OIG Information

Agency Organization

During the audit period, the OIG was divided into three bureaus plus an Intake Assessment Section under the Inspector General:

- The **Bureau of Investigations** is responsible for investigating cases of abuse or neglect at State-operated DHS facilities and at community agencies. The Bureau divides investigation responsibilities into two areas: the Northern Bureau covers the northern one-third of the State and the Southern Bureau covers the southern two-thirds of the State. Both Bureaus operate together as a single system.

- The **Bureau of Training and Technical Support** is responsible for coordinating and tracking training received by OIG investigators.

- The **Bureau of Evaluation and Review** conducts internal studies and unannounced site visits to facilities.

During FY 98, the OIG had 52 staff consisting of 30 investigators, 7 management, 9 professional (non-supervisory), and 6 clerical staff (one investigator and one clerical staff were employed for only one month each in FY 98). There were a total of 15 investigators located in the Southern Bureau and 15 located in the Northern Bureau.

INVESTIGATIONS OF ABUSE OR NEGLECT AT STATE-OPERATED FACILITIES AND COMMUNITY AGENCIES

The Office of the Inspector General is required by the Act to investigate all reported incidents of abuse or neglect at State operated facilities. OIG may also investigate reports of alleged abuse or neglect at State funded or DHS licensed facilities (community agencies) (210 ILCS 30/6.2).

Abuse is defined in statute as “any physical injury, sexual abuse, or mental injury inflicted on a resident other than by accidental means.” Statute defines neglect as “a failure in a long term care facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a resident’s physical or mental condition” (210 ILCS 30/3). According to the OIG FY 97 annual report, the Department’s policy is based on this definition; however, it defines abuse in terms of actions by staff responsible for the care and treatment of the individual.

Exhibit 1-3 shows the types of incidents that are required by this policy to be reported to OIG. Using the OIG interpretation of the statute, there are four different types of investigations. The first two types are OIG investigations of abuse or neglect at State operated facilities and those that statue authorizes the OIG to conduct at community agencies which involve mistreatment of residents by facility or agency staff. The other two types are investigations conducted by facility staff and community agency staff at their respective locations which do not involve mistreatment of residents by staff, such as theft or other misconduct.

As shown in Exhibit 1-3, OIG policy distinguishes between mistreatment of residents by employees and incidents which are not necessarily attributable to staff. The OIG FY 97 annual report says that the OIG's primary role is the investigation of allegations of abuse or neglect by employees. Consequently, OIG has investigated only those cases described in the left side of Exhibit 1-3, where the allegation involves staff, or where there is the potential for abuse or neglect by staff. OIG delegates the investigations of other incidents (reflected in the right side of Exhibit 1-3) to the facilities or community agencies that report them. OIG then reviews and accepts these other investigations to fulfill its statutory responsibility to investigate all abuse or neglect.

Exhibit 1-3
TYPES OF INCIDENTS REPORTABLE TO THE INSPECTOR GENERAL

ABUSE OR NEGLECT	OTHER REPORTABLE INCIDENTS
Mistreatment of Residents by Employees: 1a. Physical abuse requiring emergency medical 1b. Other physical abuse 1c. Sexual abuse 1d. Verbal/psychological abuse 1e. Neglect	1f. Other improper employee conduct 2. Resident Death 3. (a) Injuries requiring emergency medical treatment or (b) treatment non-accidental injuries inflicted by another person 4. Unauthorized resident absence from a facility 5. Certain sexual incidents between residents 6. Theft of resident property 7. All other allegations of misconduct, malfeasance, misfeasance or other conduct serious enough to warrant reporting

Source: DHS Policy and Procedures Directive 01.05.06.03

OIG INVESTIGATION PROCESS

Since the 1995 amendment to the Act gave the OIG the authority to investigate allegations of abuse or neglect at community agencies, the OIG kept those investigations separate from the facility investigations. There was a separate Bureau of Community Investigations with its own investigators and its own investigative procedures. However, beginning in March 1997 the OIG combined the investigators into one bureau for all investigations, no longer distinguishing between the two. Investigators now use the same policies, procedures, investigation methodologies, and investigation guidelines on both types of investigations.

The investigation process begins when an allegation is reported and an intake form is completed. The case is then assigned to the investigator responsible for that facility or region. Facility personnel collect physical evidence and interview staff and residents about the alleged abuse or neglect as instructed by the OIG investigator. The investigator reviews case information, develops an investigative plan, and conducts the investigation at the facility or community agency. At the conclusion of the investigation, a "Preliminary Report" is prepared which describes the investigation methodology and its conclusion. This report is reviewed by designated case reviewers and then by the Bureau Chief. Only substantiated cases are reviewed by the Acting Deputy Inspector General. The OIG sends a Cover Memo to the facility or community agency stating the findings and recommendations in the case. The facilities can request a reconsideration or clarification of the case findings if there is a disagreement. If abuse or neglect is substantiated, the facilities/agencies are required to submit a written response to the OIG which includes implementation dates. Statutes do not require OIG staff to review the written response. Therefore, once the written response is received, the case can be closed.

OTHER STATE AGENCIES

While the Act requires OIG to investigate abuse or neglect, other State agencies also have statutory responsibility to investigate potential instances of abuse or neglect. The Departments of Children and Family Services, Public Health, and State Police all must investigate certain instances of abuse or neglect. Amendments to the Act require OIG to promulgate rules which set forth instances where two or more State agencies could investigate an allegation so that OIG investigations do not duplicate other investigations.

Illinois State Police

State Police is required to investigate all instances of potential criminal activity. The Act requires the OIG to notify State Police within 24 hours of receiving an allegation where a possible criminal act has been committed. State Police then decides if there is possible criminal activity. If so, they investigate the case; if not, the case is referred back to OIG to investigate. OIG policy requires that the following incidents be reported to State Police for possible criminal investigation: physical abuse or neglect with a serious injury; sexual abuse with either credible evidence or injury; criminal activity within 14

days of discharge; transactions where an employee receives personal gain or profit; all deaths; and other incidents deemed appropriate by OIG.

However, even in cases investigated by the State Police, OIG may conduct a separate investigation after the State Police investigation is completed. State Police officials stated that this is because they only look at the criminal aspects of the incident; it is up to 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, their investigations focus on regulatory issues, which include State Administrative Code, Medicare, and Medicaid. Public Health said their investigations are not duplicative of OIG investigations because they look for regulatory issues, not specific instances of personnel abuse or neglect. However, OIG investigations often examine the policies and procedures in place as well. In fact, OIG investigative guidelines require a Second Cover Memorandum be sent to the facility or community agency when the investigation has revealed an issue of a systemic nature. We noted several such memos in our review of OIG case files.

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 of all persons under the age of 18 to DCFS. DCFS then has 14 days to investigate and determine if the abuse or neglect is indicated and a total of 60 days to conduct the investigation. Officials at DCFS stated that they occasionally conduct joint investigations with OIG.

Duplicated Investigations

Draft OIG rules did not include provisions that set forth that the OIG will not conduct duplicate investigations at State operated facilities to investigations conducted by another State agency. The OIG would potentially conduct duplicate investigations with the Departments of State Police, Public Health, and Children and Family Services. During the audit period, the OIG had interagency agreements with State Police and Public Health, but neither address procedures for handling situations where investigations may be duplicated. The State Police agreement specifies the types of incidents that OIG should refer. The agreement with Public Health gives both agencies the authority to investigate and requires that they share the results of completed investigations; it also allows Public Health to delegate its investigative authority to OIG. There is currently

no final agreement with DCFS, although an agreement has been drafted and both agencies are reviewing the document.

Statutes do address the issue of duplication. An amendment to the Act requires that OIG's "promulgated rules shall clearly set forth that in instances where 2 or more State agencies could investigate an allegation of abuse or neglect, the Inspector General shall not conduct an investigation that is redundant to an investigation conducted by another State agency." OIG draft rules contained a provision stating that for investigations conducted at community agencies, OIG will not conduct a redundant investigation. Investigations at State operated facilities were not addressed. Therefore, the potential for duplicative investigations still exists. In addition to not complying with the legislative mandate, having more than one agency investigate the same incident may result in inefficient use of State resources.

Recommendation Number One:

The Inspector General should comply with the provisions of 210 ILCS 30/6.2 and include in its rules provisions that set forth that OIG will not conduct an investigation that is redundant to an investigation conducted by another State agency at State operated facilities. These provisions could be further clarified in interagency agreements between OIG and other State agencies that conduct investigations of abuse or neglect.

(RECOMMENDATION REPEATED FROM DECEMBER 1996)

Office of Inspector General's Response:

Agreed. In compliance with the statute, the new administrative Rule, which became effective in October 1998, and OIG Guidelines are designed to avoid duplicate investigations as much as possible; for example, OIG administrative investigations do not duplicate State Police's criminal investigations. However, by April 1, 1999, we will submit a revision to the Rule's current prohibition at community agencies to also include the Department's facilities. By July 1, 1999, we will work with other state agencies to clarify applicable interagency agreements to specifically state this as well.

TRENDS IN ALLEGATIONS OF ABUSE AND NEGLECT

Based on the Department definition of incidents reportable to OIG (see Exhibit 1-3 on page 8), OIG receives reports on several types of incidents, including those that are suspected to be abuse or neglect by staff. In FY 98, 6,509 total incidents were reported to OIG. When the incident is suspected to be mistreatment by staff, it is usually classified in the categories 1a to 1e listed in Exhibit 1-3.
Exhibit 1-4 shows the total numbers of incidents reported to OIG and the number that were suspected to be abuse or neglect when reported.

As shown in Exhibit 1-4, the number of total incidents reported to OIG dropped significantly between FY 95 and FY 96 and remained fairly constant between FY 96 and FY 98. The number of abuse or neglect allegations, those incidents classified as "1a" to "1e" at intake, has increased, with the exception of a decline in 1996. OIG officials stated they are currently analyzing why the number of allegations of abuse or neglect reported increased so much between Fiscal Years 1996 and 1997. They said that each facility with increases is being studied more closely. A previous study of increases in allegations of abuse or neglect conducted by the OIG came to no conclusive reason for the increases.

