



# STATE OF ILLINOIS OFFICE OF THE AUDITOR GENERAL

Frank J. Mautino, Auditor General

## REPORT DIGEST

### PROGRAM AUDIT

**Release Date:  
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Audit performed in  
accordance with  
**20 ILCS 1305/1-17(w)**

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### EXECUTIVE SUMMARY

## Illinois Department of Human Services Office of the Inspector General

The Department of Human Services Act (Act) requires the Office of the Inspector General (OIG) to investigate allegations of abuse and neglect that occur in mental health and developmental disability facilities operated by the Department of Human Services (DHS). The Act also requires the OIG to investigate allegations of abuse and neglect that occur in community agencies licensed, certified, or funded by DHS to provide mental health and developmental disability services.

In FY17, DHS operated 14 State facilities. For FY17, there were also a total of 421 community agencies with 4,552 program sites (i.e., CILAs, group homes, day programs, etc.) that were under the investigative jurisdiction of the OIG. This represents an increase of 1,079 program sites since our FY10 audit or 31 percent.

In this audit we reported that:

- Total allegations of abuse and neglect reported to the OIG increased from 2,468 in FY10 to 3,698 in FY17 or 50 percent.
- The timeliness of completion for OIG investigations has deteriorated significantly since our FY10 audit. For FY10, 85 percent of closed cases were completed within the 60 working day requirement. For FY17, 50 percent of closed cases were completed within 60 working days.
- OIG case reports we reviewed generally were thorough, comprehensive, and addressed the allegation.
- The number of abuse and neglect investigations closed has increased substantially since FY10 (from 2,162 in FY10 to 3,601 in FY17); however, the substantiation rate has remained consistent. The substantiation rate for abuse and neglect investigations closed for FY10 was 12 percent, while it was 13 percent for FY17.
- DHS, in some cases, still takes an extended amount of time to receive and approve the actions taken by community agencies or State-operated facilities. For 4 of 20 investigations sampled (20%), the OIG could not provide an approved written response. These four investigations had been completed for an average of 180 days as of September 1, 2017, with a range of between 106 days to 289 days since the case was completed.
- The Quality Care Board did not have seven members during FY16 and FY17 as is required by the Act. In September 2017, a board member resigned leaving the Board with only three members. Four members are needed for a quorum.
- The OIG could not provide documentation to show that investigators had received the required initial training courses delineated in OIG Directives.

The audit report contains a total of 13 recommendations to the OIG and DHS. The OIG and DHS generally agreed with the recommendations in the report.



## AUDIT SUMMARY AND RESULTS

The Department of Human Services Act (Act) (20 ILCS 1305/1-17(w)) directs the Auditor General to conduct a program audit of the Department of Human Services (DHS), Office of the Inspector General (OIG) on an as-needed basis. The Act specifically requires the audit to include the Inspector General’s compliance with the Act and effectiveness in investigating reports of allegations occurring in any facility or agency. This is the 12th audit we have conducted of the OIG since 1990.

The Act requires the OIG to investigate allegations of abuse and neglect that occur in mental health and developmental disability facilities operated by DHS. The Act also requires the OIG to investigate allegations of abuse and neglect that occur in community agencies licensed, certified, or funded by DHS to provide mental health and developmental disability services (20 ILCS 1305/1-17(a)).

In FY17, DHS operated 14 State facilities. For FY17, there were also a total of 421 community agencies with 4,552 program sites (i.e., CILA’s, Group Homes, Day Programs, etc.) that were under the investigative jurisdiction of the OIG. This represents an increase of 1,079 program sites since our FY10 audit or 31 percent.

Total allegations of abuse and neglect reported to the OIG have increased since our 2010 audit. In FY10, 2,468 allegations were reported. In FY17, allegations of abuse and neglect increased to 3,698 or 50 percent. Allegations reported at community agencies increased from 1,501 in FY10 to 2,714 in FY17 or 81 percent. (pages 1-4)

### TIMELINESS OF INVESTIGATIONS

The timeliness of completion for OIG investigations has deteriorated significantly since our FY10 audit. For FY10, 85 percent of closed cases were completed within the 60 working day requirement. For FY17, 50 percent of closed cases were completed within 60 working days. This represents a decrease of 35 percent since the previous audit. In May 2017, the OIG’s administrative rules were amended to remove the requirement that investigations be completed within 60 working days. However, this requirement is still included in the OIG’s Directives.

