OFFICE OF THE AUDITOR GENERAL

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Performance Audit
Report Highlights

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Performance Audit of the

Community Integrated Living Arrangement Program

Background:

Legislative Audit Commission Resolution Number 164, adopted March 14, 2023, directed the Auditor General to conduct a performance audit of the Department of Human Services' (DHS) oversight and monitoring of the Community Integrated Living Arrangement (CILA) program. CILAs are living arrangements certified by a community mental health or developmental services agency where eight or fewer recipients with mental illness or recipients with a developmental disability reside under the supervision of the agency.

DHS, through its Bureau of Accreditation, Licensing, and Certification (BALC), is responsible for the licensing of CILA providers. Other DHS areas join BALC in monitoring and oversight of the CILA program.

There were 235 CILA providers specializing in care for individuals with developmental disabilities in operation as of July 13, 2023. For the period FY21-FY23, the State expended more than $2.2 billion on CILAs.

Key Findings:

CILA Licensing Process

- In accordance with the CILA rule, DHS conducts licensing surveys of CILA programs. During the COVID-19 pandemic, DHS implemented a temporary self-assessment process for licensing. However, DHS failed to ensure that all CILA providers followed protocols relative to **self-assessments**. **Thirty-six percent of our sample population had no self-assessment** during the period beginning July 2020 through May 2021, a period determined by DHS. The **average number of days between BALC surveys for those CILA providers without self-assessments was 889 days**. Additionally, BALC officials also failed to conduct all of its monitoring activities during the self-assessment period by not completing all required interviews of residents, guardians, and CILA staff.

- DHS failed to conduct BALC licensing surveys in a thorough, accurate, and timely manner. We found instances of BALC **not following established criteria** in the review of CILA providers for determining whether a license should be renewed.

- DHS serves a Notice of Violation (NOV) when deficiencies are noted during a survey. We noted several issues with the use of NOV forms:
  - DHS failed to report violations identified in self-assessments and BALC reviews on a NOV form. In the case of one self-assessment, **DHS did not issue an NOV despite a provider self-reporting nine violations**. Sixteen out of forty-seven NOVs in our sample had violations noted during full and focus surveys that were **not included on the NOV**.
  - Additionally, violations reported on NOVs **were not entered into the DHS's NOV database**. Seven out of sixteen self-assessments received an NOV with violations and had some or all violations missing from the NOV database. Additionally, 14 of 47 BALC surveys had some or all violations from the NOV not entered into the NOV database.

- CILA providers are required to report suspected instances of abuse or neglect against individuals to the DHS Office of the Inspector General (OIG). However, DHS failed to ensure that BALC surveyors reviewed whether the timeliness of CILA providers reporting of OIG incidents complied with reporting requirements. We found **34 instances**, at five providers, where evidence **showed noncompliant reporting yet the scoring did not parallel the late reporting**.
- DHS allowed a CILA provider to remain serving residents on a continued license even though its original license had been **expired for nearly 900 days**. While **DHS had no documentation in its file** for the provider and the providers dispute with the Office of the State Fire Marshal, **DHS issued three continuations** for the CILA license.

DHS Monitoring of the CILA Program

- A DHS CILA monitoring unit has **operated for five fiscal years under a draft policy and procedure manual**. Additionally, a DHS licensing unit had a policy and procedure manual that **had conflicting requirements** related to survey requirements.
- DHS failed to enforce admissions restrictions on CILA providers that were on probation based on unacceptable licensing survey scores. The failure led to five individuals from our sample being **admitted to providers that failed to achieve minimally acceptable scores** from BALC officials.
- DHS failed to **assign division monitors** to oversee corrective actions by CILA providers with the worst licensing survey scores. This failure is a violation of administrative rule.
- DHS **failed to sanction a CILA provider that repeatedly refused to cooperate with OIG investigations** of allegations against the provider. Our examination of OIG investigative reports found **22 instances** where the provider violated State law or rule by not cooperating with OIG investigations. DHS could **not provide any documentation** to show it took any actions against the provider for a failure to cooperate.
- DHS failed to **consistently apply** CILA rules to all providers that failed to correct noted deficiencies. While some providers had CILA licenses revoked, **others were allowed to continue in the program** despite not correcting deficiencies. Additionally, for providers allowed to remain in the program, DHS **did not have documentation** to support plans of correction for the uncorrected deficiencies.

Emergency Call Notifications

- Public Act 101-0075 required facilities licensed under the CILA Act to notify DHS when emergency calls are made from the facility. The Public Act also required DHS to adopt rules to implement the new requirement. However, DHS failed to follow State statute and develop administrative rules for emergency notifications made from CILA locations. While DHS did revise the CILA Rule **1,246 days after the effective date of the emergency notification requirement**, that revision **failed to contain a definition of "emergency call" or any penalties for non-compliance**.
- DHS developed the Critical Incident Reporting Analysis System (CIRAS) to capture electronic reports from providers and Independent Service Coordinators (ISCs) for critical incidents involving individuals with developmental disabilities. However, DHS failed to hold CILA providers that were not compliant with CIRAS reporting requirements accountable. Over the period FY20-FY23, **41 percent of CIRAS incident reports were not made within the required two working day requirement**. Failure to enforce the reporting requirements resulted in one CILA provider taking **563 days, on average, to report FY20 incidents**.
- DHS failed to enforce its own procedures relative to **CILA providers maintaining the requisite number of reporters** for the CIRAS system.
- All CIRAS submissions require either a next day follow up or a 10-day follow up. However, DHS failed to take steps necessary to ensure ISCs conducted follow up activities as required by Department procedure. This resulted in 76 percent of the **next day follow up** to cases either not being conducted or not conducted timely. Additionally, **10,617 cases that required 10-day follow up were not conducted** by the ISC. For the 10-day follow up, 28 percent of the cases were not initially followed up timely. Finally, DHS **could not provide sufficient documentation to support its own compliance** with the procedures for following up with ISCs.
- DHS has implemented a process for reporting critical incidents that **results in under-reporting**. DHS requirements for abuse, neglect, and exploitation require reporters to send those allegations to OIG. However, when OIG is unable to substantiate the allegations, the information is not included in the reporting of critical incidents in the CIRAS database. CILA providers and ISCs have **reporting understandings that differ** from the DHS reporting criteria.

Key Recommendations:

The audit report contains 15 recommendations directed to DHS:

- DHS should ensure that BALC consistently applies licensing protocols, such as self-assessments, even during times of unprecedented events, such as COVID-19, to all CILA providers.
- DHS should ensure BALC surveys are conducted in a thorough, accurate, and timely manner.