OIG investigates the incidents that are suspected to be staff abuse or neglect of residents, which are classified by Department policy as "1a" through "1e" (listed in Exhibit 1-3). However, sometimes OIG suspects possible abuse or neglect in the other incidents reported under the policy that are not actually classified as abuse or neglect. Whenever abuse or neglect is suspected, regardless of the classification of the case, OIG will investigate the case.

The OIG annual reports have traditionally reported the investigations of incidents classified as "1a" to "1e" separately from those investigations OIG conducted of other incidents. However, reporting information on all incidents investigated by OIG together gives a clearer picture of how OIG is meeting its statutory requirement to investigate all allegations of abuse or neglect.

Exhibit 1-4
TOTAL INCIDENTS REPORTED TO OIG
Fiscal Years 1995-1998

Fiscal Year	Abuse/ Neglect	Other	Total
1995	987	6,387	7,374
1996*	945	5,512	6,457
Facility	838	5,512	6,350
Community	107	**	107
1997	1,479	5,278	6,757
Facility	1,114	4,999	6,113
Community	365	279	644
1998	1,597	4,912	6,509
Facility	1,214	4,524	5,738
Community	383	388	771

* Authorization for conducting community agency investigations effective December 7, 1995.

** Community agency information not reported by OIG.

Source: OAG 1996 Program Audit, 1996 Annual Report, and OIG Investigation Log

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.

Initial work began on this audit in January 1998 and Fieldwork was concluded in September 1998. We interviewed representatives of the Inspector General's Office, the Department of Public Health, Department of State Police, and the Department of Children and Family Services. We reviewed documents at the Inspector General's Office, State Police, DCFS, and Public Health and interagency agreements with State Police and Public Health and a draft interagency agreement with DCFS. 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 audit and reviewed statistics from the Investigations Log. Our audit work included follow-up on previous audit recommendations, standards used to conduct investigations, and training requirements of staff.

We assessed risk by reviewing recommendations from all four previous OAG audits, OIG internal documents, policies and procedures, management controls, and statutory amendments. Assessing the effectiveness of investigations was the primary objective of the audit. Compliance with the Act was also reviewed as a part of this audit.

The Auditor General's Office has previously conducted four program audits which reviewed the Office of the Inspector General's effectiveness in investigating alleged cases of abuse or neglect. The Auditor General's Office has also released three other audit reports concerning abuse or neglect reporting that described trends and patterns in State-operated facilities. These were released in November 1992, June 1994, and April 1996.

REPORT ORGANIZATION

Chapter Two examines the timeliness of OIG investigations.

Chapter Three discusses the thoroughness of OIG investigations and the OIG case review process.

Chapter Four reviews actions, sanctions, and recommendations.

Chapter Five discusses training, reporting to the Department of Professional Regulation, and OIG database Year 2000 compliance.

TIMELINESS OF ABUSE OR NEGLECT INVESTIGATIONS

Chapter Two

CHAPTER CONCLUSIONS

In Fiscal Year 1998 the overall timeliness of case completion has deteriorated. Approximately 86 percent of cases closed in Fiscal Year 1998 took more than the 60 days allowed in DHS Policy to complete. In Fiscal Year 1997, 59 percent of cases exceeded the 60 day time requirement.

In addition, the number of cases taking more than 200 days to complete increased to 211 (16%) in FY 98 from 13 (1%) cases in FY 97. These cases in our sample often did not contain the required 60 Day Status Report. If the report was present, it often did not indicate substantive reasons for the delay.

OIG Investigation Guidelines in effect during our audit eliminated many of the incremental case investigation timeliness requirements applicable in the last audit. We noted that case review took a median of 33 days in FY 98 as compared to 22 days in FY 97. During our previous audit, case file reviews were required to be completed in three days. In this audit, we also noted an average of 51 days for the OIG investigator to conduct an interview. Our previous audit noted an average of 35 days to conduct an interview.

In substantiated cases, the OIG procedure for implementing notification and response requirements do not fully conform with statutory time and document requirements for reporting to the Secretary of the Department of Human Services.

INVESTIGATION TIMELINESS

The effectiveness of an investigation is diminished if it is not conducted in a timely manner. In our last audit 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. Department of Human Services policy requires that investigations be completed as expeditiously as possible and should not exceed 60 days absent exceptional circumstances.

Overall timeliness of the OIG's investigations has been an issue in the previous four audits, and is again in FY 98. The percentage of cases taking more than the required 60 days to complete increased significantly in FY 98 to 86 percent (1,121 of 1,308). Our

previous audit which covered Fiscal Year 1996 reported only 50 percent of cases not closed within the 60 days required by DHS Policy. Fiscal Year 1997 had 59 percent (568 of 964) of cases over 60 days.

Timeliness Requirements Eliminated in Investigation Guidelines

In addition to overall timeliness, Investigation Guidelines from prior periods contained several incremental timeliness for completion of various stages of an abuse or neglect investigation. Only the DHS policy requirement that investigations be completed within 60 days of the incident report remained for this audit. Timeliness used in previous audits to measure OIG's effectiveness that were eliminated from guidelines in effect during the audit period include:

- 3 days from the incident report to collect the initial investigation documentation and complete the checklist used by facility staff to collect the information;
- 3 day review requirement in the Investigation Guidelines; and
- 3 days before, the day of, and 1 day after an incident occurred collection of progress notes.

There was, however, a new time requirement added by an amendment to the Act (P.A. 90-252) which allows the Inspector General 10 days after the transmittal of a completed investigation where abuse or neglect is substantiated or administrative action is recommended to provide a report on the case to the Secretary of Human Services and to the agency in which the abuse or neglect is alleged to have happened. The statute also states that the report is to include a written response from the facility or agency to the case. This requirement has been difficult for the OIG to implement and is discussed later in this chapter.

For purposes of comparison to previous audits, the following sections measure the results to various timeliness even though some are no longer required in the Investigation Guidelines.

Cases Taking Over 200 Days to Complete

In FY 98, the number of cases taking over 200 days to complete increased significantly. In FY 97, there were only 13 of 964 (1%) cases closed that took over 200 days to complete. In FY 98, 211 of 1,308 (16%) cases were closed after 200 days. OIG representatives said that they were aware this number would increase because the OIG started the fiscal year with approximately 400 cases from the previous fiscal year. In our sample of cases, we tested 16 cases over 200 days old and noted that many of them had no 60 Day

Status Report in the file that would indicate what caused them to be delayed. Six of the 16 cases we sampled over 200 days old, had been reassigned to a different investigator after the initial 60 days had passed. We also noted in our review of all sample cases, the 60 Day Status sheet, when available, most often indicated that the investigator was working on another case or working on a high priority case. Exhibit 2-1 shows the number of days to completion for the FY 97 and FY 98 cases closed.

Our measurement of the time to complete an investigation was taken from the time an incident was reported to the OIG until the OIG completion date. Overall, it took an average of 130 days to complete an investigation of employee abuse or neglect in FY 98 and an average of 76 days in FY 97.

Exhibit 2-1
NUMBER OF DAYS TO COMPLETE INVESTIGATIONS
Cases Closed During FY97 and FY98

	FY 97	%	FY 98	%
0-60	396	41%	187	14%
61-90	262	27%	242	19%
91-120	161	17%	212	16%
121-180	115	12%	384	29%
181-200	17	2%	72	6%
> 200	13	1%	211	16%
TOTAL	**964**		**1,308**	

Note: Data excludes cases investigated by State Police.

Source: 1997 and 1998 Investigations Logs.

Five facilities and the community agencies had the largest number of cases over 200 days old. Together they accounted for 73 percent of the cases greater than 200 days to complete. Elgin Mental Health Center had 40 of the 211 cases over 200 days old followed by Kiley Developmental Center (24), Choate Mental Health and Developmental Center (17), Tinley Park Mental Health Center (17), and Singer Mental Health and Developmental Center (16). The community agencies combined had 40 cases over 200 days old.

Exhibit 2-2
TYPES OF ALLEGATIONS FOR CASES OVER 200 DAYS TO COMPLETE
Cases Closed FY 98

Type of Allegation	*Number*
Physical Abuse - Requiring Emergency Medical Treatment (1a)	1
Physical Abuse - not Requiring Emergency Medical Treatment (1b)	83
Sexual Abuse (1c)	19
Verbal Abuse (1d)	25
Neglect (1e)	48
Other Improper Employee Conduct (1f)	5
Recipient Injury Requiring Emergency Medical Treatment (3a)	3
Death (2)	26
Other Reportable Incidents (7)	1
TOTAL	211

Source: OIG Investigations Log

Exhibit 2-2 shows the types of allegations for cases taking over 200 days to complete. Allegations of physical abuse not requiring emergency medical treatment (1b) and neglect (1e) were the most prevalent in this category of cases.

Time to Initiate the Investigation

One possible way to help determine why an investigation exceeded the 60 day time requirement established in DHS Policy is to measure the length of time it took to initiate the investigation; and one way to measure how quickly an investigation was initiated is to measure the amount of time to the first OIG interview. If an allegation of abuse or neglect is reported and assigned to an investigator but nothing happens for two months except facility staff taking initial statements and collecting evidence, or if the case has been reassigned after 60 days, the investigation has already exceeded the 60 day timeline. Memories may have also faded or witnesses may become unavailable for follow-up interviews.

Even though Investigation Guidelines do not contain specific time requirements for conducting a first OIG interview, improvement is needed in the timeliness of the OIG investigator's first interview. In FY 98, our sample of cases noted that in 38 percent (70 of 186) of investigations, the first OIG interview was not conducted for more than one month after the incident was reported to the OIG and took an average of 51 days overall. In our previous audit sample, 34 percent of the first OIG interviews were not conducted within one month of being reported to the OIG (average of 35 days).

We also measured the time it took from the first OIG interview to the last OIG interview. In 5 percent (9 of 186) cases, the OIG took more than 100 days between the first and last interview and 4 of the 9 cases took more than 150 days. The average for all cases investigated by OIG in our sample was 25 days.

