OFFICE OF THE AUDITOR GENERAL

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Performance Audit

Report Highlights

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Program Audit of the

Department of Human Services Office of the Inspector General

Background:

The Department of Human Services Act (Act) directs the Auditor General to conduct a program audit of the Department of Human Services, Office of the Inspector General on an as-needed basis. Section 1-17(w) of the Act that establishes the authority for this audit can be seen in Appendix A. 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 State-operated facility or community agency (20 ILCS 1305/1-17(w)).

The Office of the Auditor General has previously conducted 13 program audits of DHS OIG. The first audit was released in 1990 and the most recent in 2021, which covered FY18 through FY20. This audit covers FY21 through FY23.

Key Findings:

The Department of Human Services 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.

During FY23, there were a total 394 community agencies with 4,217 program sites that were under the investigative jurisdiction of the OIG. In addition, there were also 13 State-operated facilities under the investigative jurisdiction of the OIG. OIG investigators in many cases are responsible for hundreds of program sites covering large areas of the State, as well as State-operated facilities.

- The total number of allegations in FY21 (2,423) was the lowest number of allegations received since FY11 (2,255). However, the total number of allegations increased to 2,772 in FY22 and 3,281 in FY23. For FY11 through FY23, community agency allegations accounted for 59 to 73 percent of all reported allegations of abuse or neglect. For FY21, FY22, and FY23, community agency allegations accounted for 61 percent, 62 percent, and 59 percent of all reported allegations of abuse or neglect, respectively.
- Cases took an average of **205 calendar days** to complete during FY23, or an increase of 25 days, when compared to the FY20 audit.
- For FY23, 22 percent of cases were completed within 60 calendar days, which represents an 8 percent decrease in timeliness from the prior audit and a 14 percent decrease when compared to FY21 (36%) and FY22 (36%).
- The timeliness of case file reviews has worsened since the FY20 audit. During **FY20,** it took the OIG on average **41 days** to complete a supervisory review of substantiated cases. During this audit period, the average number of calendar days to review substantiated cases for **FY21** was **71 days**, for **FY22** was **66 days**, and for **FY23** was **86 days**.
- The Department of Human Services Act and the OIG's administrative rules require that allegations be reported to the OIG Hotline within four hours of initial discovery of the incident of alleged abuse or neglect. For FY21 through FY23, the percentage of allegations not reported within the statutorily required four hours for community agencies was between 15 and 16 percent. For State-operated facilities during the same time period, the number of allegations not reported within the four-hour time frame was between 7 and 10 percent.
- For FY21 through FY23, auditors found that 20 of the 42 (48%) unannounced site visit reports were sent outside of 60 days. No supporting documentation could be provided to show that an OIG employee was on site for the second unannounced site visit date at each State-operated facility for FY22 and FY23.

- During the audit period, FY21 through FY23, the OIG requested to hire for 38 positions. **Of these 38 hiring requests**, 17 positions had been filled as of August 17, 2023, and **21 were still vacant**. Once the position was posted, two positions were filled within three months, **ten positions took between 4 and 6 months to fill, and five positions took between 7 and 12 months to fill after the hiring request was made.**
- For FY23, DHS reported that **5,024** of **7,206 (70%**) State-operated facility employees had overtime. The **5,024** employees accumulated **1,606,962 hours of overtime during FY23**; **793** of these employees accumulated between **501 and 997 hours of overtime**, and **330** employees accumulated over **1,000** hours of overtime during FY23 (**318 of these 330 were employees with a direct care job title**). **These 318 employees accumulated a total of 443,527 hours of overtime during FY23**. Multiple academic studies have found that excessive amounts of overtime can have a detrimental effect on the care provided to residents or patients, as well as the health care workers providing the care.

Key Recommendations:

The audit report contains 12 recommendations including:

- The Office of the Inspector General should work to improve the timeliness of investigative case completion by identifying the barriers that are preventing timely completion and seeking the appropriate remedies for the issues identified.
- The Office of the Inspector General should work to improve the timeliness of OIG conducted interviews, and State-operated facility and community agency liaison conducted statements, including:
  - ensuring initial written statements are taken within 72 hours per OIG directive; and
  - ensuring the complainant and/or required reporter and the victim and/or guardian are interviewed by an OIG investigator within 15 working days of assignment per OIG directive.
- The Office of the Inspector General should ensure that investigations are reviewed by the Investigative Team Leader or Bureau Chief within fifteen working days of receipt absent extenuating circumstances as required by OIG directives.
- The Department of Human Services should ensure that all employees at State-operated facilities receive training in prevention and reporting of abuse, neglect, and exploitation as required by administrative rules, and the Department of Human Services Act (20 ILCS 1305/1-17(h)).
- The Office of the Inspector General should take steps to ensure that unannounced site visit reports are sent to State-operated facilities within 60 days of the site visit being completed as required by OIG Directive.
- The Office of the Inspector General and the Department of Human Services should work together to identify and mitigate the bottlenecks in the hiring process and address pay structure imbalances for management positions.
- The Department of Human Services should conduct a staffing analysis to determine if staffing levels at State-operated facilities are adequate. The staffing analysis should take into consideration the need to reduce excessive amounts of employee overtime, especially for direct care employees.

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

Report Digest

The Department of Human Services Act (Act) 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. Section 1-17(w) of the Act that establishes the authority for this audit can be seen in Appendix A. 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 State-operated facility or community agency (20 ILCS 1305/1-17(w)).

The Office of the Auditor General has previously conducted 13 program audits that reviewed the OIG's effectiveness in investigating allegations of abuse and neglect. The first audit was released in 1990 and the most recent in 2021, which covered FY18 through FY20. This audit covers FY21 through FY23. Digest Exhibit 1 shows the current status of the recommendations from the previous audit. (pages 1, 9-11)

Digest Exhibit 1
STATUS OF OIG RECOMMENDATIONS FROM PRIOR AUDIT PERIOD

Rec. #	Subject	Current Status
1	Allegation Reporting	Repeated
2	Investigator Assignment	Repeated
3	Case Completion Timeliness Standards	Partially Implemented
4	Timeliness of Interviews and Statements	Partially Implemented
5	Timeliness of Supervisory Review	Partially Implemented
6	Case Tracking and Closure Forms	Repeated
7	DHS Approval of Written Responses (*Not a recommendation within this audit because of OAG Compliance Examination finding*.)	Repeated
8	Quality Care Board (OIG and DHS) (*Recommendation 7 within this audit*.)	Repeated
9	Investigator Training (*Recommendation 8 within this audit*.)	Repeated
10	Facility Prevention and Reporting Training *(Recommendation 9 within this audit.)*	Partially Implemented
11	Community Agency Prevention and Reporting Training	Implemented
12	Rule 50.30(f) Training	Not Repeated
13	Unannounced Site Visit Reports *(Recommendation 10 within this audit.)*	Partially Implemented
14	Community Agency Site Visits	Not Repeated
15	OIG Annual Reports	Not Repeated
16	OIG Data	Not Repeated

Note: See Exhibit 5 within report (page 9) for full description of Current Status.

Source: OAG summary of updated status of the FY18 through FY20 DHS OIG audit recommendations.

Background

The OIG was initially established by Public Act 85-223 in 1987, which amended the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/1 *et seq*.). Under this Act, the OIG was required to conduct investigations of abuse and neglect within State-operated facilities serving the mentally ill and developmentally disabled. In 1995, the role of the OIG was expanded to include the authority to investigate reports of abuse and neglect at State-operated facilities or programs not only operated by DHS (facilities), but also those licensed, certified, or funded by DHS (community agencies). This includes State-operated mental health centers and developmental centers, Community Integrated Living Arrangements (CILAs), developmental training programs, and outpatient mental health services.

State-Operated Facilities

A State-operated facility is a mental health facility or a developmental disabilities center operated by DHS. As of July 2023, there were 13 State-operated facilities, with one being a dual facility. Six of these facilities are mental health facilities, and six are developmental centers. Choate, located in southern Illinois, is both a mental health facility and a developmental disabilities center.

Digest Exhibit 2
UNDUPLICATED INDIVIDUALS SERVED IN STATE-OPERATED FACILITIES
FY10 through FY23

Year	Developmental Centers	Mental Health Centers	Total
FY10	2,485	10,237	12,722
FY11	2,279	9,469	11,748
FY12	2,037	8,960	10,997
FY13	1,918	6,829	8,747
FY14	1,854	6,762	8,616
FY15	1,798	5,709	7,507
FY16	1,897	5,459	7,356
FY17	1,878	5,109	6,987
FY18	1,853	4,587	6,440
FY19	1,881	4,319	6,200
FY20	1,891	3,863	5,754
FY21	1,761	3,397	5,158
FY22	1,859	3,587	5,446
FY23	1,875	3,827	5,702

Source: OIG annual reports.