Although FY17 data provided by the OIG showed improvement in timely reporting of allegations of abuse and neglect, timeliness could not be determined for 20 percent of facility allegations and 22 percent of community agency allegations. This was because the incident discovered time/date was reported as unknown, was inaccurate, or the time/date recorded was not specific. For FY17, the percent of allegations not reported within the statutorily required four hours was 11 percent at community agencies and 5 percent at State-operated facilities. Compared to FY10, late reporting at State facilities has decreased or improved from 10 percent in FY10 to 5 percent in FY17. For community agencies, late reporting improved from 13 percent in FY10 to 11 percent in FY17.

The OIG needs to improve the timeliness of investigator assignment and supervisory approval.

**The timeliness of completion for OIG investigations has deteriorated significantly since our FY10 audit.**

- **OIG directives require that investigations be assigned to an investigator within one working day of the Bureau Chief or Investigative Team Leader (ITL) receiving the intake.** For investigations closed during FY17, 96 percent (3,643 of 3,797) were initially assigned within one working day of the allegations being added to the OIG database. However, when compared to the date reported, nearly 50 percent (1,891 of 3,797) of investigations took two or more working days to be assigned to an investigator.
- **OIG directives require the ITL or Bureau Chief to review cases within seven working days of receipt absent extenuating circumstances.** For cases closed in FY17, 55 percent (2,079 of 3,797) were approved within 7 working days of submission.

The time it takes to obtain a written statement or interview from the alleged victim and perpetrator has increased since our last audit in FY10. Even though the OIG no longer requires critical interviews, we continue to look at the amount of time it takes to collect statements and interview the alleged victim and the alleged perpetrator in abuse and neglect cases.

For FY17 cases we sampled where there was a victim identified, it took an average of 26 days from the reporting of an incident for the alleged victim to be interviewed or a statement to be taken. Comparatively, for FY10 cases sampled where there was a victim identified, it took an average of 9 days to complete statements or interviews for the alleged victim.

For FY17 cases we sampled where there was a specific alleged perpetrator identified, it took an average of 45 days from the reporting of an incident for the alleged perpetrator to be interviewed or a written statement to be taken. Comparatively, for FY10 cases we sampled where there was a perpetrator identified, it took an average of 17 days to complete statements or interviews for the alleged perpetrator.

**Open cases and average caseloads have increased dramatically since our 2010 audit.**

Open cases and average caseloads have increased dramatically since our 2010 audit. Overall, open cases increased from 485 total cases as of August 2010 to 1,797 as of August 2017. For the investigative bureaus, caseload averages as of August 2010 ranged from a high of 23 cases per investigator in the Metro Bureau to a low of 12 in the South Bureau. For August 2017, caseload averages ranged from a high of 65 cases per investigator in the Metro Bureau to a low of 29 in the North Bureau. (pages 19-30)

### **THOROUGHNESS OF INVESTIGATIONS**

OIG case reports we reviewed generally were thorough, comprehensive, and addressed the allegation. However, in our sample of investigations, we found that injury reports were not in the case file for 5 of 32 (16%) investigations sampled where there was an allegation of an injury being sustained. Photographs were not in the case file for 10 of 30 (33%) investigations sampled. Medical records, treatment plans, or progress notes were also missing in 4 of 130 investigations sampled (3%).

We reviewed a sample of FY17 closed cases to determine whether there was a statement or interview with the alleged victim and the alleged perpetrator.

Of the 130 cases we reviewed, 4 cases (3%) involved an alleged victim who was verbal and the case file did not contain a written statement or interview with the alleged victim. Six cases (5%) did not contain documentation of a written statement or interview with the alleged perpetrator.