Under OIG guidelines, the investigator will be assigned to the case within 24 hours of the intake report (more serious cases are assigned within one hour of intake report). The investigator may direct facility staff to conduct certain initial investigation procedures (such as taking initial written statements, gathering certain documents etc.). OIG investigators feel that by communicating with facility staff early in the investigation, they have more control and can conduct a quality and more efficient investigation.

Timeliness of Case File Reviews

Timeliness requirements for supervisory review have been eliminated since the last audit. During the prior audit, OIG supervisors were required to review each investigation within three working days of receipt. Guidelines during the present audit period included a three level supervisory review with no mention of a timeline. The only specific time requirement concerned the amount of time the OIG had to send the report to the facility/agency after all reviews are complete.

Once the investigator completes the investigation and writes the Preliminary Report, the report is submitted for review. During the audit period, guidelines stated that the investigative case file (including the preliminary report) is reviewed by the trained Reviewer, Bureau Chief, and if necessary (substantiated cases and special cases), the Inspector General, however, guidelines did not mention a specific time requirement to complete these reviews (Reviewer or Bureau Chief). In FY 98, the median number of days in review was 33 days. In FY 97, the median number of days in review was 22.

If investigation reports are not reviewed in a timely manner, case follow-up or additional investigation may be difficult. Witnesses could become unavailable or accounts of the incident may change. Untimely review will delay notification of the facility/agency and will increase the time an employee is left on administrative leave in cases where administrative leave is utilized.

Recommendation Number Two:

The Inspector General needs to develop a process to ensure the timeliness in investigations of employee abuse and neglect in order to comply with the DHS Policy. The Inspector General should also ensure that case reports are reviewed in a timely manner.

(RECOMMENDATION REPEATED FROM DECEMBER 1996)

Office of Inspector General Response:

Agreed. In response to the increasing number of allegations received by OIG, additional appropriations were approved by the Governor and the General Assembly to hire ten staff to be phased in during FY99. We will further continue to emphasize timely completion of investigations and reviews.

FACILITY NOTIFICATION AND RESPONSE

After the Preliminary Report review process is completed and the report has been accepted by the Inspector General, the facility/agency needs to be notified of the investigation results. In addition, amendments to the Act effective July 1997, added time requirements for submission of a report on substantiated cases to the Secretary of the Department of Human Services.

Notifying Facilities/Agencies

Investigation Guidelines state that the Inspector General/designee must submit a copy of the "Preliminary Report" to the Authorized Representative (Facility Director or community agency Executive Director) within 5 working days of acceptance of the report. This time frame is measured from the date all reviews were completed (indicating the Inspector General's acceptance), to the date the notification letter was sent to the facility/agency. Our review of case files indicated that this timeline was met in 79 percent (165 of 209) of the cases in our sample.

Facility/Agency Requests for Clarification of Findings

Once the facility/agency receives the investigation results, the OIG guidelines established a detailed reconsideration/clarification process which allows the authorized representative 10 working days to submit a written response. In substantiated cases, the response must contain a written response including steps on how they will protect the recipient from abuse or neglect, including implementation dates. The facility/agency may also request the Inspector General to provide clarification of the findings or reconsideration of the findings based on additional information submitted by the authorized representative. The Inspector General has 10 days to respond to the request for clarification or reconsideration. If no clarification is requested the Preliminary Report becomes final 10 working days from the date the report was received by the facility/agency. There was one case in our sample where the facility/agency demonstrated the use of the clarification or reconsideration option outlined in the Investigation Guidelines.

Notifying the Secretary of the Department Human Services of Substantiated Cases

In substantiated cases or where administrative action is recommended, statutory amendments require the OIG to provide a report to the Secretary of the Department of Human Services and to the facility/agency within 10 days of the transmittal of a completed investigation. The statute also requires that the facility/agency response be included in the report.

This requirement has been difficult for the OIG to implement because of the definition of the term "completed". The OIG defines the term completed to mean when all reviews have been completed and the report is sent to the agency/facility. The OIG's definition of "completed" occurs before the agency responds to the recommendation because OIG guidelines allow the agency/facility potentially 30 days to respond to their

recommendations. Therefore, a copy of the facility/agency response could not be included in a report to the Secretary 10 days after the report finishes the review process.

The OIG practice has been to send a notification letter to the facility/agency at the point when the reviews are done. This notification letter is also copied to the Secretary of the Department of Human Services. However, when the notification letter is sent to the Secretary at this point, the facility/agency response and a written response can not be included because the facility/agency and the Secretary are receiving initial copies at the same time. In addition, the statute requires that the written response and the facility/agency response be included in the Secretary's copy. Using this interpretation of the statute, the OIG will not be able to meet the 10 day requirement because of the facility/agency notification process and the statutory requirements.

Recommendation Number Three:

The Inspector General should clarify their facility/agency notification policies so that statutory requirements can be met.

Office of Inspector General Response:

Agreed. We will fully implement the recommended changes by December 31, 1998.

THOROUGHNESS OF ABUSE OR NEGLECT INVESTIGATIONS

Chapter Three

CHAPTER CONCLUSIONS

OIG case reports generally were thorough, comprehensive, and addressed the allegation. All cases files in our sample contained a case report.

Case file documentation has improved since the last audit. However, we found that 18 percent (34 of 186) of OIG investigations were missing one or more required documents. In our prior audit, 44 percent of case files were missing one or more pieces of required case file documentation. Some of the required documentation missing in our sample of cases for FY 98 include: photos not taken in 25 percent of cases in which there was a visible injury; diagrams of the location where the incident occurred were not prepared in 9 percent of the cases; and injury reports were missing in 7 percent of the cases for which there was an alleged injury.

As in prior audits, however, we found problems with documentation of supervisory review. Of the cases requiring a case review form, 16 percent (30 of 186) did not have the review form.

OIG developed a form to track cases taking longer than the 60 days allowed in DHS Policy. We found that 48 percent (51 of 106) of the cases sampled over 60 days old were missing the required form used to explain "extenuating circumstances" for delay. Some case files containing the form noted "extenuating circumstances" for delay such as; "working on other cases", "scheduled day off", and "holiday" while OIG guidelines suggest examples of "extenuating circumstances" such as the unavailability of witnesses or the unavailability of important documents. Investigation Guidelines, however, did not contain procedures for reviewing status reports or for handling cases with unacceptable excuses for delay.

Despite the fact that investigations delegated to facilities and community agencies did not meet the standards OIG requires for investigations conducted by its investigators, they were generally accepted by the OIG. Two of 19 facility and 19 of 87 community agency investigations in our sample were missing at least one piece of

documentary evidence required in OIG investigations. These case files also did not follow OIG guidelines for content and organization.
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Furthermore, because facility and community agency investigation files had missing or incomplete review forms, there was no evidence of review by OIG staff. These investigations should be reviewed by OIG for acceptance or rejection in order to meet their statutory responsibility. Thirty-two percent (6 of 19) of facility and 89 percent (77 of 87) of community agency case files in our sample did not have a Review Sheet. Without this documentation, we were unable to determine whether the OIG is meeting its statutory responsibility for reviewing and closing these cases.

INVESTIGATION THOROUGHNESS

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. The investigator's primary responsibility is to collect facts and information in order to accurately determine the manner in which the incident occurred. The type of evidence collected depends, to some extent, on the nature of the allegation. However, some types of evidence must be collected regardless of the allegation.

As noted in our previous audit, certain initial investigatory steps taken shortly after an allegation becomes known are very important for an effective investigation. These steps include among others: taking an accurate initial written report of the allegation; completing a comprehensive physical examination report; and securing and/or sketching or photographing the scene of the incident. Facility staff are instructed by OIG investigators in what evidence they should collect.

The OIG investigator's primary responsibility is to ensure that the necessary information was collected in order to identify and clarify the manner in which the incident occurred. The collection of supporting documentation such as the incident report, photos, time sheets, progress notes, diagrams, injury reports, restraint/seclusion monitoring, and visitors logs are essential to completing a thorough investigation.

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.

A well-written final report is also essential to an effective investigation because it often provides a basis for management's decision on the action warranted in the case. At the OIG, the investigator's final report is reviewed by up to three levels of management who must "sign off" on the case before a recommendation is sent to the facility.

Therefore, it is important that the final case report be clear and convincing to anyone who reads it.

COLLECTION OF EVIDENCE

Documentary evidence collection has improved since the last audit. We found that 18 percent (34 of 186) of investigations were missing one or more required documents. In our prior audit, 44 percent of case files were missing required case file documentation. Improvement in overall case file thoroughness is still needed as was cited in our four previous audits. OIG Investigation Guidelines eliminated the documentation checklist that used to be filled out by facility staff and instead included a list of items for the investigators to consider. Therefore, certain pieces of documentary evidence are still required to be collected by the Investigation Guidelines. Exhibit 3-1 shows the incidents of missing documents by category for cases closed in FY 96 and FY 98. The following sections summarize some of the remaining OIG documentation requirements and the number of cases missing documents.

Exhibit 3-1
EXAMPLES OF MISSING DOCUMENTATION
FY 96 and FY 98

	Percent Missing	
Document	**FY 96**	**FY 98**
Injury Report	9%	7%
Photos	46%	25%
Diagrams	12%	9%
Shift Log	13%	9%
Visitor's Log	15%	26%
Progress Notes	7%	3%
Restraint/Seclusion Monitoring Record	7%	20%

Source: OAG analysis of 148 FY 98 and 278 FY 96 closed OIG abuse or neglect investigations.

Photographs

OIG Investigation Guidelines state that photographs are required in all instances where an injury has been sustained as a result of an incident. When injuries have been inflicted as a result of an alleged incident of abuse or neglect, the investigator should ensure that they are photographed. Photographs of injuries serve as demonstrative evidence to assist the investigator to determine the severity of the injury and whether the injury is consistent with the allegation (i.e. whether the injury could have been inflicted in the manner in which it was stated in the allegation and whether the injury could have been inflicted within the time frame as stated in the allegation). Photographs were missing in 10 of 40 cases where they were required.