The number of individuals served in State-operated facilities has decreased slightly since our last audit. In FY20, there were 5,754 individuals at State-operated facilities compared to 5,702 in FY23. However, since FY10, the total number of unduplicated residents at all facilities has declined by 55 percent. The number served at State mental health centers has decreased by 63 percent, and the number served at State developmental centers has decreased by 25 percent. Digest Exhibit 2 shows the number of unduplicated residents served at State-operated facilities for the period FY10 through FY23.

Community Agencies

A community agency is an agency that is licensed, funded, or certified by DHS to provide mental health services or developmental disabilities services, such as a CILA. Also falling under this category are programs licensed, funded, or certified by DHS to provide mental health services or developmental disabilities services, such as a day training program. (page 2)

OIG Organization

The headcount provided by the OIG shows the number of employees increased since our previous audit. As of June 30, 2023, the OIG had 85 employees, 11 of

these employees were contractual (7 of the 11 were part-time contractual employees). In the FY18 through FY20 OIG audit, auditors reported the OIG had 78 employees and 2 were contractual.

The five OIG investigative bureaus are organized by region. According to information provided by the OIG, as of June 2023:

- The **North Bureau** is responsible for three facilities (Elgin Mental Health Center, Kiley Developmental Center, and Mabley Developmental Center) and 860 program sites operated by 56 community agencies in 20 counties in northern and northwestern Illinois.
- The **Cook County Bureau** is responsible for two facilities (Chicago-Read Mental Health Center and Madden Mental Health Center) and 1,460 program sites operated by 172 community agencies in Cook County.
- The **Chicago Metro Bureau** is responsible for two facilities (Shapiro Developmental Center and Ludeman Developmental Center) and 395 program sites operated by 22 community agencies in five counties in the northeastern part of the State.
- The **Central Bureau** is responsible for three facilities (Fox Developmental Center, Packard Mental Health Center, and Alton Mental Health Center) and 964 program sites operated by 83 community agencies in 47 counties in the central part of the State.
- The **South Bureau** is responsible for three facilities (Chester Mental Health Center, Choate Mental Health Center/Developmental Center, and Murray Developmental Center) and 538 program sites operated by 61 community agencies in 29 counties in the southern part of the State.

Digest Exhibit 3 summarizes the five OIG investigative bureaus and the number of counties, facilities, agencies, program sites, and square mileage each is responsible for investigating.

Digest Exhibit 3
SUMMARY OF OIG INVESTIGATIVE BUREAUS AND RESPONSIBILITIES
As of June 30, 2023

OIG Bureau	Number of Investigators	Counties	Sq. Mileage by Bureau	State Facilities	Community Agencies	Program Sites
North	5	20	10,628	3	56	860
Cook County	7	1	946	2	172	1,460
Chicago Metro	7	5	3,391	2	22	395
Central	8	47	28,588	3	83	964
South	9	29	12,040	3[1]	61	538
Total	**36[2]**	**102**	**55,593**	**13**	**394**	**4,217**

[1] Includes Choate, which is a dual facility located in the South Bureau.

[2] Does not include three investigative staff who were on leave of absence as of June 30, 2023.

Source: OAG analysis and OIG data.

As of June 30, 2023, there were a total of 394 community agencies with 4,217 program sites under the investigative jurisdiction of the OIG. In the previous audit, auditors reported that there were 518 community agencies operating 4,401 programs. As is shown in Exhibit 3, OIG investigators in many cases are responsible for hundreds of program sites covering large areas of the State. For instance, the Cook County Bureau has seven investigators who are responsible for allegations reported for two State-operated facilities and 1,460 community agency program sites (**an average of 209 sites per investigator**). In the Central Bureau, eight investigators are responsible for three State-operated facilities and 964 community agency program sites across 47 counties, covering **28,588 square miles, which is 3,574 square miles per investigator**. (pages 4-7)

Trends in Reported Allegations of Abuse and Neglect

When incidents of abuse or neglect are reported, the complaints are phoned into the OIG Hotline and may come from recipients, parents or guardians, individual employees, neighbors, or friends. The Department of Human Services Act (Act) and the OIG's administrative rules require that incidents of abuse and neglect be reported within four hours of the discovery of the incident.