- DHS should ensure all violations noted during a BALC licensing survey are included in the Notice of Violation (NOV) and the NOV database.
- DHS should ensure that its surveyors comply with agency guidance and review OIG reports for timely reporting before starting a licensing survey. Additionally, if DHS does not consider BALC surveyors to be responsible for checking CILA provider compliance with OIG reporting timeliness, DHS should seek changes to the CILA Rule and its own Compliance Checklist.
- DHS should revise its licensing policies and procedures to include an acceptable number of license continuations. Additionally, DHS should define what a "short-term extension" means in relation to licensing. Finally, when a CILA provider does not present acceptable Office of the State Fire Marshal documentation during a licensing survey, DHS should enforce penalties that include admissions holds on the provider.
- DHS should finalize, formalize, and approve the Bureau of Quality Management policy and procedure manual so that monitoring of CILA providers is consistent. Additionally, DHS should make corrections needed in the BALC policy and procedure manual so that staff conducting licensing surveys have correct and approved procedures to guide actions.
- DHS should take steps necessary to comply with rules and ensure that admissions are not made to a CILA provider that is on probation.
- DHS should comply with administrative rule and assign a monitor to oversee corrective actions for CILA providers that are on a restricted license.
- DHS should develop a reporting mechanism where instances of noncooperation by CILA providers are reported to the Division of Developmental Disabilities. Additionally, when providers violate State law and administrative rule by failing to cooperate with the OIG, DHS should impose appropriate sanctions on the provider as allowed for in the Department of Human Services Act (20 ILCS 1305/1-17(p)(iv)).
- DHS should develop criteria for CILA providers relative to circumstances of license revocation. Additionally, DHS should consistently apply those criteria to all CILA providers.
- DHS should comply with the CILA Act and develop administrative rules for emergency notifications that clearly define what an emergency call is and the penalties to providers for failure to comply.
- DHS should develop sanctions for CILA providers that are non-compliant with CIRAS reporting requirements. If DHS believes it already has appropriate sanctions available, it should enforce those sanctions.
- DHS should ensure that CILA providers maintain the correct number of designated reporters and should develop a procedure that includes sanctions if a CILA provider does not maintain the correct number of designated reporters.
- DHS should ensure that ISCs comply with the requirements in the CIRAS Manual for follow up to critical incidents. Also, DHS should document its own compliance with the CIRAS Manual relative to next day contacts for applicable incidents.
- DHS should consider revising the reporting requirements in the CIRAS Manual to allow allegations reported to OIG, if they include elements that relate to critical incident reporting, to be also reported to CIRAS. If DHS chooses not to revise the requirements, then DHS should clarify the current reporting requirements for CILA providers and ISCs so that they are compliant with policy.

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

Report Digest

On March 14, 2023, the Legislative Audit Commission (LAC) adopted Resolution Number 164 directing the Auditor General to conduct a program audit of the Department of Human Services' (DHS) oversight and monitoring of the Community Integrated Living Arrangement (CILA) program. The Resolution contained several issues to examine. Our assessment of these issues is shown in Digest Exhibit 1. (page 1)

Digest Exhibit 1
ASSESSMENT OF AUDIT DETERMINATIONS

Audit Determinations	Auditor Assessment
An examination of the process for licensing developmental services agencies and certifying CILAs for persons with developmental disabilities;	• Auditors found the licensing process of provider agencies by DHS had significant deficiencies. (pages 7-31)
An examination of whether oversight and monitoring of licensed CILA providers complies with statutory and regulatory requirements, including site visits and inspections of records and premises.	• Auditors found monitoring by DHS of the CILA program lacked updated policies, consistent application of policies, and a CILA provider that repeatedly refused to cooperate with Office of the Inspector General investigations. (pages 32-46)
An examination of whether the DHS notification process for emergency calls complies with applicable laws, rules, and procedures.	• Auditors found DHS had not complied with State law in promulgating rules for emergency calls made from CILA locations. Additionally, DHS failed to hold providers accountable when the providers did not report critical incidents to DHS. Finally, the DHS system for reporting critical incidents results in under-reporting. (pages 47-66)

Source: OAG assessment of the audit determinations contained in LAC Resolution Number 164.

Background

CILAs are living arrangements certified by a community mental health or developmental services agency where eight or fewer recipients with mental illness or recipients with a developmental disability reside under the supervision of the agency. The Community Integrated Living Arrangements Licensure and Certification Act (210 ILCS 135), also known as the CILA Act, governs CILAs. The purpose of the CILA Act *"is to promote the operation of community-integrated living arrangements for the supervision of persons with mental illness and persons with a developmental disability by licensing community health or developmental services agencies to provide an array of community-integrated living arrangements for such individuals."* (pages 1-2)

Developmental Disabilities CILAs

According to Bureau of Accreditation, Licensure, and Certification (BALC) information, there were **235 CILA providers specializing in care for individuals with developmental disabilities (DD)** in operation as of July 13,

2023. The **number of residents served** in the DD CILA program has remained relatively stable for the period FY21-FY23. The adjacent text box provides end of year counts for CILA residents for FY21-FY23. (page 2)

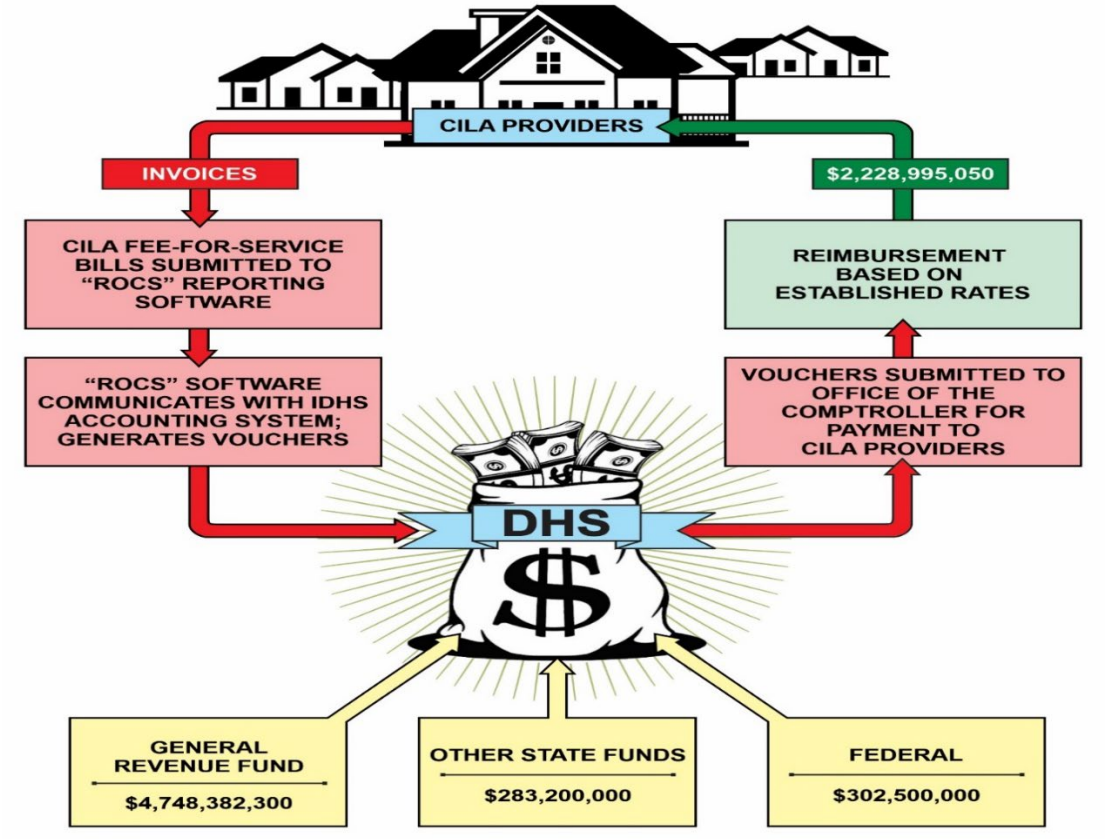
DD CILA Residents
FY21 – 11,277
FY22 – 11,132
FY23 – 11,006

Funding for the CILA Program

CILAs are funded from a handful of appropriations, both State and federal. **The appropriations fund other services on top of CILAs**. For the period FY21-FY23, **the State expended over $2.2 billion on CILAs**.