Documentation of Injury

Investigation Guidelines also require investigators to obtain copies of relevant documentation concerning injuries, including documentation that no injury was sustained. Documentation may include an Injury Report, physician/nurse examination, results of body check, nursing notes, medical progress notes, and other relevant progress notes, treatment records, and physician orders. We found 20 of 73 case files missing one or more pieces of documentation for an injury.

Progress Notes

According to OIG guidelines, copies of relevant progress notes are required for every investigation. During the audit period, OIG policy required the investigator to determine the time periods of the progress notes that will be reviewed. If the date of the incident is known, copies of notes for the date the incident occurred and additional days preceding or following the occurrence should be obtained at the discretion of the investigator. There were 4 of 143 cases in our sample that did not contain progress notes.

Previous OIG guidelines required investigators to obtain progress notes for a minimum of five days: three days before, the day of, and one day after the incident occurred. OIG investigators in our sample of cases collected more progress notes in investigations than were previously required. We noted in our sample for this audit, that 88 percent (122 of 139) of cases contained at least 5 days of progress notes.

CASE MONITORING AND SUPERVISORY REVIEW

A second element of an effective investigation is case review and monitoring. We continue to find problems with supervisory review of case files and monitoring of open investigations similar to those noted in our prior audits. In our sample of allegations investigated by OIG, 16 percent (30 of 186) did not contain the required review form.

Each OIG investigation is to be thoroughly reviewed prior to submission to the facility, and the reviewer at each level is to complete a standardized case review form for each case indicating questions, comments or instructions for the investigator that were noted during the review. A typical case will move through two and possibly (for substantiated cases) three levels of review before being sent to the facility/agency. For cases that take over 60 days to complete, the investigator is to complete a 60-Day Status Report to document the efforts being made to complete the case.

Documentation of Monitoring and Review

In addition to the investigative evidence contained in the case file, there are other OIG forms that must be completed and included in case files to monitor the case as it is processed and reviewed. The OIG requires that all files contain a Library Sheet, Sixty Day Status Sheet (if the case is over 60 days old), Case File Review Action Slip, Review Sheet and any correspondence received from the facility, community agency, or the entity that is relevant to the case.

Library Sheet

According to Investigation Guidelines, every case file must contain a Library Sheet. The Library Sheet identifies the case, investigator, team leader and investigating agency. This form's main purpose is to document the case finding, recommendation for action, and action taken in the case. It also indicates the case closure date and the type of allegation that was investigated. The information on the Library Sheet is used to enter data into the Investigation Log which tracks all cases. If the Library Sheet is not completed information in the Investigation Log may be incomplete. All case files in our sample contained a Library Sheet.

Sixty Day Status Sheet

As discussed earlier, the Sixty Day Status Sheet must be present in case files that are 60 or more days old. DHS Policy state that investigations of allegations of abuse and neglect should not exceed 60 days unless there are "extenuating circumstances." The 60 days begins when the case is received at the OIG and assigned to an investigator. Investigators are required by OIG policy to complete a Sixty Day Status Sheet to document the reason for the delay in completing the investigation. Guidelines state that absent extenuating circumstances, the case should be completed (preliminary report submitted for review) in 60 days.

In our review of cases, we noted that 51 of 106 cases requiring the 60 Day Status Report did not have one in the file. Examples of "extenuating circumstances" included in the guidelines are the unavailability of a witness or an official document. We noted that most 60 Day Status Reports noted as reasons for delay the following: "working on other cases", "regular scheduled day off," and "holiday." Furthermore, the Investigation Guidelines did not address a procedure to review these forms or for consequences for unacceptable excuses for the reason for delay.

Case File Review Action Slip

After a case is submitted for review, the review progress is documented through a Case File Review Action Slip. 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. The form also has a section where the reviewer can note when the case was sent for special review, clinical, legal, consultant, or another office. Our sample of cases showed that almost all cases did contain the Case File Review Action Slip, however; it was not always complete.

Review Sheet

The OIG Review Sheet is used by case file reviewers at each level to document their comments on the case and to suggest further instructions for investigators. Reviewers should complete a Review Sheet on every case even if they have no comments.

We noted in our sample of cases that the Review Sheet was missing in 30 of 186 cases. In some of the cases, the OIG had to locate Review Sheets for us because they were not filed in the permanent case files. If review sheets are not included in case files, we were unable to determine if the case was reviewed; and if a case is not reviewed, the quality and accuracy of the investigation could be questionable.

Recommendation Number Four:

The Inspector General should ensure that adequate supervisory review occurs on OIG investigations. All investigations should be reviewed for thoroughness and a case review form completed when required. Further, case status reports should be completed within required time frames. Investigation Guidelines should require investigators to document the acceptable reasons for investigation delays, and include procedures for review and consequences for unacceptable delays.

Office of Inspector General Response:

Agreed. We are now requiring a Case Review Form in every OIG investigation, and have substantially improved our timeliness in case review. We have completely revised our status report process to require more in-depth explanations at the end of the investigative segment and evaluation of these explanations after the case review process.

FINAL CASE REPORTS

A third element of an effective investigation is a clear and convincing case report. According to Investigation Guidelines, the Preliminary Report prepared by the OIG investigator at the conclusion of the investigation, is a summary of the evidence in an investigation with a recommendation as to whether the findings of the investigation indicate that the allegation should be substantiated, unsubstantiated, or unfounded. A preliminary report becomes final once all requests for reconsideration of the findings from the facility/agency are reconciled. In our sample of cases closed in FY 98, we noted that all of the cases contained a case report of some kind. Generally the case reports for cases reported after the current guidelines were implemented contained a report following the prescribed format.

The report should address all relevant aspects of the investigation and reveal what the investigation accomplished. Guidelines require OIG investigation preliminary reports to contain the following sections:

Allegation/complaint - Three paragraphs that describe the initial allegation, describe additional information (i.e. steps taken by the facility/agency upon the discovery of the incident), and the dates and times of notification of the incident as well as when the investigator was assigned to the investigation.

Investigative Methodology - Provides a summary of the investigation plan. It provides a clear and concise picture of the decision-making process to find the facts.

Summary of Evidence - This section presents all the facts and evidence, whether direct or circumstantial.

Analysis of Evidence - This is an analysis of the facts of the investigation and leads the reader to reach a conclusion about the allegation. The section weighs the strengths and weaknesses of the evidence and credibility factors, identifies missing links (what could not be determined or discovered), and resolves conflicting evidence.

Recommendation - This section is the investigator's recommendation for the findings and any other issues identified during the course of the investigation.

FACILITY AND COMMUNITY INVESTIGATIONS DELEGATED BY THE OIG

We also sampled allegations of abuse and neglect that were delegated to State operated facilities and community agencies for investigation. In our sample, we noted a significant difference in the documentation in these case files to those investigations conducted by the OIG. Although Investigation Guidelines do not require facility and community investigations to meet the same investigation standards and methodologies as used in OIG investigations, the OIG reviews and accepts them in order to comply with statutes. The OIG should hold the investigations they delegate to the facilities and community agencies to the same standards and methodologies used in their investigations or to approved investigation protocols as they represent the standards and methodologies the OIG determined to make an effective investigation.

The Act requires the OIG to investigate all allegations of abuse and neglect. The OIG uses their own investigators to conduct investigations involving employee on resident abuse and neglect allegations. Investigation Guidelines establish which investigations the OIG will conduct. There are two types of investigations not conducted by the OIG; abuse and neglect investigations conducted by the community agencies (categories "1a" to "1e") and investigations of other incidents (categories "1f" to "7") conducted by the facilities and the community agencies.

The community agency may investigate an allegation of abuse or neglect involving an employee and a resident if the allegation is self reported by the agency (i.e., the incident is reported to the OIG by the agency itself verses a complaint from an outside party). The facilities should never investigate an allegation of abuse or neglect as they should all be reported to the OIG for investigation. The community agencies, however, may investigate abuse and neglect allegations if they are self reported to the OIG. Often times, the community agencies report incidents of abuse and neglect to the OIG after the investigation has already been completed by them and action has been taken against the perpetrator.

Collection of Evidence

Eleven percent (2 of 19) of the facility investigations and 22 percent (19 of 87) of the community agency investigations in our sample were missing at least one of the documents the OIG requires in their investigations. Often times, case files for facility and community agency investigations of other incidents contained only a Library Sheet, Incident Report form, or the OIG Intake form.

Supervisory Review

In addition, there was not any evidence of review in some of these cases because they did not contain any of the review forms required in OIG case files. Eighty-nine percent (77 of 87) community and 32 percent (6 of 19) facility cases did not contain the appropriate case review documentation. Once the facility or community agency completes their investigation the OIG staff review the investigations for thoroughness and acceptance. The OIG Investigation Guidelines include a section on Approval of Community Agency Investigative Protocols. This section establishes how the community agency investigation protocols are reviewed to demonstrate how the agency will conduct an objective, thorough, and timely investigation. The OIG has stated that they are not yet approving community agency protocols for investigations because the new administrative rules have not yet been approved and the new Policy and Procedure Directive has not been implemented. Once this happens the protocols will be approved.

Investigation Guidelines do not contain a protocol for investigations conducted by the facilities. In our prior audit, the OIG responded that their proposed draft rules required OIG approval of facility protocols which must include documentation of investigative procedures, conclusions reached, and reviews. OIG stated they have not developed an investigation protocol because under the current guidelines, the facilities should not conduct any investigations of abuse or neglect. The most recent draft of the administrative rules states that the facility's method of investigation shall be comparable to those standards in the OIG Investigation Guidelines. The draft rules then elaborate on the approval process for community agency protocols. The OIG does not dictate the form or content of facility investigations. They have offered training to the facility staff conducting these investigations which is discussed in more detail in Chapter 5.