Digest Exhibit 4
ALLEGATIONS OF ABUSE AND NEGLECT REPORTED
FY11 through FY23

Year	Facility Allegations	Community Agency Allegations	Total
FY11	712	1,543	2,255
FY12	746	1,753	2,499
FY13	797	2,120	2,917
FY14	987	2,357	3,344
FY15	888	2,455	3,343
FY16	932	2,373	3,305
FY17	984	2,713	3,697
FY18	1,172	2,700	3,872
FY19	1,152	2,423	3,575
FY20	915	1,886	2,801
FY21	948	1,475	2,423
FY22	1,044	1,728	2,772
FY23	1,335	1,946	3,281

Note: Beginning in FY21, OIG included death reports as part of total allegations received in the annual reports. Death reports are not included in this exhibit in order to remain consistent with prior OIG audits.

Source: OIG annual reports and OIG data.

Digest Exhibit 4 shows the total number of allegations decreased in FY20 and FY21 before increasing again in FY22 and FY23. The total number of allegations in FY21 (2,423) was the lowest number of allegations received since FY11 (2,255). For FY11 through FY23, community agency allegations accounted for 59 to 73 percent of all reported allegations of abuse or neglect. For FY21, FY22, and FY23, community agency allegations accounted for 61 percent, 62 percent, and 59 percent of all reported allegations of abuse or neglect, respectively.

In March 2020, the Governor issued a Gubernatorial Disaster Proclamation for the COVID-19 public health emergency. The Disaster Proclamation ended on May 11, 2023. The COVID-19 public health emergency was in effect during the majority of the audit period and affected how the OIG conducted investigations due to the Stay-At-Home Order, and as reported in the FY20 audit, impacted allegation reporting as well. (page 15)

Timeliness of Reporting Allegations

The Department of Human Services Act (Act), and the OIG's administrative rules require that allegations be reported to the OIG Hotline within four hours of initial discovery of the incident of alleged abuse or neglect (20 ILCS 1305/1-17(k)).

Digest Exhibit 5
ALLEGATIONS OF ABUSE AND NEGLECT NOT REPORTED WITHIN FOUR HOURS OF DISCOVERY
FY21 through FY23

Fiscal Year	Facility	Community Agency
FY21	7%	16%
FY22	10%	15%
FY23	9%	16%

Source: OAG analysis of OIG data.

As shown in Digest Exhibit 5, for FY21 through FY23, the percentage of allegations not reported within the statutorily required four hours for **community agencies** was between 15 and 16 percent. For **State-operated facilities** during the same time period, the number of allegations not reported within the four-hour time frame was 7 percent during FY21, 10 percent during FY22, and 9 percent during FY23. There was a significant percentage of allegations for which auditors could not determine if the incident was reported within the required four hours. For **State-operated facilities**, the number of cases where timeliness could not be determined ranged from 18 percent in FY22 to 23 percent in FY23. For **community agencies** the number of cases where timeliness could not be determined ranged from 19 percent in FY21 to 25 percent in FY23. (pages 22-23)

Investigation Timeliness

The timeliness of OIG investigations is critical because victims may forget what happened or not be able to recount what happened consistently, physical evidence may become lost over time, and employees or alleged perpetrators may no longer be available for interviews because of either a change in jobs or termination. This includes timeliness of the assignment of the investigation, timeliness in conducting interviews, and timeliness of supervisory review. (page 25)

Timeliness of Assignment

For investigations closed and not referred to the Illinois State Police, local law enforcement, or initially determined to be non-reportable, 91 percent of FY21 cases (2,433 of 2,662) were assigned within three working days, 92 percent of FY22 cases (2,367 of 2,573) were assigned within three working days, and 93 percent of FY23 cases (2,519 of 2,704) were assigned within three working days. (page 25)

Timeliness of Investigations

OIG directives state that the OIG **strives to complete investigations in 60 workdays**; however, the directive on conducting investigations requires the Investigative Bureau Chief to ensure investigations are completed within 60 days from assignment absent extenuating circumstances. Generally, 60 working days works out to over 80 calendar days. For consistency with prior audits, auditors will continue to report timeliness in both calendar and working days so that comparisons can be made over time.

Digest Exhibit 6
CALENDAR DAYS TO COMPLETE ABUSE AND NEGLECT INVESTIGATIONS
FY21 through FY23

Days to Complete Cases	Percentage of Cases Completed FY21	FY22	FY23
0-60 Days	**36%**	**36%**	**22%**
61-90 Days	14%	17%	20%
91-120 Days	9%	10%	14%
121-180 Days	10%	11%	14%
181-200 Days	2%	3%	3%
>200 Days	28%	24%	27%
Percent > 60 Days	**64%**	**64%**	**78%**
Total Cases Completed	**2,496**	**2,350**	**2,551**

Note: Totals may not add due to rounding.