CILA funding is considered a fee-for-service and is typically **billed on a monthly basis**. While each CILA resident has an **individually determined CILA rate based on their assessed needs**, each of those **rates fund a portion of the operating cost of a CILA**. Digest Exhibit 2 provides information showing the flow of funds for the CILA program. (pages 3-5)

Digest Exhibit 2
FLOW OF FUNDING FOR COMMUNITY-BASED SERVICES INCLUDING CILAS
FY21-FY23



Note: DHS does not have appropriated funding specifically for the CILA program. The DHS appropriation language is for all community-based services provided to individuals with intellectual and developmental disabilities.

Source: OAG developed from DHS information.

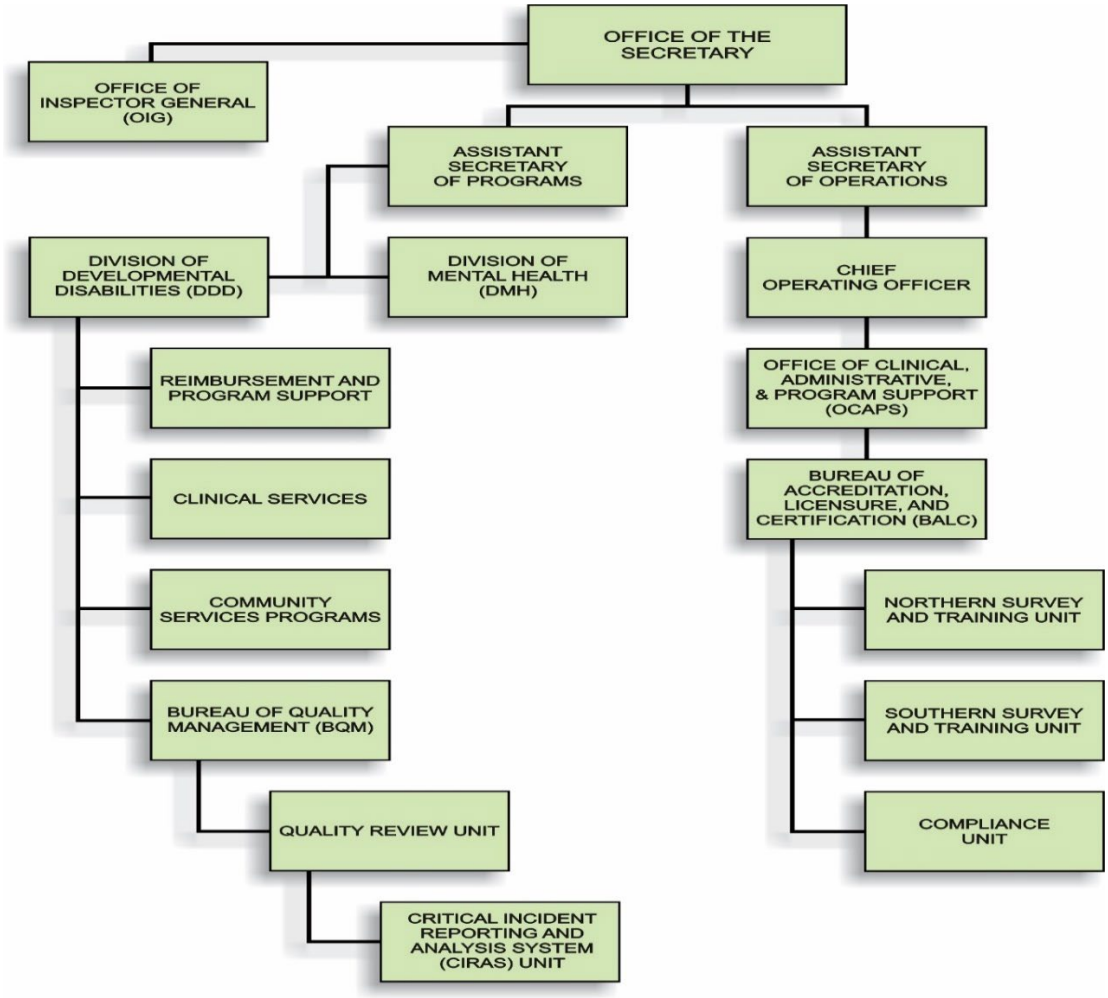
Department of Human Services

DHS Mission Statement

To provide equitable access to human/social services, support, programs, and resources to enhance the lives of all who are served by DHS.

The CILA Act (210 ILCS 135) provides that DHS is the entity charged with the licensure of providers for the CILA program. DHS is responsible for a wide variety of human service programs. The adjacent text box details the DHS Mission Statement. Digest Exhibit 3 provides an organizational chart for the DHS areas associated with CILAs. The major units involved with the CILA program are BALC, the Division of Developmental Disabilities (DDD), the Bureau of Quality Management (BQM), and the Office of the Inspector General (OIG). (pages 5-6)

Digest Exhibit 3
DHS ORGANIZATIONAL UNITS INVOLVED WITH CILA
FY21-FY23



Source: OAG developed from DHS information.

CILA Licensing Process

BALC has the responsibility to ensure that community agencies conform to established standards that indicate their appropriateness to be included as partners in achieving the DHS mission. The CILA Act (210 ILCS 135/4(b)) requires that **the licensure system be administered by a unit within DHS, which shall be administratively independent of units responsible for funding agencies**. (page 7)

Inconsistent Self-Assessments

During the COVID-19 pandemic, DHS published, on July 22, 2020, a memorandum titled Temporary Self-Assessment Process and New Site Inspection Process. The memo notified providers of the plan to accommodate licensing based on the COVID-19 challenges. The memo stated, *"The self-assessment process is being utilized as a method for compliance with rule and to ensure health and safety of the individuals we all serve."*

DHS failed to ensure that all CILA providers followed protocols relative to self-assessments. Thirty-six percent of our sample population **had no self-assessment during the period beginning July 2020 through May 2021, a period determined by DHS**. **The average number of days between BALC surveys for those CILA providers without self-assessments was 889 days**. Additionally, BALC officials also failed to conduct all of its monitoring activities during the self-assessment period by not completing all required interviews of residents, guardians, and CILA staff.

Digest Exhibit 4 provides a time analysis for the 25 providers in our sample in relation to the self-assessments. Our analysis found:

- 36 percent (9 of 25) of our licensing sample **had no self-assessment conducted** on its operations;
- 78 percent (7 of 9) of the providers with no self-assessment **did have a BALC licensing survey prior to and after** the self-assessment period;
- **891 days was the average time between BALC licensing surveys for the seven providers**; and
- 22 percent (2 of 9) of the providers without a self-assessment also **did not have** a BALC licensing survey prior to the self-assessment period. (pages 9-12)

Digest Exhibit 4
SELF-ASSESSMENT TIME ANALYSIS
Audit Sample Testing of 25 CILA Providers