Case Reports

Community agency case reports of abuse and neglect (intake classifications of "1a" to "1e") were missing in 4 of 26 cases (15%) in our sample and only 2 of 26 contained all elements of an OIG case report. Only 11 of 19 facility and 14 of 61 community agency investigations of other incidents (intake classifications of "1f" to "7") in our sample contained case reports. None of these reports from facilities and community agencies included all of the elements required in OIG case reports**.** These case reports in our sample of non OIG investigated cases were significantly different from those conducted by the OIG investigators. The case report is used as the primary case review tool to evaluate the adequacy of the investigation. If case reports are not comprehensive and contain the elements required in OIG reports, they may not adequately document the outcome of the case.

Even though these non OIG investigations lacked certain documents commonly found in OIG investigations, there was no evidence that some of the investigations were reviewed. Despite the fact that these investigations did not meet OIG standards, most cases in our sample were still accepted by the OIG. Only 8 of the community investigations not meeting OIG standards had documentation of review.

Recommendation Number Five:

The Inspector General should begin approving community agencies' investigative protocols and reviewing community agency investigations against the protocols. The OIG should develop and implement a protocol for facility investigations. The OIG should also document their review of facility and community agency investigations and return unacceptable case files to facilities and community agencies for correction or further investigation.

Office of Inspector General Response:

Agreed. We have established a committee to review and approve community agency investigative protocols according to set standards. We have begun using our Case Review Form to document our reviews of community agency investigations and will document our comments back to the community agencies for correction or further investigation. OIG will conduct or direct all allegations reportable to OIG from the facilities under the new Rule.

ACTIONS, SANCTIONS, AND RECOMMENDATIONS

Chapter Four

CHAPTER CONCLUSIONS

Of the 1,466 abuse or neglect cases closed in FY 98, the OIG substantiated abuse or neglect in 276 cases. The OIG also substantiated abuse or neglect in an additional 29 other incidents which were not alleged to be abuse or neglect at intake, for a total of 305 substantiated cases.

Facilities and community agencies took administrative action, such as suspension or termination, against employees in 251 (82%) of these cases. Other actions taken against employees included: general retraining, specific staff retraining, policy creation/revision, treatment/program change, facility structure change, and procedure clarification.

New requirements established in statutes have not been fully implemented by the OIG. Statutes now require facilities and community agencies to submit a written response to the OIG in substantiated cases. In addition, the OIG is required to establish an appeals process to resolve differences between the OIG and the facilities and community agencies, and to report all substantiated cases to the Secretary of the Department of Human Services within ten days of a case becoming final.

The OIG has not imposed sanctions against facilities or defined when sanctions should be used. Since January of 1990, statutes have given the OIG the authority to recommend to the Department of Public Health (DPH) and the Department of Human Services (DHS), that sanctions be imposed against facilities operated by DHS for the protection of the residents. The OIG has not imposed sanctions in the last three years.

In Fiscal Year 1998 the OIG conducted unannounced site visits at all of the State operated facilities using a site visit protocol developed during 1996 and adopted in January 1997.

SUBSTANTIATED ABUSE AND NEGLECT CASES

Of the 1,466 abuse or neglect cases closed in FY 98, the OIG substantiated allegations in 276 cases. The OIG also substantiated abuse or neglect in an additional 29 other incidents which were not alleged to be abuse or neglect at intake, for a total of 305 substantiated cases.

Exhibit 4-1 shows the past three years' substantiation rates. These numbers and percentages include substantiated cases investigated by OIG and include only the 276 allegations of abuse and neglect that were substantiated. Exhibits 4-2 and 4-3 reflect the total 305 substantiations. In addition, Exhibit 4-1 shows that substantiation rates at facilities have increased since FY 96. In FY 96, the OIG substantiated 33 cases of abuse or neglect at community agencies. The number of substantiated cases at community agencies increased to 148 in FY 98. FY 96 was the first year for which OIG had the authority to conduct investigations of abuse and neglect at community agencies.

Exhibit 4-1
ABUSE & NEGLECT CASES
CLOSED AND SUBSTANTIATED
(Based On Category of Allegation at Intake)
FY 96 - FY 98

	Cases Closed	Substantiated Cases	Percentage Substantiated
FY 96			
Facility	1001	76	8%
Community	75	33	44%
FY 97			
Facility	850	73	9%
Community	266	106	40%
FY 98			
Facility	1,129	128	11%
Community	337	148	44%

Source: OIG 1996 Annual Report, OAG 1996 Program Audit and 1997 and 1998 OIG Investigation Logs.

According to OIG staff, the substantiation rate at community agencies should not be compared to the substantiation rate at the facilities because often times a community agency only reports an allegation of abuse or neglect to the OIG after their investigation is completed and only if the allegation was substantiated by them. Therefore, a higher proportion of the allegations of abuse and neglect from the community agencies may be substantiated by the OIG compared to the facility cases where all allegations must be investigated.

RECOMMENDATIONS AND ACTIONS

At the conclusion of the investigation, the OIG investigator determines whether the evidence in the case indicates that the allegation of abuse or neglect is substantiated, unsubstantiated, or unfounded. The case is reviewed and a letter is sent to the facility or agency notifying them of the results of the investigation. If the allegation is substantiated, the letter

recommends what type of action the OIG thinks should be taken. In Fiscal Year 1998, facilities or agencies took some kind of action in 95 percent of cases substantiated by the OIG.

Exhibit 4-2
SUBSTANTIATED CASES BY TYPE OF ALLEGATION AND ACTIONS TAKEN
(Based on all Allegations Regardless of Category at Intake)
Fiscal Year 1998

TYPE OF ALLEGATION	INVESTIGATED BY		TOTAL	ACTIONS TAKEN
	OIG	Community Agency		
Physical Abuse - Emergency Medical Treatment	1	1	2	Administrative Action, None
Physical Abuse - Non Emergency Medical Treatment	48	57	105	Administrative Action, None, Retraining, Policies/procedures
Sexual Abuse	12	5	17	Administrative Action, None
Verbal/Psychological Abuse	31	33	64	Administrative Action, None, Retraining, Policies/procedures
Neglect	72	16	88	Administrative Action, None, Retraining, Policies/procedures, Treatment change, Structural change
Other Improper Employee Conduct	3	0	3	Administrative Action
Recipient Death	12	0	12	Administrative Action, None, Retraining, Policies/procedures Treatment change
Injury - Emergency Medical Treatment	2	1	3	Administrative Action
All other Injuries	0	1	1	Policies/procedures
Recipient Absence - Unauthorized	1	6	7	Administrative Action, Retraining
Sexual Conduct with Recipient	0	3	3	Administrative Action Policies/procedures
TOTAL	182	123	305	

* Does not include investigations conducted by State Police or the facilities. Source: OAG analysis of 1998 data from OIG Investigation Log.

Recommendations for actions in substantiated cases fall into ten different categories:

- No action;
- General staff retraining;
- Policy revision or creation;
- Procedural clarification;
- Structural change to facility;
- Medical/Clinical review;
- Legal review;
- Administrative action against staff;

- Specific retraining of employee; and
- Treatment/ programmatic changes.

Exhibit 4-2 shows the type of allegation, who investigated the allegation, and the action taken in the 305 substantiated cases closed in FY 98. There are cases where an action was recommended but no action was taken. In some of these cases the perpetrator resigned before the action could be taken.

Administrative actions were taken in 82 percent of the cases and was the most frequently used action in both OIG and community agency investigations. Administrative actions which include but are not limited to suspension, termination, reprimand, and counseling. Exhibit 4-3 in turn, shows the 305 substantiated cases by the type of action taken and by the source of investigation.

Exhibit 4-3
ACTIONS TAKEN ON SUBSTANTIATED CASES
Fiscal Year 1998

	Investigated by OIG	Investigated by Community Agency	TOTAL
Administrative Action	149	102	251
General Retraining	2	4	6
Policy Creation/Revision	6	3	9
Procedure Clarified	5	3	8
Specific Staff Retraining	6	5	11
Facility Structure Change	1	0	1
Treatment/Program Change	3	0	3
No Action	10	6	16
Total Substantiated	182	123	305

Source: OAG analysis of OIG 1998 Investigation Log

The exhibit shows that there were 16 cases where no action was taken. We reviewed three OIG investigated cases where there was an action recommended but no action taken and found that in one case the employee to be disciplined resigned, in one case there was an input error, and in the third case the facility/agency did not agree with the recommended action and did not take action. The OIG referred the case to the appropriate DHS division and had not been informed of the outcome. Agency investigated cases with no action taken were cases where the investigation was completed and action taken before the OIG received notification of the case.

Second Cover Memos

In addition to the notification letters sent to facilities and community agencies which inform them of the outcome of the investigation, the OIG has established the Second Cover Memo. A Second Cover Memo may be sent to a facility/agency if the allegation is believed to have been caused by a systemic issue or if it is determined that the allegation could have been avoided if another mechanism had been in place. The memo makes recommendations of actions for the facility/agency to take in order to fix the systematic

issue (i.e. modifying the procedure for supervisory monitoring of Personal Assistant performance when recipients are transferred to the hospital). This is different from making a recommendation for action against an employee. There were 8 incidents in our sample of cases where a Second Cover Memorandum was used in FY 98. These memos were for cases involving deaths, physical abuse not requiring emergency medical treatment, neglect, and other improper employee conduct.

OIG investigators evaluate the need for a Second Cover Memo in all investigations. If a memo is deemed necessary, recommendations for actions to be taken by the facility/agency fall into the following categories:

- No Issue Founded,
- Facility/Unit Training,
- Relevant Policy,
- Relevant Procedure,
- Structural/Physical Unit,
- General Medical/Clinical, and
- General Legal.

NEW REQUIREMENTS

Amendments to the Act established new requirements for the OIG which have not been fully implemented. In addition, guidelines established to address these statutory amendments conflict with other OIG statutory requirements. Statutes now (1) require facilities and community agencies to submit a written response in substantiated cases, (2) require an appeals process to resolve differences between the OIG and the facilities and community agencies, and (3) require the OIG to report all substantiated cases to the Secretary of the Department of Human Services within ten days of completion (210 ILCS 30/6.2).