Source: OAG analysis of OIG data.

Digest Exhibit 6 shows the percentage of cases completed in terms of ranges of the number of **calendar days** to completion for FY21, FY22 and FY23. Case completion is measured from the date the allegation of abuse or neglect is reported to the OIG to the date the investigative report is sent to the State-operated facility or community agency notifying them of the investigative outcome. For FY23, 22 percent of cases were completed within 60 calendar days, which represents an 8 percent decrease in timeliness from FY20 and a 14 percent decrease when compared to FY21 (36%) and FY22 (36%), as shown in Digest Exhibit 6. **Cases took an average of 205 calendar days to complete during FY23, or an increase of 25 days, when compared to FY20.** (pages 27-28)

Timeliness of Investigative Statements and Interviews

During fieldwork, a random sample of 50 investigations was selected for testing. As part of testing, the timeliness of statements taken and investigative interviews was reviewed.

OIG directives requires written statements to be taken by the **State-operated facility or community agency liaison immediately**, but no later than **72 hours** from the time the allegation was reported. However, during fieldwork testing, auditors found that for the 39 investigations where a victim could give a statement, 18 (46%) took over 72 hours. For the 41 investigations where an alleged perpetrator was available for a statement to be taken, 28 (68%) took over 72 hours to be completed.

The OIG updated their investigative directive on February 18, 2022, to include time frames for OIG investigators interviewing the complainant and/or required reporter and the victim and/or guardian. An OIG directive requires the OIG to interview the complainant and/or required reporter and the victim and/or guardian within 15 working days of case assignment. All other necessary interviews are to be conducted in a timely manner. Of the 39 investigations within our sample which had a victim who was verbal, 5 (13%) were not interviewed within 15 working days. The length of time for the interview to occur for these five cases ranged from 24 to 536 working days. Of the 33 investigations within our sample where a complainant was able to be interviewed, 5 (15%) were not interviewed within 15 working days. The interviews took place between 49 and 573 working days for these five cases.

There is no requirement in the OIG's directives for the time frame to interview the alleged perpetrator. However, OIG's directives do require the case to be completed within 60 working days unless there are extenuating circumstances.

Within the sample, auditors identified 10 investigations, which took the OIG over 60 working days to interview the alleged perpetrator. For these 10 cases, it took between 61 and 859 working days to interview the alleged perpetrator.

Conducting interviews quickly is essential in conducting effective investigations. As time passes, victims who have a developmental disability or mental illness may be more likely to forget what happened or be unable to recount what happened accurately. It may be more difficult to contact the complainant or required reporter, victims or their guardians, as well as witnesses, or perpetrators due to moving or a change in employment. (pages 32-33)

Timeliness of Supervisory Review and Approval

The timeliness of case file reviews has worsened since our last audit in FY20. During **FY20,** it took the OIG on average **41 days** to complete a supervisory review of substantiated cases. During this audit period, the average number of calendar days to review substantiated cases for **FY21** was **71 days**, for **FY22** it was **66 days**, and for **FY23** it was **86 days**.

The Investigative Team Leader or the Bureau Chief may send the case back to the investigator for further investigation. Once the Bureau Chief approves a substantiated case, OIG directives require that it be forwarded to the Deputy Inspector General for review and approval. The Inspector General is also required to review all Health Care Worker Registry cases.

OIG's database does not track cases that were sent back for additional investigation. Therefore, our analysis only shows the total calendar days from the date submitted for review until the Bureau Chief signed the case as reviewed. Improvements in the time it takes to review substantiated cases could have a substantial effect on the overall timeliness of case completion at the OIG. (page 34)

Thoroughness of Abuse and Neglect Investigations

Auditors randomly selected a sample of 50 closed investigations from FY23. The sample was weighted and stratified by OIG investigative bureau and by the number of closed community agency investigations and closed State-operated facility investigations. The results of testing are not projectable to the population.