All of the cases we reviewed contained a Case Tracking Form and a Case Routing and Approval Form. Although all of the cases sampled contained these forms, for 36 of 130 (28%) case files reviewed, the Case Tracking Form was not complete. For 26 of 130 (20%) case files reviewed, the Case Routing and Approval Form was incomplete. (pages 31-34)

**The number of abuse and neglect investigations closed has increased substantially since FY10 (from 2,162 in FY10 to 3,601 in FY17); however, the substantiation rate has remained consistent.**

**ACTIONS, SANCTIONS, AND RECOMMENDATIONS**

The number of abuse and neglect investigations closed has increased substantially since FY10 (from 2,162 in FY10 to 3,601 in FY17); however, the substantiation rate has remained consistent. The substantiation rate for abuse and neglect investigations closed for FY10 was 12 percent, while it was 13 percent for FY17.

DHS, in some cases, still takes an extended amount of time to receive and approve the actions taken by community agencies or State-operated facilities. State-operated facilities and community agencies are required to submit a written response to DHS for all substantiated cases of abuse and neglect, or cases with other administrative issues within 30 calendar days from receipt of the investigative report. In our sample of investigations, there were 20 cases that required a written response. Of the 20 cases in our sample that required a written response, 1 of 20 (5%) took more than six months from the date the case was completed until the written response was approved by DHS. For 4 of 20 investigations sampled (20%), the OIG could not provide an approved written response. These four investigations had been completed for an average of 180 days as of September 1, 2017, with a range of between 106 days to 289 days since the case was completed.

During FY16 and FY17, the OIG did not recommend any sanctions regarding community agencies or State-operated facilities. The OIG has not recommended a sanction related to a State-operated facility for at least the past 24 years (1994-2017). During FY09, the OIG recommended that DHS’ Division of Developmental Disabilities take immediate action against one community agency, up to and including sanctions. (pages 35-43)

**OTHER ISSUES**

The Quality Care Board (Board) did not have seven members during FY16 and FY17 as is required by statute. For FY16, the Board also did not meet quarterly as required by statute and did not always have a quorum at all of the meetings that were held. As of October 2017, the OIG was unable to provide approved meeting minutes for scheduled meetings in February 2017 or May 2017 and, therefore, we could not determine whether these meetings were held or whether there was a quorum present to conduct business. In September 2017, a board member resigned leaving the Board with only three members. Four members are needed for a quorum. A lack of membership on the Board was also an issue in the previous audit released in 2010. The statutory requirement for having two members of the Board be a person with a disability or the parent of someone with a disability was not being met.

**In September 2017, a board member resigned leaving the Board with only three members. Four members are needed for a quorum.**

The Board cannot fulfill its statutory responsibilities “to monitor and oversee the operations, policies, and procedures of the Inspector General” with chronic vacancies, expired terms, and a lack of input from persons with a disability or a parent of such person.

The OIG could not provide documentation to show that investigators had received the required initial training courses delineated in OIG directives. Further, a number of classes that fall under required initial training for investigators are no longer available because of the discontinuation of the NetLearning system. Training information provided by the DHS Division of Mental Health and the Division of Developmental Disabilities showed that some employees at State-operated facilities were not receiving training in prevention and reporting of abuse and neglect (Rule 50 training). DHS does not monitor community agencies for compliance with training requirements.

The Act requires the Inspector General to conduct unannounced site visits to each facility at least annually (20 ILCS 1305/1-17(i)). FY16 and FY17 site visit information provided by the OIG showed a reduction in time spent on site, number of areas reviewed, and findings. In FY15, all 14 unannounced site visits were conducted over a two-day period. In FY16, 5 of the 14 visits were conducted over a two-day period. In FY17, 5 of the 14 were two-day visits. The FY15 unannounced site visits covered four different areas, two of which were medically related, and resulted in 51 findings. In FY16, two areas were examined, neither was medically related, and the site visits resulted in 15 findings. For FY17, three areas were examined resulting in a total of seven findings. (pages 45-56)

### **RECOMMENDATIONS**

The audit report contains a total of 13 recommendations to the Office of the Inspector General and the Department of Human Services. The OIG and DHS generally agreed with the recommendations in the report. Appendix E to the audit report contains the agency responses.

This performance audit was conducted by staff of the Office of the Auditor General.

**SIGNED ORIGINAL ON FILE**

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AMEEN DADA  
Division Director

This report is transmitted in accordance with Section 3-14 of the Illinois State Auditing Act.

**SIGNED ORIGINAL ON FILE**

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FRANK J. MAUTINO  
Auditor General

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