Written Responses

Public Act 90-252 effective July 29, 1997, amended the Act to require facilities and community agencies to submit a written response in substantiated cases. The plan should include the actions the facility/agency 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. We noted that 56 of 182 substantiated cases investigated by OIG showed that a written response had been submitted. Of the 56 substantiated cases with written responses, 45 were facility cases and 11 were agency cases. Only 3 of 123 substantiated cases investigated by community agencies had written responses.

Appeals Process in Substantiated Cases

In FY 98, there were 3 of the 305 cases where the allegation of abuse or neglect was substantiated but the facility/agency did not accept the recommendation of the OIG. However, there were no cases where the facility or community agency used either the new formal appeals process required by statutes or reported to the Secretary of the Department of Human Services to reconcile the difference of opinion.

A new requirement was added to the Act which states that there shall be an appeals process for any person or agency that is subject to any action based on a recommendation. We noted in our review of cases that the facility or community agency generally took the OIG recommended action. However, even though the OIG recommends corrective actions to facilities/agencies, the recommendations are not always implemented. Our prior audit noted that in cases where the facility/community agency disagreed with the recommended action, the facility generally provided additional information or the OIG changed the recommendation.

However, if a facility/agency does not agree with the OIG's recommendation for corrective action and chooses not to use the appeals process, statutes provide authority to the Secretary of the Department of Human Services to accept or reject the response from the facility/agency. The Secretary may require Department personnel to visit the facility or agency for training, technical assistance, programmatic, licenser, or certification purposes in order to correct the problem.

Recommendation Number Six:

The Inspector General should assure facilities and community agencies submit written responses in a timely manner. The Inspector General should also ensure that an appeals process is established and is used to reconcile differences between facilities/community agencies and the OIG recommendations.

Office of Inspector General Response:

Agreed. By February 1, 1999, we will develop an internal process to track and file written responses. We will work with the Department to ensure that our file copy is the approved one. The Rule effective October 1998 established an appeals process.

SANCTIONS

The OIG has not issued sanctions against any facility during the last three years. In addition, the OIG has not developed formal written criteria to determine when sanctions should be recommended. The Act (210 ILCS 30/6.2) gives the Inspector General broad authority to recommend sanctions. Sanctions are intended to ensure the protection of residents such as closing a facility, transferring or relocating residents or appointing on-site monitors.

Our last audit released in December 1996 recommended that the OIG develop specific criteria for sanctions and implement them as necessary because the Act does not clearly define when and under what circumstances a sanction should be issued by the OIG. The OIG responded that it was not within their purview to define "sanction" since the legislative intent was unknown. They also stated they would participate in discussions with appropriate parties to define this term and develop criteria. OIG staff stated during this audit that the task of defining criteria and circumstances under which sanctions should be recommended is on the Quality Care Board's agenda. The OIG is seeking their guidance on this issue.

The Quality Care Board's purpose is to monitor and oversee the operations, policies, and procedures of the Inspector General and to assure the prompt and thorough investigation of allegations of neglect and abuse. By clearly defining criteria or occurrences where a sanction should be considered, and formalizing the process for issuing a sanction, the OIG could clarify and strengthen its role in ensuring the safety of residents in State-operated facilities.

Recommendation Number Seven:

The Inspector General should develop specific criteria for sanctions and implement them if necessary to help ensure the prevention of abuse and neglect.

(RECOMMENDATION REPEATED FROM DECEMBER 1996)

Office of Inspector General Response:

Agreed. We have been working with the Quality Care Board to develop criteria for recommending sanctions. We estimate completion and implementation by July 1, 1999.

SITE VISITS

The OIG is conducting annual unannounced site visits of all State operated facilities as required by 210 ILCS 30/6.2. In Fiscal Year 1998, the OIG conducted unannounced site visits at all of the facilities using a site visit protocol developed during 1996 and adopted in January 1997. The OIG developed the protocol using input from consumers, advocates, family members, facility and Department administrators, other Department staff, and OIG investigators.

Even though the protocol was general in nature, we reviewed the documentation from the FY 98 site visits and noted that the protocol appeared to have been applied effectively to each of the facilities. The site visits focused on pertinent issues at each of the facilities, and they appeared to provide useful information to the facilities.

The site visit protocol states that the site visit is a review of systems and processes within the facility that directly affect individuals receiving services, and is conducted from the perspective of the individuals who are receiving the services. The protocol is outcome based. The site visits usually last approximately three to five days. At the conclusion of the site visit, a memo is written to the network and facility administrators to document that the site visit took place, to indicate the activities of the site visit and to highlight issues discussed.

SYSTEM RECOMMENDATION

According to the OIG, prevention of abuse and neglect may require dealing with issues broader than systematic issues identified either in a second memo on a single case or in a causal study of all substantiated cases. The following issues have been identified by the OIG and system recommendations made to the Department:

- ***Written Responses*** - The OIG worked with the Division of Disability and Behavioral services to develop a clear process for review of written responses and Administrative Reviews as the result of OIG findings and for the Division to take appropriate action as necessary.

- ***Recipient Credibility*** - OIG sent a memo to the Secretary proposing that CMS arbitrators be provided training on recipient credibility issues. The Quality Care Board sent the Secretary a letter asking him to address this issue.

There were also other recommendations the OIG has continued to work on through Fiscal Year 1998 which include, the content and consistency of morning reports, revision of the foster care model, and fair and consistent discipline based on findings of the investigation.

OTHER ISSUES

Chapter Five

CHAPTER CONCLUSIONS

Training of OIG investigators has improved since our last audit. However, not all OIG investigators have received the training required by OIG policy. Of the 30 investigators, 12 (40%) were lacking one or more of the 15 required courses. In our prior audit, 17 of 19 (89%) were lacking one or more of the required courses.

In addition to OIG investigator training, the OIG has not monitored the training received by facility investigators who conduct facility investigations and the preliminary investigative steps in OIG investigations.

The OIG's database administrator has not formalized the system documentation of the Investigation Log or ensured that the Log is Year 2000 compliant.

OIG and other DHS employees are not reporting to the Department of Professional Regulation (DPR) as required by statutes. We found one instance in our sample of community cases where a private physician misdiagnosed a patient's condition but we found no evidence that the instance was ever reported to DPR as required.

OIG INVESTIGATOR TRAINING

Training has improved since the last audit, however, not all OIG investigators are receiving training that is required by OIG policy and the Act. 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.

To conduct an effective investigation, OIG investigators must be adequately trained. The criteria for OIG investigator training are clearly defined in OIG's policies and procedures. As of March 8, 1997, all OIG investigators were required to receive the 15 courses listed in Exhibit 5-1.

In addition to the specific courses required in OIG policy, each investigator is required to obtain at least 10 hours per year of continuing training related to investigations, report writing, systems improvement, or the provision of services to those with mental illness or developmental disabilities.

The list of required courses differs from that of the previous audit. All but the Drug Free Workplace course in the initial orientation list are new. Of the 9 additional courses required, none are new. Overall six courses were eliminated in the new guidelines after OIG reviewed what courses were essential for investigators. Courses eliminated included:

- Active Treatments,
- CPR,
- Habilitation/Treatment Planning Process,
- Leisure Time Activities,
- Mental Health Needs of People with Mental Retardation, and
- Positive Interactions.

The majority of these required courses are not conducted by OIG staff. Instead, each OIG investigator receives these courses at a facility. The Bureau of Training and Technical Support tracks OIG employee training and notifies supervisors of the need for training. Since January 1, 1998, approximately 42 different courses encompassing 14 of the required courses were offered throughout the State.

Exhibit 5-1
TRAINING COURSES REQUIRED FOR OIG INVESTIGATORS

ORIENTATION

Prevention and Identification of Abuse and Neglect
AIDS/HIV in the Workplace
Drug Free Workplace
Orientation to the Department
Sexual Harassment
Employee Assistance Program

OTHER ADDITIONAL COURSES REQUIRED

Basic Investigations Course
Advanced Investigations Course
Aggression Management
Communications
Hearing Impairment
Introduction to Developmental Disabilities
Introduction to Mental Illness
Legal Issues
Restraints
10 Hours Continuing Training Per Year

Source: OIG Investigation Guidelines

Exhibit 5-2
NUMBER OF INVESTIGATORY COURSE DEFICIENCIES BY OIG INVESTIGATORS

Number of Courses Needed	Number of Investigators
None	18
1-4 courses needed	7
5-9 courses needed	2*
10 or more courses needed	3**

* One person was employed for 1 month at the start of FY 98.
**These individuals were employed in February, March and June of 1998.

Source: OAG analysis of OIG data.

Exhibit 5-2 shows the number of courses investigators are lacking as of June 30, 1998. Of the 30 investigators, 12 (40%) were missing one or more courses. This is a considerable improvement over our last audit that showed 17 of 19 (89%) investigators were missing one or more of the required courses. The three employees needing 10 or more courses started with the OIG in February, March, and June of 1998.

Training of Review and Intake Staff

Not only the investigators should be trained in the investigation process. Review and Intake personnel should also meet training requirements established in the Investigation Guidelines. Exhibit 5-3 shows the number of other personnel involved in the investigation process that do not have all of the required training courses. These eight employees include management employees involved in the review process and intake assessment workers.

Exhibit 5-3
NUMBER OF INVESTIGATORY COURSE DEFICIENCIES BY OTHER OIG PERSONNEL

Number of Courses Needed	Number of Investigators
None	2
1-4 courses needed	4
5-9 courses needed	2
10 or more courses needed	0

Source: OAG analysis of OIG data.

In order to effectively evaluate a case file for thoroughness and effectiveness, a reviewer should be fully trained in the investigation process. Of the eight employees included in Exhibit 5-3, five may be involved in the review process. If a reviewer is not familiar with the investigation process, there is an increased risk that an inadequately investigated allegation will be closed. Similarly, the three employees determining where an allegation should be referred for investigation should be trained in the investigation procedures. If intake staff are not trained in the investigation process, they may refer allegations inappropriately to investigators or other State agencies.

Recommendation Number Eight:

The Inspector General should ensure that every person employed to conduct investigations receives the required training courses as established by OIG policy.