OIG case reports auditors reviewed were generally thorough, comprehensive, and addressed the allegations. Case files contained interviews and witness statements, injury reports, pertinent medical records, and treatment plans, as well as photographs. (page 37)

Documentation of Case Monitoring and Review

In 5 of the 50 (10%) investigations sampled, the Case Tracking Form was not completely filled out. The section, which identified the accused party and the finding, was left blank. For 26 of the 50 (52%) investigations sampled, according to the Case Closure Checklist, it appeared that the Investigative Team Leader or Bureau Chief did not review the case file as required. Instead the initial reviewer either signed or initialed for the Bureau Chief, which circumvents the purpose of

the second review. For three investigations (6%), there was no signature or initials for the Investigative Team Leader or Bureau Chief, and for one investigation (2%), the Case Closure Checklist was not filled out. (page 39)

Quality Care Board

The Act establishes a Quality Care Board (Board) within the Office of the Inspector General. The Board is required to monitor and oversee the operations, policies, and procedures of the Inspector General to ensure the prompt and thorough investigation of allegations of neglect and abuse. The Act requires the Board to be composed of seven members appointed by the Governor with the advice and consent of the Senate. Two members are required to be a person with a disability or a parent of a person with a disability.

The Board did not meet the statutory requirement of having seven members during the audit period, and two members had been serving on expired terms. Statutory requirements regarding Board membership state that upon the expiration of each member's term, a successor shall be appointed; in the case of a vacancy in the office of any member, the Governor shall appoint a successor for the remainder of the unexpired term. The Board cannot fully function as directed by statute to "monitor and oversee the operations, policies, and procedures of the Inspector General" with vacancies and neglected membership requirements (20 ILCS 1305/1-17(u)). (pages 49-51)

Training

The Department of Human Services Act contains requirements related to OIG training programs (20 ILCS 1305/1-17(h)). The Act requires the Inspector General to:

- *Establish a comprehensive program to ensure every person authorized to conduct investigations receives ongoing training relative to investigation techniques, communication skills, and the appropriate means of interacting with persons receiving treatment for mental illness, developmental disability, or both mental illness and developmental disability; and*
- *Establish and conduct periodic training programs for facility and agency employees concerning the prevention and reporting of any one or more of the following: mental abuse, physical abuse, sexual abuse, neglect, egregious neglect, or financial exploitation…Nothing in this section shall be deemed to prevent the Office of Inspector General from conducting any other training as determined by the Inspector General to be necessary or helpful.* (page 52)

Investigator Training

Auditors received training data for OIG employees, including hire date for new employees, the trainings completed, the date of each training, and each employee's job title for FY21, FY22, and FY23. Auditors found 6 of 9 (67%) newly hired investigative employees did not have documentation to support completion of the required new hire trainings.

Auditors also reconciled the training information provided for OIG employees required to have continuing training. During FY21, 7 of 61 (11%) OIG employees were missing between 1 and 7 trainings. During the prior audit, 5 of the 61 (8%) employees who were required to have continuing training in FY20 did not complete it, which is comparable to FY21. However, for FY22 and FY23, compliance with the required trainings was significantly worse. During FY22, 34 of 56 (61%) OIG employees did not meet the training requirements. These 34 employees were missing between 2 and 6 trainings. During FY23, 27 of 53 (51%) OIG employees did not meet the training requirements. These 27 employees were missing between 1 and 7 trainings. (pages 52-53)

Rule 50 Training

The OIG's administrative rules outline the training requirements for State-operated facility and community agency employees. This training is commonly referred to as "Rule 50 training." The OIG provides State-operated facilities and community agencies with Rule 50 training materials through PowerPoint presentations on the DHS website, and the community agency or State-operated facility provides the training for its employees. All employees at community agencies and State-operated facilities are required to have Rule 50 training upon being hired, and then at least biennially thereafter (59 Ill. Adm. Code 50.20(d)(2)).

The Act does not require the OIG to monitor compliance with training; it only requires that the OIG establish and conduct training concerning prevention and reporting of abuse and neglect. (pages 53-54)

Documentation provided by DHS showed that employees at State-operated facilities did not always receive the statutorily required Rule 50 training. The Division of Mental Health could not provide calendar year 2021 Rule 50 training at facilities; they could only provide an aggregate total for calendar years 2016 through 2021. **For that time period the overall percentage for compliance with Rule 50 training was 87 percent**. Compliance with Rule 50 training was provided for calendar years 2022 and 2023.

The information provided shows that none of the State-operated facilities reached 100 percent compliance with the Rule 50 training requirement for all three calendar years 2021 through 2023. Shapiro had the lowest completion percentage of the Developmental Centers (83% during CY22), and Madden had the lowest completion percentage of the Mental Health Centers (94% during CY23). Auditors could not determine the completion percentages for the Mental Health Centers for calendar year 2021 for reasons explained previously.