Provider	Previous Full Review Date	Self-Assessment Date	Next Full Review Date	Days Between Full Reviews
Abundant Possibilities	N/A	N/A	09/20/22	N/A
Arrowleaf	10/22/18	09/08/20	05/17/21	938
Avancer Homes	09/12/18	N/A	01/11/21	852
Broadstep Academy-IL	05/31/18	07/14/20	05/10/21	1,075
Brownstone Services	10/10/19	N/A	01/25/21	473
Caring Hands of Illinois	11/20/19	09/08/20	11/22/21	733
Compassionate Living Home	N/A	07/20/20	01/05/22	N/A
Divine Center	12/04/18	N/A	08/15/22	1,350
Family Association Plus	10/30/19	08/10/20	02/22/22	846
Harmony House CILA	01/15/20	N/A	05/18/22	854
Heroes of the Game	N/A	N/A	05/23/22	N/A
Homes of Hope	03/14/19	N/A	07/06/21	845
Joseph Rehabilitation Center	03/28/17	08/10/20	11/08/21	1,686
Kwanza Suites Corporation	01/04/18	06/29/20	04/12/21	1,194
Liberty Enterprises	01/14/20	N/A	05/09/22	846
Lutheran Social Services of Illinois	11/13/18	08/24/20	04/04/22	1,238
Millennium Gardens	08/29/18	07/07/20	04/26/21	971
Patterson House	01/06/20	N/A	10/17/22	1,015
Pinnacle Opportunities	10/18/18	09/09/20	12/16/21	1,155
Random Acts of Kindness	04/10/19	07/20/20	07/19/21	831
Royal Living Center	07/27/18	08/24/20	08/08/22	1,473
Shore Community Services	03/16/17	07/20/20	08/09/21	1,607
Trilogy	12/27/17	09/08/20	02/22/22	1,518
Universal Homes	10/07/19	08/10/20	05/02/22	938
Victory Homes	08/07/19	08/03/20	07/11/22	1,069

Note: The BALC files for Abundant Possibilities and Compassionate Living Home contained no prior full survey on the Pre-Survey Checklists. The BALC file for Heroes of the Game contained no Pre-Survey Checklist nor evidence of a prior full survey.

Note: An agency in good standing should be seen within 730 days (every 2 years).

Source: OAG developed from BALC licensing.

Licensing Deficiencies

DHS failed to conduct BALC licensing surveys in a thorough, accurate, and timely manner. We found instances of BALC **not following established criteria** in the review of CILA providers for determining whether a license should be renewed.

DHS' BALC licensing files showed that not all follow-up surveys or focus reviews were completed in a timely manner prior to required deadlines. There were **34 full licensing surveys conducted** for the 25 providers in our sample. Thirty-five percent (12 of 34) of the surveys **were conducted late**. Three examples of the late follow-up surveys include:

- Patterson House had a full survey in January 2020. The next full survey should have been conducted 2 years later, but instead it was conducted **about 9 months late** in October 2022.
- Avancer had a full survey in September 2018. The next full survey should have been conducted 2 years later, but instead it was not conducted until January 2021. There also was not a self-assessment on file for Avancer.
- Homes of Hope had a full survey in March 2019. The next full survey should have been conducted 2 years later, but instead it was conducted **about 4 months** late.

BALC licensing files did not contain the required documentation for BALC full surveys and focus reviews. Auditors found that some documents were incomplete while others were complete, but appeared to be duplicated.

Out of the 34 full surveys, auditors found that some BALC documents **appeared to be duplicated or contain duplication** across surveyor assessments and therefore evaded survey standards.

For example, in one full survey of Broadstep Academy-IL, two surveyors conducted staff interviews. One BALC surveyor interviewed five people at two different locations **all with the same responses and the same typo in the response to the same question**. The other BALC surveyor interviewed six people at two locations with all the same responses excluding individuals and medication taken.

Auditors found **several errors in DHS' Compliance Checklist scoring** used for the CILA level licensing determination on the 34 **full surveys**.

Twenty-four full survey compliance checklists (71%) **were not scored correctly**. Examples of mistakes in scoring include:

- criteria deemed "N/A" when "N/A" **was not an option** for the criteria;
- criteria compliance determined to be unacceptable but then assigned points as if the criteria was "N/A"; and
- points awarded on the Compliance Checklist **did not match the final calculations** on the Compilation Scoresheet.

Fifty-nine percent (20 of 34) of the compliance percentage calculations calculated by auditors were different from the compliance percentage calculated by DHS with three of these **resulting in a different CILA licensing level**. (pages 13-21)

Notice of Violation Deficiencies

DHS failed to report violations identified in self-assessments and BALC reviews on a Notice of Violations (NOVs) form. In the case of one self-assessment, **DHS did not issue an NOV despite a provider self-reporting nine violations**. Sixteen out of forty-seven NOVs in our sample had violations noted during full and focus surveys that were **not included on the NOV**. Additionally, violations reported on NOVs **were not entered into the DHS NOV database**. Seven out of

sixteen self-assessments received an NOV with violations and had some or all violations missing from the NOV database. Additionally, in our sample, 14 of 47 BALC surveys had some or all violations from the NOV not entered into the NOV database. (pages 21-25)

BALC Review of OIG Reporting Timeliness

DHS failed to ensure that BALC surveyors reviewed whether the timeliness of CILA providers reporting of the Office of the Inspector General (OIG) incidents complied with reporting requirements. We found **34 instances**, at five providers, where evidence **showed noncompliant reporting, yet the scoring did not parallel the late reporting**.

BALC utilizes a CILA licensing survey instrument titled Compliance Checklist to test provider compliance with the CILA Rule. One section of the CILA Rule (59 Ill. Adm. Code 115.320(g)(3)) relates to "unusual incidents" and contains a requirement for CILA providers to *"ensure that suspected instances of abuse or neglect against individuals in programs which are licensed by [DHS] are reported to the Office of the Inspector General."* The checklist lists each standard and then provides the surveyor with a guideline to follow when evaluating the provider on the standard. For the section described above, the guideline for the surveyor states, ***"Review any OIG reports before going to survey to check reporting time of within 4 hours after discovery of incident."*** [Emphasis added.]

We examined cases where the incident date for an OIG reported case **exceeded** the 4-hour reporting requirement for **completed cases** by the OIG for our discovery sample of providers. We found **34 cases** where the provider had not reported the incident to the OIG in accordance with statute and administrative rule.

For those non-compliant completed cases, we compared the start date for the BALC survey to the OIG date of final report and calculated the number of days that BALC licensing surveyors had to review cases before starting the licensing survey. The time BALC surveyors had to review the **closed OIG cases ranged from 13 to 437 days**.

The results of our analysis **question the scoring on the BALC licensing surveys**. Digest Exhibit 5 details the 34 cases from our analysis. For example:

- **Cases 1 and 2** in Digest Exhibit 5 are allegations against the same CILA provider. The incidents were reported to the OIG **19 and 2 days after** the incident occurred which is **outside the 4-hour requirement**. The date of the final OIG reports were April 6, 2021, and October 29, 2020. The BALC survey began July 19, 2021, in both cases. **BALC surveyors had 104 and 263 days to review those reports** prior to starting the survey. It does not appear they did that review because on the Compliance Checklist the surveyor said the standard was not applicable.
- **Cases 9 through 25** in Digest Exhibit 5 all relate to the same provider with a BALC survey commencing on August 22, 2022. **All 17 of the cases had noncompliant reporting** dates by the CILA provider to the OIG. BALC

surveyors again had ample time to review the reports, ranging from **14 to 437 days**. Yet the surveyors scored the provider as substantial compliance (2 out of 3 points) when 17 incidents were not timely reported.