(RECOMMENDATION REPEATED FROM DECEMBER 1996)

Office of Inspector General Response:

Agreed. Minimum hiring requirements for an OIG investigator include college level education in law, government, or a related field and professional investigative experience. OIG requires supplemental training as available. All OIG investigators employed for at least a year have received all available required training.

TRAINING OF FACILITY STAFF

The OIG does not monitor the training received by staff that conduct investigations at facilities unless training is provided or sponsored by the OIG. In addition to monitoring training for their own investigators, the OIG should monitor the training of staff at the facilities who conduct investigations and who also routinely conduct the initial steps of OIG investigations.

We did note an improvement in the number of initial statements taken by facility/agency staff listed as attending Basic Investigator training offered by the OIG. We noted 49 of 590 (8%) initial statements taken in our sample of cases that were conducted by untrained staff.

Since the OIG is statutorily responsible for the investigations conducted by the facilities, the OIG should ensure that all investigators conducting the investigations are properly trained. The OIG Bureau of Training and Technical Support should monitor the training of facility staff to ensure the courses they receive adequately prepare them for the investigations they conduct at the facilities.

Most required training of OIG investigators is offered and scheduled through the training coordinators at the State operated facilities. OIG also has sponsored training, to fulfill both Basic and Advanced investigation courses. Any other training facility staff receive is not tracked by the OIG. If OIG does not ensure that facility investigators conducting these investigations are properly trained, the OIG may compromise the quality of the investigation and cannot assure that it is complying with statutes. The only way the OIG was able to demonstrate that facility staff were properly trained was through a listing of staff who attended particular courses at the facilities.

In Fiscal Year 1998, facility staff conducted 88 percent (5,017 of 5,696) of investigations not done by the OIG. They also routinely conducted the initial steps in OIG investigations at the facilities. Therefore, it is important that these facility staff be trained appropriately in investigation techniques to help ensure the quality of investigations. Chapter 3 has already noted that a quality investigation also requires adequate collection of evidence and supervisory review.

Recommendation Number Nine:

The Inspector General should monitor the training acquired by facility staff conducting investigations of abuse and neglect at facilities. This will help to ensure that investigations are conducted by properly trained staff.

Office of Inspector General Response:

Agreed. We have made great efforts to provide training on-site for facility staff who conduct initial interviews. By June 30, 1999, we will develop an ongoing system of monitoring and ensuring adequate investigative training of new facility interviewers.

OIG INVESTIGATIONS LOG COMPUTER SYSTEM

The OIG has addressed most of the database issues in our previous audit which identified systems and programming issues having the potential to affect data integrity and system compatibility. The OIG database administrator has not yet finalized formal system documentation of the Investigations Log because changes may still be made to the Log in the coming months as the proposed administrative rules go into effect. In addition, the Administrator has not yet ensured that the Investigations Log is Year 2000 compliant.

The Administrator stated that they were waiting to finish the system documentation because changes may still be made, based on whether additional changes are made in the proposed rules. Once the rules have become effective, the system documentation will be completed. The Administrator also stated that there is a Year 2000 “patch” available from the software manufacturer but it has not yet been installed on the OIG system.

Other issues identified during the last audit, including edit checks to ensure valid data is entered into the Log, network security passwords and off-site back-up of the Log, have been addressed.

Recommendation Number Ten:

The Inspector General should formalize systems documentation for the Investigations Log after administrative rules become effective. The Inspector General should also take steps necessary to ensure that the database system is Year 2000 compliant.

Office of Inspector General Response:

Agreed. We are nearly finished with the formal systems documentation, awaiting final implementation of the Rule. All computers that access the Log are Year 2000 compliant. We are in the process of modifying the system itself to accommodate dates after 2000, and this should be completed and tested by February 28, 1999.

REPORTING TO THE DEPARTMENT OF PROFESSIONAL REGULATION

OIG and other DHS employees are not reporting to the Department of Professional Regulation (DPR) as required by statute. The Medical Practice Act (225 ILCS 60/23(A)(1)) requires that all health care institutions licensed by the Department of Public Health report to the Medical Disciplinary Board of the Department of Professional Regulation when an institution disciplines a physician for acts which may directly threaten patient care. Further, it requires that all State agencies, boards, commissions, and departments report any instance which may constitute unprofessional conduct related directly to patient care (225 ILCS 60/23(A)(5)).

When an OIG investigation reveals potential issues related to patient care, the case is referred to the Division of Clinical Services within DHS. This Division uses physicians to review the information in the case and determine if there are findings regarding recipient care. If the review determines that clinical care issues exist, both OIG and the facility are notified.

OIG officials stated they would not refer a case to DPR since they are not physicians and do not feel they are qualified to make medical judgments. They felt Clinical Services would be the appropriate entity to refer such cases, since Clinical Services employs physicians. Clinical Services, however, said that they do not notify DPR because it is the responsibility of the facility or community agency. However, the Medical Practices Act only requires the facility or community agency to report when action is taken against the physician.

We found one instance in our sample of community agency cases where a private physician misdiagnosed a patient's condition but we could find no evidence that the instance was ever reported to DPR as required.

OIG officials stated that a departmental policy does exist which establishes when and who is to notify DPR in these cases. Officials also said the policy has not been followed and the department has been working on a policy revision since FY 97 in order to clarify the issue of who and when physicians should be reported to DPR. The new policy is still in draft form.

Recommendation Number Eleven:

The Inspector General should develop a protocol which dictates responsibility for reporting appropriate licensed individuals to the Department of Professional Regulation when cases of abuse and neglect involve patient care.

Office of Inspector General Response:

Agreed. We will ensure reporting of licensed professionals to the Department of Professional Regulation as appropriate.

APPENDICES

APPENDIX A

210 ILCS 30/6.8

Appendix A

210 ILCS 30/6.8

s 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 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.

This Section is repealed on January 1, 2000.

APPENDIX B

SAMPLING AND ANALYTICAL METHODOLOGY

APPENDIX B

SAMPLING AND ANALYTICAL METHODOLOGY

We obtained the Investigations Log maintained by OIG of all cases reported to OIG for Fiscal Years 1997 and 1998. For information regarding the numbers of cases reported and closed, timeliness of case investigation, numbers of cases substantiated, and actions taken for those two years, we used the information contained in the Investigations Log.

To determine whether the information in the Log was accurate, we compared the information compiled from the sample case files to the information in the Log and discussed any discrepancies with OIG. Further, we analyzed information in the Fiscal Year 1997 OIG Annual Report and were able to reconcile any differences by examining the Change Log for the Investigations Log of changes made after the end of the fiscal year.

We also conducted a random sample of cases closed during fiscal year 1998 to assess the quality of the investigation. We used this sample to determine whether investigators followed the OIG investigation guidelines in conducting investigations, including notifications to other agencies, collecting appropriate and relevant documentation, and documenting the investigative conclusions. Further, we determined whether there was evidence that the cases were reviewed according to OIG established procedures.

Based on OIG projections and using systematic random sampling with a confidence level of at least 95 percent and an acceptable error rate of 10 percent, we selected a total of 285 cases in four categories. However, because some cases were selected in more than one category and data misclassifications, some samples fell below our projected confidence level. The total number of unique cases sampled was 273 as follows:

107 cases investigated by OIG that occurred at state-operated facilities;
54 cases investigated by OIG that occurred at community agencies;
25 death cases investigated by OIG regardless of where the incident occurred;
87 cases investigated by the community agency where the incident occurred.

In addition to the systematic random sample, we randomly selected 20 cases investigated by the state-operated facilities in order to review case file thoroughness. We selected 5 death cases and 5 other cases investigated by the facilities for both the Northern and Southern Investigative Bureaus. One death case was also selected in our sample of 273 therefore, total cases tested was 19.

Using selected information collected from the cases in our sample, we created a database for analysis purposes.

APPENDIX C

RATES OF SUBSTANTIATED EMPLOYEE ABUSE OR NEGLECT CASES BY FACILITY FOR INVESTIGATIONS CLOSED

FISCAL YEARS 1997 AND 1998

Appendix C
Rate of Substantiated Employee Abuse of Neglect Cases by Facility

(Based on all Allegations Regardless of Category at Intake)
Fiscal Years 1997 and 1998

Facility	FISCAL YEAR 1997			FISCAL YEAR 1998		
	Number Closed	Number Substantiated by OIG	Substantiation Rate	Number Closed	Number Substantiated by OIG	Substantiation Rate
Alton	394	7	2%	397	23	6%
Chester	360	0	0%	355	1	0%
Chicago-Read	222	2	1%	219	1	0%
Choate	440	2	0%	644	17	3%
Elgin	663	10	2%	595	16	3%
Fox	23	2	9%	31	1	3%
Howe	429	6	1%	330	8	2%
Jacksonville	614	3	0%	439	5	1%
Kiley	388	16	4%	342	10	3%
Lincoln	351	1	0%	435	5	1%
Ludeman	294	2	1%	355	0	0%
Mabley	124	0	0%	97	0	0%
Madden	224	1	0%	220	4	2%
McFarland	80	2	3%	113	4	4%
Metro C&A**	164	4	2%	59	7	12%
Meyer**	1	0	0%	0	0	0%
Murray	182	1	1%	290	5	2%
Shapiro	268	10	4%	198	3	2%
Singer	193	6	3%	269	16	6%
Tinley Park	203	1	0%	161	9	6%
Zeller	81	2	2%	111	4	4%
Community Agencies	448	117	26%	746	166	22%
Facility-99*	3	0	0%	2	0	0%
TOTALS	**6,149*** **	**195**	**3%**	**6,408*** **	**305**	**5%**

* Facility-99 cases are those "Special Cases" that have not been identified to a specific facility number. Please note that these do not include the cases numbers >9900 that are also "Special Cases" that were identified with a facility and have been included with the facility numbers. There were 4 in FY97 and 13 in FY98.

** Meyer Mental Health facility closed during December 1996 and had only one case that was outstanding and closed during FY97. Metro C&A facility closed June 30, 1997.