In the prior audit, DHS officials stated that training on Rule 50 is required annually as a proactive measure to ensure that employees are well versed regarding Rule 50 and the expectations regarding treatment of and for residents/patients. Although the data provided shows that there was an improvement when compared to the prior audit period, employees at State-operated facilities are still not always receiving Rule 50 training annually, as required by DHS. Not ensuring that all State-operated facility employees receive

Rule 50 training on the prevention and reporting of abuse and neglect may put the health and safety of residents and patients at risk. (pages 53-55)

Unannounced Site Visits

The Department of Human Services Act requires the Inspector General to conduct unannounced site visits to each State-operated facility at least annually for the purpose of reviewing and making recommendations on systemic issues relative to preventing, reporting, investigating, and responding to all of the following: mental abuse, physical abuse, sexual abuse, neglect, egregious neglect, or financial exploitation (20 ILCS 1305/1-17(i)).

The Inspector General reviews and approves the unannounced site visit report, and the approved report is sent to the State-operated facility. Report drafting, approval, and sending the report to the facility are required to be completed within 60 days of the unannounced site visit. (page 57)

Timeliness of Site Visit Reports

For FY21 through FY23, auditors found that 20 of the 42 (48%) reports were sent outside of 60 days. During FY21, unannounced site visits had to be conducted remotely because of the public health emergency due to COVID-19. For the FY22 and FY23 unannounced site visits, information received showed that there were two site visit dates for each site visit. However, no supporting documentation could be provided to show that an OIG employee was on site for the second site visit date at each State-operated facility. Additionally, for FY22 and FY23, there was an excessive amount of time that passed between the first and second site visit dates for numerous site visits. During FY22, **the second site visit date for all 14 site visits occurred between 36 and 177 days after the initial site visit, with an average of 100 days between the dates**. During FY23, **the second site visit date for the 14 site visits occurred between 37 and 149 days after the initial site visit, with an average of 95 days between the dates**.

It is important that unannounced site visit reports are delivered to State-operated facilities in a timely manner in order to rectify any issues that are identified as a result of the unannounced site visit as quickly as possible and to promote the safety and well-being of the residents living within the facilities. (pages 58-60)

OIG Staffing Issues

As shown in Digest Exhibit 7, during the audit period, FY21 through FY23, the OIG requested to hire for 38 positions. **Of these 38 hiring requests**, 17 positions had been filled as of August 17, 2023, and **21 were still vacant**. Once the position was posted, two positions were filled within three months, **ten positions took between 4 and 6 months to fill, and five positions took between 7 and 12 months to fill after the hiring request was made.**

Digest Exhibit 7
TIMEFRAME FOR OIG HIRING REQUESTS TO GO THROUGH HIRING PROCESS
FY21 through FY23 (As of August 14, 2023)

	0-3 Months	4-6 Months	7-9 Months	10-12 Months	Over 12 Months
OIG hire request to position posted date[1]	33	4	0	0	0
Position posted date to hire date[2]	2	10	3	2	0
Positions vacant from hire request date[3]	5	7	7	2	0

[1] One hire request, which was made on 04/06/23, was not posted as of 08/14/23.
[2] 17 positions had been filled as of 08/17/23.
[3] 21 positions remained vacant as of 08/17/23.

Source: OAG analysis of OIG hiring data.

OIG officials stated that multiple bureaus have lost headcount; if there is a lack of investigators, then timeliness worsens and caseloads increase. According to OIG officials, they are unable to hire investigators fast enough to maintain their headcount. Additionally, OIG officials explained that **in the near future, there will be Bureau Chiefs that will be making less than lead investigators because of the current pay schedule, and there are currently employees that are applying for demotions.**

Review of OIG Salary Data

Because of the concerns raised by OIG officials regarding an imbalance in pay structure between Investigative Team Leaders and Bureau Chiefs, auditors reviewed the calendar 2023 salaries for all OIG investigative staff. Digest Exhibit 8 shows that 5 of 8 Investigative Team Leaders were making more than at least one Bureau Chief. Of these, four were making more than 2 of the 3 Bureau Chiefs, and one was making more than all three Bureau Chiefs. Of the 37 Investigators in the analysis, 27 were making more than at least one of the Investigative Team Leaders, and two of these Investigators were also making more than 2 of the 3 Bureau Chiefs. (pages 61-63)

Digest Exhibit 8
ANNUAL SALARY COMPARISON OF OIG INVESTIGATIVE STAFF[1]
CY23

	Yes	No
Investigative Team Leader Annual Salary Higher than Bureau Chief	5	3
Investigator Annual Salary Higher than Investigative Team Leader	27	10
Investigator Annual Salary Higher than Bureau Chief	2	35

[1] For the 48 employees with available Comptroller salary information. There are **3** Bureau Chiefs, **8** Investigative Team Leaders, and **37** Investigators within this analysis.