- **Cases 26 through 34** in Digest Exhibit 5 are the same provider as the previous bullet point. **All nine cases were not reported timely** and even though BALC surveyors again had ample time to review the OIG reports, the surveyors **still listed the standard as not applicable**. (pages 25-28)

Digest Exhibit 5
TIMELY REPORTING ANALYSIS BY CILA PROVIDERS TO OIG
Audit Sample Testing of 5 CILA Providers

Case #	Incident Date	Report Date to OIG	Date of Final OIG Report	Days Between Final OIG Report and Start of BALC Survey	Start Date of BALC Survey	Point Scores on BALC Survey
1	08/08/20	08/27/20	04/06/21	104	07/19/21	N/A
2	08/19/20	08/21/20	10/29/20	263	07/19/21	N/A
3	08/28/22	08/29/22	04/21/23	87	07/17/23	3/3
4	11/04/20	11/05/20	04/06/21	41	05/17/21	3/3
5	03/01/20	09/22/20	11/24/20	48	01/11/21	2/3
6	11/28/20	12/03/20	10/20/21	19	11/08/21	N/A
7	04/09/21	04/19/21	09/22/21	47	11/08/21	N/A
8	10/05/20	10/06/20	04/27/21	13	05/10/21	3/3
9	02/21/21	02/23/21	06/25/21	423	08/22/22	2/3
10	02/28/21	03/01/21	06/11/21	437	08/22/22	2/3
11	03/01/21	03/02/21	06/25/21	423	08/22/22	2/3
12	03/26/21	03/29/21	07/13/21	405	08/22/22	2/3
13	05/22/21	05/27/21	09/09/21	347	08/22/22	2/3
14	05/27/21	07/06/21	09/09/21	347	08/22/22	2/3
15	08/23/21	08/26/21	01/11/22	223	08/22/22	2/3
16	09/27/21	09/29/21	05/24/22	90	08/22/22	2/3
17	10/08/21	10/12/21	12/23/21	242	08/22/22	2/3
18	10/15/21	10/18/21	01/06/22	228	08/22/22	2/3
19	01/25/22	01/26/22	03/24/22	151	08/22/22	2/3
20	03/20/22	03/22/22	05/31/22	83	08/22/22	2/3
21	05/09/21	05/10/21	02/25/22	178	08/22/22	2/3
22	06/18/21	06/21/21	01/20/22	214	08/22/22	2/3
23	07/25/21	07/26/21	01/20/22	214	08/22/22	2/3
24	08/07/21	08/09/21	12/16/21	249	08/22/22	2/3
25	02/05/22	02/22/22	08/08/22	14	08/22/22	2/3
26	02/14/22	02/15/22	11/23/22	19	12/12/22	N/A
27	03/07/22	03/08/22	10/31/22	42	12/12/22	N/A
28	06/23/22	06/27/22	11/18/22	24	12/12/22	N/A
29	06/26/22	07/02/22	10/11/22	62	12/12/22	N/A
30	06/27/22	07/01/22	10/25/22	48	12/12/22	N/A
31	09/21/22	09/27/22	11/23/22	19	12/12/22	N/A
32	04/07/22	04/11/22	06/10/22	185	12/12/22	N/A
33	05/03/22	05/04/22	06/02/22	193	12/12/22	N/A
34	06/19/22	06/22/22	11/28/22	14	12/12/22	N/A

Source: OAG developed from DHS information.

CILA License Continuations

DHS allowed a CILA provider to **remain serving residents on a continued license even though the provider's original license had been expired for nearly 900 days**. Even though **DHS had no documentation in its file** for the provider and the providers dispute with the Office of the State Fire Marshal, **DHS issued three continuations** for the CILA license. (pages 28-31)

DHS Monitoring of the CILA Program

The Division of Developmental Disabilities, the Bureau of Quality Management, and the Office of the Inspector General conduct the main monitoring of the CILA program, outside of the licensing process.

Monitoring Policy and Procedure Manuals

A DHS CILA monitoring unit has **operated for five fiscal years under a draft policy and procedure manual**. Additionally, a DHS licensing unit had a policy and procedure manual that had **conflicting requirements** related to survey requirements.

Updated and approved policy and procedure manuals are an effective internal control for organizations that monitor programs such as CILA. When policies and procedures are not in finalized approved form, employees may find themselves unclear of their roles and responsibilities, which may impact productivity and efficiency. This could also lead to the inconsistent treatment of providers. Additionally, lack of guidelines can lead to a lack of accountability. (pages 35-36)

CILA Admissions During Probation Period

DHS failed to enforce admissions restrictions on CILA providers that were on probation based on unacceptable licensing survey scores. The failure led to five individuals from our sample being **admitted to providers that failed to achieve minimally acceptable scores** from BALC officials.

Probation is a situation where compliance with minimally acceptable standards necessitates immediate corrective action to ensure that individuals' life, safety, or quality of care are not in jeopardy. When a CILA provider receives a licensing survey score of a Level 4 or worse, the **provider is to be placed in a probationary period for a period limited to 90 days**. During the probationary period, the provider must make changes sufficient to bring the agency **back into good standing** with DHS.

DHS allowing CILA admissions to providers while they are on probation not only violates administrative rule but risks the individual being admitted receiving substandard care from a provider that did not achieve adequate licensing standard scores. (pages 36-38)

CILA Corrective Action Monitors

DHS failed to **assign division monitors** to oversee corrective actions by CILA providers with the worst licensing survey scores. This failure is a violation of administrative rule.

When a CILA provider, during the licensing survey process, receives a score equivalent to a Level 5, it must take corrective action to come back into good standing within 60 days of the exit conference for the licensing survey. During that period, **DDD is required to assign** a monitor to oversee the progress of the CILA provider in taking the corrective actions.

Auditors reviewed all surveys as part of licensing testing. In our sample of 25 CILA providers, there were 34 instances of full surveys conducted by BALC. **Fifteen percent (5 of 34) of the full surveys resulted in Level 5 scoring and the need for a monitor**. The five providers were:

- Broadstep Academy-IL;
- Family Association Plus;
- Random Acts of Kindness;
- Joseph Rehabilitation Center; and
- Kwanza Suites Corporation.

Only two of the five providers were assigned a monitor as required by administrative rule. (pages 38-39)

Lack of Cooperation with OIG Investigations by CILA Provider

DHS **failed to sanction a CILA provider that repeatedly refused to cooperate with OIG investigations** of allegations against the provider. Our examination of OIG investigative reports found **22 instances** where the provider violated State law or rule by not cooperating with OIG investigations. DHS could **not provide any documentation** to show it took any actions against the provider for a failure to cooperate.

During the audit, we selected five CILA providers for discovery testing. One of those was Broadstep Academy-IL (Broadstep), a provider that **received over $23.6 million** for CILA services for the period FY21-FY23.

We requested and received OIG cases for the five providers for the period July 1, 2020, to June 30, 2023. We examined the OIG case files for the providers and found that Broadstep **appears to have violated both State law and State rule** in the investigations of the cases. Digest Exhibit 6 details the **22 instances of noncooperation by the provider**. (pages 40-43)

Digest Exhibit 6
NONCOOPERATION WITH OIG INVESTIGATIONS
Broadstep Academy-IL

Criteria: Agencies must provide OIG with all written statements and any documents in a timely manner.