***The number of cases closed for FY97 and FY98 includes cases investigated by the facilities and the Illinois State Police (DII). The number of cases substantiated only includes those cases substantiated by the OIG. There were 4-FY98 facility cases, and 19-FY97 and 12-FY98 DII cases that were substantiated as abuse or neglect.

APPENDIX D

ALLEGATIONS OF ABUSE OR NEGLECT

FISCAL YEARS 1997 AND 1998

Appendix D
All Incidents and Allegations Reported by Incident Category
Fiscal Year 97

FACILITIES	Abuse/ Neglect	Other Employee Misconduct	Recipient Death	Serious Recipient Injury	Minor Recipient On Recipient Injury	UA	Recipient Sexual Misconduct	Theft of Recipient Property	Other	Total Number Reported
DD FACILITIES										
Fox	1	2	1	10	18	0	0	0	0	32
Howe	83	5	5	44	247	3	7	0	23	417
Jacksonville	38	5	3	21	470	43	20	3	12	615
Kiley	74	6	1	106	197	8	20	3	9	424
Lincoln	19	2	7	27	316	2	1	0	3	377
Ludeman	38	2	5	1	285	8	4	0	7	350
Mabley	3	0	0	28	76	7	12	2	0	128
Murray	9	0	4	9	151	0	1	0	1	175
Shapiro	55	4	11	56	118	4	5	2	5	260
MH FACILITIES										
Alton	149	45	1	0	202	3	18	1	8	427
Chester	123	51	2	16	178	0	15	3	4	392
Chicago-Read	37	7	3	8	129	62	14	0	4	264
Elgin	150	51	4	4	434	16	18	7	25	709
Madden	29	7	2	5	153	36	5	3	7	247
McFarland	16	2	0	11	28	5	9	1	4	76
Metro C&A	68	18	1	22	31	12	21	1	10	184
Tinley Park	39	12	3	3	115	31	11	0	6	220
Zeller	19	6	1	8	38	13	7	1	2	95
DUAL FACILITIES										
Choate	95	12	1	12	340	10	26	0	5	501
Singer	69	18	2	6	87	21	11	0	6	220
COMMUNITY AGENCIES	365	11	50	38	104	25	32	1	18	644
99 CASES (Special Cases)	8	1	1	0	0	0	0	0	2	12
TOTALS	**1,487**	**267**	**108**	**435**	**3,717**	**309**	**257**	**28**	**161**	**6,769**

Appendix D
All Incidents and Allegations Reported by Incident Category
Fiscal Year 98

FACILITIES	Abuse/ Neglect	Other Employee Misconduct	Recipient Death	Serious Recipient Injury	Minor Recipient On Recipient Injury	UA	Recipient Sexual Misconduct	Theft of Recipient Property	Other	Total Number Reported
DD FACILITIES										
Fox	3	1	1	1	20	0	0	0	0	26
Howe	83	5	9	50	207	7	9	0	20	390
Jacksonville	37	5	4	23	344	47	7	1	10	478
Kiley	81	6	2	61	159	6	8	0	2	325
Lincoln	20	2	9	90	289	1	1	0	2	414
Ludeman	28	0	5	61	299	3	6	2	9	413
Mabley	11	1	3	18	60	4	3	0	2	102
Murray	19	2	13	60	206	1	6	0	5	312
Shapiro	26	2	8	37	100	3	1	1	8	186
MH FACILITIES										
Alton	173	31	2	3	198	2	24	0	5	438
Chester	125	53	1	10	158	0	11	0	19	377
Chicago-Read	41	1	1	10	82	35	2	0	3	175
Elgin	154	48	7	14	345	17	12	0	23	620
Madden	29	4	4	6	144	24	7	2	9	229
McFarland	28	6	4	12	44	7	4	0	9	114
Metro C&A	5	1	0	2	3	0	4	0	1	16
Tinley Park	40	5	3	5	98	14	16	0	4	185
Zeller	10	2	4	17	43	13	9	0	4	102
DUAL FACILITIES										
Choate	231	15	3	5	297	16	27	0	6	600
Singer	70	6	4	25	109	7	8	0	7	236
COMMUNITY AGENCIES	383	20	84	68	151	16	39	0	10	771
99 CASES (Special Cases)	1	3	1	0	0	0	0	0	3	8
TOTALS	**1,598**	**219**	**172**	**578**	**3,356**	**223**	**204**	**6**	**161**	**6,517**

APPENDIX E

INSPECTOR GENERAL RESPONSES

Jim Edgar, *Governor*

Illinois Department of Human Services

Howard A. Peters III, *Secretary*

Office of the Inspector General

December 11, 1998

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

Dear Mr. 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.

We would very much like to thank Audit Manager Kelly Millelstaedt and her staff for a thorough, objective, and timely audit. We found Kelly, Bill Helton, Jill Ballion, Amber Donnel, and Brenda Barker to be consistently open and unbiased, and we especially appreciated the extent to which they sought to comprehend a complicated system of expectations.

I am including a diskette with the responses saved in MS Word for Windows 2.0 format. If you have any questions, please feel free to call me at (217) 786-6829.

Sincerely,

Pat Curtis
Inspector General

cc: Howard A. Peters III, DHS Secretary
Jim Donkin, DHS Internal Auditor
OIG Management Team

OAG Recommendation 1:
The Inspector General should comply with the provision of 210 ILCS 30/6.2 and include in its rules provisions that set for that OIG will not conduct an investigation that is redundant to an investigation conducted by another State agency at State operated facilities. These provisions could be further clarified in interagency agreements between OIG and other State agencies that conduct investigations of abuse and neglect.

OIG Response:
Agreed. In compliance with the statute, the new administrative Rule, which became effective in October 1998, and OIG Guidelines are designed to avoid duplicate investigations as much as possible; for example, OIG administrative investigations do not duplicate State Police's criminal investigations. However, by April 1, 1999, we will submit a revision to the Rule's current prohibition at community agencies to also include the Department's facilities. By July 1, 1999, we will work with other state agencies to clarify applicable interagency agreements to specifically state this as well.

OAG Recommendation 2:
The Inspector General needs to develop a process to ensure the timeliness in investigations of employee abuse and neglect in order to comply with the DHS policy. The Inspector General should also ensure that case reports are reviewed in a timely manner.

OIG Response:
Agreed. In response to the increasing number of allegations received by OIG, additional appropriations were approved by the Governor and the General Assembly to hire ten staff to be phased in during FY99. We will further continue to emphasize timely completion of investigations and reviews.

OAG Recommendation 3:
The Inspector General should clarify their facility/agency notification policies so that statutory requirements can be met.

OIG Response:
Agreed. We will fully implement the recommended changes by December 31, 1998.

OAG Recommendation 4:
The Inspector General should ensure that adequate supervisory review occurs on OIG investigations. All investigations should be reviewed for thoroughness and a case review form completed when required. Further, case status reports should be completed within required time frames. Investigation Guidelines should require investigators to document the acceptable reasons for investigation delays, and include procedures for review and consequences for unacceptable delays.

OIG Response:

Agreed. We are now requiring a Case Review Form in every OIG investigation, and have substantially improved our timeliness in case review. We have completely revised our status report process to require more in-depth explanations at the end of the investigative segment and evaluation of these explanations after the case review process.

OAG Recommendation 5:

The Inspector General should begin approving community agencies' investigative protocols and reviewing community agency investigations against the protocols. The OIG should develop and implement a protocol for facility investigations. The OIG should also document their review of facility and community agency investigations and return unacceptable case files to facilities and community agencies for correction or further investigation.

OIG Response:

Agreed. We have established a committee to review and approve community agency investigative protocols according to set standards. We have begun using our Case Review Form to document our reviews of community agency investigations and will document our comments back to the community agencies for correction or further investigation. OIG will conduct or direct all allegations reportable to OIG from the facilities under the new Rule.

OAG Recommendation 6:

The Inspector General should assure facilities and community agencies submit written responses in a timely manner. The Inspector General should also ensure that an appeals process is established and is used to reconcile differences between facilities/community agencies and the OIG recommendations.

OIG Response:

Agreed. By February 1, 1999, we will develop an internal process to track and file written responses. We will work with the Department to ensure that our file copy is the approved one. The Rule effective October 1998 established an appeals process.

OAG Recommendation 7:

The Inspector General should develop specific criteria for sanctions and implement them if necessary to help ensure the prevention of abuse and neglect.

OIG Response:

Agreed. We have been working with the Quality Care Board to develop criteria for recommending sanctions. We estimate completion and implementation by July 1, 1999.

OAG Recommendation 8:
The Inspector General should ensure that every person employed to conduct investigations receives the required training courses as established by OIG policy.
OIG Response:
Agreed. Minimum hiring requirements for an OIG investigator include college level education in law, government, or a related field and professional investigative experience. OIG requires supplemental training as available. All OIG investigators employed for at least a year have received all available required training.

OAG Recommendation 9:
The Inspector General should monitor the training acquired by facility staff conducting investigations of abuse and neglect at facilities. This will help to ensure that investigations are conducted by properly trained staff.

OIG Response:
Agreed. We have made great efforts to provide training on-site for facility staff who conduct initial interviews. By June 30, 1999, we will develop an ongoing system of monitoring and ensuring adequate investigative training of new facility interviewers.

OAG Recommendation 10:
The Inspector General should formalize systems documentation for the Investigations Log after administrative rules become effective. They should also take steps necessary to ensure that the database system is Year 2000 compliant.

OIG Response:
Agreed. We are nearly finished with the formal systems documentation, awaiting final implementation of the Rule. All computers that access the Log are Year 2000 compliant. We are in the process of modifying the system itself to accommodate dates after 2000, and this should be completed and tested by February 28, 1999.

OAG Recommendation 11:
The Inspector General should develop a protocol which dictates responsibility for reporting appropriate licensed individuals to the Department of Professional Regulation when cases of abuse and neglect involve patient care.

OIG Response:
Agreed. We will ensure reporting of licensed professionals to the Department of Professional Regulation as appropriate.

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