Source: OIG headcount and Illinois Comptroller Employee Salary database.

DHS State-Operated Facility Issues

Auditors reviewed the overtime hours reported for DHS State-operated facility staff for FY23. DHS reported that 5,024 of 7,206 (70%) State-operated facility employees had overtime during this time period. The 5,024 employees accumulated 1,606,962 hours of overtime during FY23; 793 of these employees accumulated between 501 and 997 hours of overtime, and 330 employees accumulated over 1,000 hours of overtime during FY23 (318 were

employees with a direct care job title). The additional income from accumulating an excessive amount of overtime could create an incentive for employees to continue working overtime when they physically and mentally should not be working.

Multiple academic studies have found that excessive amounts of overtime can have a detrimental effect on the care provided to residents or patients, as well as the health care workers providing the care. Many of the potential consequences may be attributable to sleep deprivation, which is strongly associated with excessive overtime. Digest Exhibit 9 shows the 318 direct care employees with over 1,000 hours of overtime accumulated during FY23 by job title. The job titles which had the highest number of employees with overtime are Mental Health Technician I, Mental Health Technician II, Mental Health Technician III, and Security Therapy Aide I. These four job titles account for 253 of the 318 employees with over 1,000 hours of overtime, and represent 349,138 of the 443,527 (79%) total hours of overtime accumulated by these 318 employees. The job descriptions for these positions show that direct interaction with residents is their primary responsibility.

Digest Exhibit 9
DHS FACILITY DIRECT CARE EMPLOYEES WITH OVER 1,000 HOURS OF OVERTIME
By Job Title for FY23

Job Title	Number of employees	Total OT Hours	Avg Hrs/ Employee
Mental Health Technician II	146	205,035	1,404
Security Therapy Aide I	41	54,702	1,334
Mental Health Technician I	36	47,353	1,315
Mental Health Technician III	30	42,049	1,402
Security Officer	16	22,424	1,402
Mental Health Technician IV	14	21,918	1,566
Registered Nurse II	14	18,279	1,306
Security Therapy Aide II	7	10,733	1,533
Registered Nurse I	5	6,783	1,357
Rehabilitation Workshop Instructor I	2	2,355	1,178
Rehabilitation Workshop Instructor II	2	4,567	2,283
Habilitation Program Coordinator	1	2,058	2,058
Mental Health Specialist Trainee	1	1,123	1,123
Physical Therapy Aide III	1	1,112	1,112
Residential Services Supervisor	1	1,964	1,964
Security Officer Sergeant	1	1,072	1,072
Totals	**318**	**443,527**	**1,395**

Source: OAG analysis of DHS data.

On June 7, 2023, the OIG released a report titled "Reducing Abuse and Neglect at Choate Mental Health and Developmental Center." The report outlined several issues the OIG found while conducting their review of the State-operated facility including: staffing shortages; employee fatigue; inappropriate staff behavior,

such as mocking residents; lack of individualized treatment for residents; cover-up culture; obstacles to residents reporting allegations of abuse and neglect; staff non-reporting of misconduct; retaliation for reporting allegations of abuse and neglect, including fear of losing their job; and misreporting allegations of abuse and neglect. The OIG has not conducted a similar review on any of the other State-operated facilities. However, because there are a high number of allegations at several of the other State-operated facilities, it is likely that many of the issues discussed within the report on Choate are also occurring within these facilities as well. **The OIG does not have the statutory authority to address many of these issues, which are potentially contributing to the abuse and neglect of residents.** (pages 64-70)

Audit Recommendations

This audit report contains 12 recommendations. Eight are directed to the Office of the Inspector General, two are directed to the Department of Human Services, and two are directed at both OIG and DHS. The OIG and DHS agreed with the recommendations. Complete responses are included in this report as Appendix F.

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

SIGNED ORIGINAL ON FILE

JOE BUTCHER
Division Director

This report is transmitted in accordance with Sections 3-14 and 3-15 of the Illinois State Auditing Act.

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

FJM:PMR