OIG Case #	Date Case Reported to OIG	Documentation Issues Noted by OIG
1222-0448	05/27/22	Failed to provide Case Notes and Nursing Notes to assist OIG with its investigation.
1222-0460	06/02/22	Failed to provide Case Notes, General Events Reports, or Behavior Logs to assist OIG with its investigation.
1222-0475	06/10/22	Failed to provide Case Notes and Nursing Notes to assist OIG with its investigation.
1222-0487	06/16/22	Failed to provide Case Notes, Nursing Notes, and Dentist Orders to assist OIG with its investigation.
1223-0013	07/08/22	Failed to provide Case Notes, Nursing Notes, General Events Reports, or Training Records to assist OIG with its investigation.
1223-0014	07/08/22	Failed to provide Case Notes, Nursing Notes, and Shower Logs to assist OIG with its investigation.
1223-0097	08/30/22	Failed to provide Case Notes, Nursing Notes, or General Events Reports to assist OIG with its investigation.
1023-0125	09/27/22	Failed to provide any Repositioning documents that were required to be logged to assist OIG with its investigation.
1222-0358	04/11/22	Failed to provide Staff Schedule, Case Notes, and Nursing Notes to assist OIG with its investigation.
1222-0441	05/24/22	Failed to provide Staff Schedule to assist OIG with its investigation.
1222-0450	05/26/22	Failed to provide Case Notes and General Events Reports to assist OIG with its investigation.

Criteria: Agencies are required to report allegations to OIG within 4 hours.

OIG Case #	Date Case Reported to OIG	Incident Date	OIG Recommendation
1222-0498	06/22/22	06/19/22	Broadstep Academy address DSP late reporting of allegation.
1223-0222	11/16/22	11/11/22	Broadstep Academy address DSP late reporting of allegation.
1022-0246	03/22/22	03/21/22	Broadstep Academy address DSP late reporting of allegation.
1021-0185	03/01/21	02/28/21	Broadstep Academy address DSP late reporting of allegation.
1021-0206	03/29/21	03/26/21	Broadstep Academy address DSP late reporting of allegation.

Criteria: Agencies required to provide information, including relevant documents and photographs.

OIG Case #	Date Case Reported to OIG	Information Deficiencies Noted by OIG
1022-0354	06/27/22	Broadstep failed to provide photographs or a medical assessment.
1023-0001	07/02/22	Broadstep failed to provide photographs or a medical assessment.
1023-0019	07/16/22	Broadstep failed to have statements taken for the investigation.
1021-0214	04/02/21	Broadstep failed to provide photographs and photographic logs.

Criteria: Cooperation with OIG Investigation.

OIG Case #	Date Case Reported to OIG	Deficiencies Noted by OIG
1023-0002	07/04/22	Broadstep failed to fully cooperate with OIG investigation by refusing to answer questions.
1023-0123	9/27/22	Broadstep failed to fully cooperate with OIG investigation by refusing to answer questions.

Note: DSP means Direct Service Provider

Source: OAG developed from OIG information.

Inconsistent License Revocation

DHS failed to **consistently apply** CILA rules to all providers that failed to correct noted deficiencies. While some providers had CILA licenses revoked, **others were allowed to continue in the program** despite not correcting deficiencies. Additionally, for providers allowed to remain in the program, DHS **did not have documentation** to support plans of correction for the uncorrected deficiencies.

During our licensing testing, we found two CILA providers with issues surrounding a **failure to correct deficiencies**. The facts, from DHS documentation, are provided below:

- Family Association Plus: **Received nearly $1.3 million between FY21-FY23 for one agency controlled site with a capacity of seven residents**
  - On March 4, 2022, received notice from BALC of **47 instances of violating the CILA Rule**;
  - All violations in the Notice of Violations were addressed in the provider's plan of correction, which was **to be implemented by April 4, 2022**;
  - On March 23, 2022, BALC found the POC acceptable and **approved the plan**;
  - On June 1, 2022, in a focus review follow-up, BALC found **40 percent (19 of 47) of the violations had not been corrected**;
  - The BALC file for this provider **did not contain a POC** for the focus review violations even though one **was required** with a submission deadline of July 1, 2022;
  - Our license testing exceptions, **which noted the lack of a POC**, went to DHS on March 20, 2024;
  - DHS responded to our BALC Reviews exceptions on May 6, 2024;
  - DHS **did not dispute** the lack of a POC exception;
  - **On October 19, 2022, DHS informed Family Association Plus that its license had been renewed through February 28, 2024.**
- Caring Hands CILA of Illinois: **Received nearly $1.3 million between FY21-FY23 for one agency controlled site with a capacity of seven residents**
  - On November 29, 2021, received notice from BALC of **35 instances of violating the CILA Rule**;
  - Thirty-seven percent (13 of 35) of the violations **were not addressed in the provider's POC**, which was **to be implemented in January 2022**;
  - On January 18, 2022, BALC found the POC acceptable and **approved the plan even though it did not address all of the CILA Rule violations**;
  - On March 10, 2022, in a focus review follow-up, BALC found **20 repeat findings indicating violations had not been corrected**;

- The BALC file for this provider **did not contain a POC** for the focus review violations even though one **was required** with a submission deadline of April 11, 2022;
- Our license testing exceptions, **which noted the lack of a POC**, went to DHS on March 20, 2024;
- DHS responded to our BALC Reviews exceptions on May 6, 2024;
- DHS **did not dispute** the lack of a POC exception;
- **On October 20, 2022, DHS informed Caring Hands CILA of Illinois that its license had been renewed through November 30, 2023.**

When DHS does not consistently apply sanctions to CILA providers, it **questions the equality of the monitoring efforts** for the CILA program. Additionally, when CILA providers acquire large numbers of CILA Rule violations and do not take the steps to address and fix the violations it **calls into question the care the residents of those CILAs receive**. (pages 43-46)

Emergency Call Notifications

Public Act 101-0075 added the following requirement to the CILA Act (210 ILCS 135/13.2):

> *"**Any facility licensed under this Act shall notify** [DHS] when emergency calls are made from the facility." "[DHS] **shall** adopt any rules necessary to implement this Section, including, but not limited to, reporting procedures and protocols and **penalties for failing to report**."* [Emphasis added.] (page 47)

Failure to Develop Emergency Call Administrative Rules

DHS failed to follow State statute and develop administrative rules for emergency notifications made from CILA locations.

The amendment to the CILA Act was passed July 12, 2019, and was effective January 1, 2020. DHS updated the administrative rules relative to CILAs with an effective date of May 31, 2023. **It took DHS 1,246 days since the effective date of the emergency notification requirement to update its rule, and the rule did not include the definition of an "emergency call" nor were penalties for non-compliance detailed.**

DHS' failure to develop administrative rules related to emergency notifications is a violation of State statute and could lead to inconsistent reporting. Additionally, the lack of penalties for non-compliance of reporting by CILA providers only **increases the possibility that cases are not reported and individuals may remain in or be placed in a harmful environment**. (pages 47-49)

CIRAS Report Timeliness

DHS failed to hold CILA providers that were not compliant with the Critical Incident Reporting Analysis System (CIRAS) reporting requirements accountable. Over the period FY20-FY23, **41 percent of CIRAS incident reports were not**

made within the required two working day requirement. Failure to enforce the reporting requirements resulted in one CILA provider taking **563 days, on average, to report FY20 incidents**.

DDD developed CIRAS to capture electronic reports from providers and Independent Service Coordinators (ISCs) for **critical incidents** involving individuals with developmental disabilities in the State's Medicaid Waiver program. DHS uses the CIRAS system as the monitoring source for the emergency notification requirements in the CILA Act (210 ILCS 135/13.2). Definitions of the 11 types of critical incidents are provided in the CIRAS Manual. Auditors note that **none of the definitions developed by DHS defines "emergency calls."**

We analyzed the data and found **38,494 total incidents reported to CIRAS** during FY20-FY23. The total CIRAS reports increased each year during the reporting period. Digest Exhibit 7 breaks down the reports by fiscal year and whether the report was timely or untimely.

Digest Exhibit 7
NUMBER OF TIMELY AND UNTIMELY CIRAS INCIDENTS REPORTED
FY20-FY23

FY	Unable to Determine [1]	Timely	Untimely	Total
FY20	2	3,934	3,327	7,263
FY21	1	4,526	3,468	7,995
FY22	0	7,130	4,271	11,401
FY23	2	7,172	4,661	11,835
Total	5	22,762	15,727	38,494

Note: [1] Data entry error in CIRAS database, report date occurred prior to incident date.

Source: OAG developed from DHS CIRAS database.

We compared the report date to the incident date to determine **whether the provider was timely** based on compliance with the CIRAS Manuals two working day requirement. We found:

- 59 percent of the incidents were reported timely to CIRAS, and
- 41 percent of the incidents were not reported timely.

We analyzed how long it took providers to actually report incidents into CIRAS. For providers that were untimely based on criteria in the CIRAS Manual, 26 percent (10,162 of 38,494) of the reports were made from 3 to 7 days after the incident. For **87 incident reports, the provider took over one year to report the incidents to CIRAS**. Digest Exhibit 8 provides a **breakdown by period** for the untimely reporting.

Digest Exhibit 8
TIMELINESS REPORTING OF CIRAS INCIDENTS
FY20-FY23

Time	# Incident Reports	Percentage of Incident Reports
Within 2 days (timely)	22,762	59.13%
3-7 days	10,162	26.40%
8-30 days	3,935	10.22%
31-60 days	806	2.09%
61-180 days	625	1.62%
181-365 days	112	0.29%
Over One Year	87	0.23%
Unable to Determine [1]	5	0.01%
Total	38,494	100.00%

Note: [1] Data entry error in CIRAS database, report date occurred prior to incident date.

Source: OAG developed from DHS CIRAS database.

Some of the providers in our license-testing sample had difficulties complying with the two working day requirement. We found:

- Lutheran Social Services of Illinois (LSSI) reported 20 incidents applicable in FY20. **It took the provider, on average, 563 days to report the incidents**. In FY21, LSSI **averaged 410 days to report the 46 incidents** applicable to FY21.
- Shore Community Services reported four incidents applicable to FY22. However, **it took Shore Community Services an average of 142 days to make the reports**.

We asked DHS if it has ever penalized a CILA provider for failing to report emergency calls. On December 7, 2023, DHS reported, ***"DDD has not penalized a CILA provider for failure to report emergency calls."*** [Emphasis added.]

Our review of BQM waiver reviews for CILA provider Broadstep Academy-IL found 27 instances where BQM discovered that the provider did not comply with CIRAS reporting requirements. In 2 instances, the BQM **reviewer instructed the provider to enter the incident in CIRAS**. In 14 instances, the BQM reviewer, on the applicable review form, **instructed the provider that, *"Going forward, begin entering any incident that meets CIRAS reporting requirements."*** [Emphasis added]

Failure to report incidents to CIRAS in a timely manner is a violation of DHS policy. Further, non-compliance with reporting requirements can affect the safety and health of individuals entrusted with care in the CILA homes. (pages 49-54)

Emergency Notification Designated Reporter Deficiencies

DHS failed to enforce its own procedures relative to **CILA providers maintaining the requisite number of reporters** for the CIRAS system.

The CIRAS Manual states, *"At a minimum, two (2) designated agency reporters must be registered for CIRAS per agency to assure staff are always available for timely reporting of incidents."*

Our analysis of the designated reporter compliance with the CIRAS manual found a number of issues. The analysis is summarized in Digest Exhibit 9. We found:

- 43 percent (10 of 23) of the CILA providers in our sample testing **never designated a 2nd CIRAS reporter,** according to DHS provided documentation;
- Broadstep Academy-IL had no designated reporters as of January 1, 2020; **it took Broadstep 1,253 and 1,254 days to designate reporters** after the effective date of the emergency notification requirements of the CILA Act; and
- Brownstone Services also had no designated reporters as of January 1, 2020; **it took Brownstone 953 and 1,107 days to designate reporters** after the effective date of the emergency notification requirements of the CILA Act. (pages 54-57)

Digest Exhibit 9
CIRAS REQUIRED NUMBER OF DESIGNATED REPORTERS
Audit Testing Sample of 25 CILA Providers

Provider	# Reporters by 1/1/20	# days after 1/1/20 Named 1st Reporter	Named 2nd Reporter	FY21-FY23 CILA Payments
Arrowleaf	2	N/A	N/A	$5,547,015
Avancer Homes	1	N/A	665	$16,584,534
Broadstep Academy-IL	0	1,253	1,254	$23,638,148
Joseph Rehabilitation Center	1	N/A	NONE	$4,900,319
Random Acts of Kindness	2	N/A	N/A	$2,860,736
Shore Community Services	2	N/A	N/A	$3,912,662
Caring Hands CILA of Illinois	1	N/A	NONE	$1,168,464
Family Association Plus	0	597	597	$1,282,334
Lutheran Social Services of Illinois	0	815	815	$10,008,858
Royal Living Center	2	N/A	N/A	$7,834,810
Kwanza Suites Corporation	1	N/A	NONE	$449,646
Divine Center	1	N/A	NONE	$1,096,557
Patterson House	2	N/A	N/A	$2,225,274
Millennium Gardens	1	N/A	NONE	$3,977,995
Liberty Enterprises	1	N/A	1,170	$3,041,634
Harmony House CILA	1	N/A	NONE	$3,178,710
Compassionate Living Home	0	609	NONE	$1,372,223
Brownstone Services	0	953	1,107	$1,343,750
Heroes of the Game	1	N/A	NONE	$639,474
Pinnacle Opportunities	0	482	708	$1,292,636
Victory Homes	1	N/A	NONE	$1,839,256
Homes of Hope	2	N/A	N/A	$4,673,090
Universal Homes	0	479	NONE	$3,520,094

Note: Trilogy is a mental health CILA so is not included in this Exhibit. Abundant Possibilities was a new provider that was licensed in 2021.

Source: OAG developed from DHS information.

DHS Monitoring of CIRAS Follow Up by ISCs

DHS failed to take steps necessary to ensure ISCs conducted follow up activities as required by Department procedure. This resulted in 76 percent of the **next day follow up** to cases either not being conducted or not conducted timely. Additionally, **10,617 cases that required 10-day follow up were not conducted** by the ISC. For the 10-day follow up, 28 percent of the cases were not initially followed up timely. Finally, DHS **could not provide sufficient documentation to support its own compliance** with the procedures for following up with ISCs.

The CIRAS Manual states, *"All CIRAS submissions require a follow-up entry by the ISC within 10 working days of the original report."* The Manual also states, for incidents reported as Law Enforcement, Missing Individual, and Unscheduled Hospitalization, that these, *"will be flagged as priority for review within one working day upon receipt of the email and require follow-up action and documentation."*

The CIRAS Manual also lays out DDD staff responsibilities for individual incident review. For **incidents involving death, law enforcement, and missing individuals** the Manual states, *"DDD staff **will contact ISCs within one working day** following receipt of the e-mail to ensure necessary action is underway and continue to monitor the situation until it is resolved."* [Emphasis added.]

Follow Up by ISCs

We found **multiple issues of non-compliance in next day follow up** for certain critical incidents that involved law enforcement, missing individuals, and unscheduled hospitalizations. Seventy-eight percent (30,052 of 38,494) of the cases did not require next day follow up due to **not being cases** involving law enforcement, a missing individual, or an unscheduled hospitalization. Digest Exhibit 10 details, for the nine ISCs in the database, whether the cases had timely follow-up, did not have timely follow-up, or were not followed up at all by the ISCs. The 2,918 not timely cases were late between 2 and 200 days.

Digest Exhibit 10
NEXT DAY CRITICAL INCIDENT FOLLOW UP COMPLIANCE BY ISCs
FY20-FY23

ISC	Timely	Not Timely	Not Followed Up	Total
Central Illinois Service Access	81	247	250	578
Champaign County Regional Planning Commission	29	116	507	652
Community Alternatives Unlimited	586	466	416	1,468
Community Service Options	40	245	241	526
Developmental Disability Services of Metro East	0	4	6	10
Prairieland	616	663	590	1,869
Service, Inc.	50	767	850	1,667
Southern Illinois Case Coordination Services	512	54	293	859
Suburban Access	125	356	332	813
Total	2,039	2,918	3,485	8,442

Source: OAG developed from DHS CIRAS database.

We also found **multiple issues of non-compliance in the required 10-day follow up** by the ISCs. We removed the 8,442 cases specific to the next day follow up requirement from the total adult waiver cases. This left 30,052 cases that required the 10-day follow up by the ISCs. **The database showed that 10,617 of the cases had no associated follow up notes meaning the ISCs had not followed-up on these incidents**. Other cases (19,435) had follow up but it was not always timely. Our analysis found:

- 71.96 percent (13,985 of 19,435) of the cases had initial follow up within 10 days;
- 18.82 percent (3,657 of 19,435) of the cases had initial follow up between 11-30 days;
- 4.92 percent (956 of 19,435) of the cases had initial follow up between 31-60 days;
- 2.50 percent (486 of 19,435) of the cases had initial follow up between 61-90 days;
- 1.78 percent (345 of 19,435) of the cases had initial follow up between 91-180 days; and
- .03 percent (6 of 19,435) of the cases had initial follow up between 181-365 days.

Follow Up by DDD

When an incident is reported that is **categorized as death, law enforcement, or missing individual** in CIRAS, DDD will receive notification from the system. The CIRAS Manual also **requires DDD to make contact the next day with the ISC** to ensure action is underway for follow-up.

For the period FY20-FY23, the CIRAS database noted 1,772 cases where death, law enforcement or missing individual described the incident. While DHS states it contacts the ISCs the next day, DHS could **not provide sufficient documentation** to back up that claim. Digest Exhibit 11 breaks the number of cases down by category. In the case of the three specific types, we found:

- 26.6 percent (471 of 1,772) of the cases were followed up timely by the ISCs;
- 32.7 percent (580 of 1,772) of the cases were not followed up timely by the ISCs; and
- 40.7 percent (721 of 1,772) of the cases had no follow up conducted by the ISCs.

Digest Exhibit 11
NEXT DAY CRITICAL INCIDENT FOLLOW UP COMPLIANCE BY ISCs
FY20-FY23

Incident Type	Timely	Not Timely	Not Followed Up	Total
Death	91	117	144	352
Law Enforcement	185	167	231	583
Missing Individual	195	296	346	837
Total	471	580	721	1,772

Source: OAG developed from DHS CIRAS database.

Given that nearly 75 percent of the death, law enforcement, and missing individual cases were either not followed up on by the ISC or the ISC was not timely in its follow up, DHS would be well served to document the contacts to be able to show it followed procedure in the manual. (pages 57-61)

CIRAS Incident Under-Reporting

DHS has implemented a process for reporting critical incidents that **results in under-reporting**. DHS requirements for abuse, neglect, and exploitation require reporters to send those allegations to OIG. However, when OIG is unable to substantiate the allegations, the information is not included in the reporting of critical incidents in the CIRAS database. CILA providers and ISCs have **reporting understandings that differ** from the DHS reporting criteria.

Critical incidents are the alleged, suspected, or actual occurrence of an incident when there is reason to believe **the health or safety of an individual may be adversely affected** or an individual may be placed at a reasonable risk of harm. During the period FY21-FY23, CILA providers reported 29,529 incidents to the CIRAS database.

During the audit, we sampled 25 CILA providers for the licensing activities conducted by BALC. We reviewed the OIG records of five of these providers to determine if OIG allegation cases were reported to the CIRAS database. Our analysis, for the five providers, showed there were **31 instances** where allegations of abuse or neglect were **investigated by the OIG and not proven to be substantiated yet contained CIRAS reportable conditions**. See Digest Exhibit 12 for a listing of these 31 instances where the incidents **were not reported in CIRAS** but were reported to OIG; however, OIG did not substantiate the allegation. Additionally, **42 percent** (13 of 31) of the OIG cases **involved a 911 call**.

Digest Exhibit 12
CRITICAL INCIDENTS NOT REPORTED IN CIRAS
FY21-FY23

Case #	Incident Date	Report Date to OIG	OIG Allegation	OIG Finding	Applicable CIRAS Category
1	02/17/21	02/17/21	Physical Abuse	Unsubstantiated *	Medical Emergency
2	07/10/22	07/19/22	Neglect	Unsubstantiated	Unknown Injury
3	09/27/22	10/06/22	Neglect	Unsubstantiated	Unknown Injury
4	07/13/20	07/13/20	Physical Abuse	Unsubstantiated	Unknown Injury
5	02/21/21	02/23/21	Physical Abuse	Unsubstantiated	Unknown Injury
6	03/27/21	03/29/21	Physical Abuse	Unsubstantiated *	Peer-to-Staff Act
7	04/02/21	04/02/21	Physical Abuse	Unsubstantiated *	Unknown Injury
8	10/01/21	10/01/21	Neglect	Unsubstantiated *	Medical Emergency
9	10/21/21	10/21/21	Physical Abuse	Unsubstantiated	Unknown Injury
10	03/20/22	03/22/22	Physical Abuse	Unsubstantiated *	Unscheduled Hospitalization
11	06/27/22	07/01/22	Mental Abuse	Unsubstantiated *	Peer-to-Staff Act
12	10/05/22	10/05/22	Neglect	Unsubstantiated	Known Injury
13	06/18/21	06/21/21	Neglect	Unsubstantiated	Peer-to-Peer Act
14	10/31/21	11/01/21	Physical Abuse	Unfounded	Peer-to-Peer Act
15	04/07/22	04/11/22	Physical Abuse	Unfounded	Known Injury
16	04/11/22	04/11/22	Neglect	Unsubstantiated	Unknown Injury
17	04/27/22	04/28/22	Neglect	Unsubstantiated	Unscheduled Hospitalization
18	05/13/22	05/16/22	Physical Abuse	Unfounded	Peer-to-Peer Act
19	Unknown	05/27/22	Physical Abuse	Unsubstantiated *	Unknown Injury
20	Unknown	06/10/22	Physical Abuse	Unsubstantiated *	Unknown Injury
21	11/11/22	11/11/22	Neglect	Unsubstantiated	Unknown Injury
22	02/13/23	02/21/23	Neglect	Unfounded	Unknown Injury
23	03/23/23	03/23/23	Mental Abuse	Unsubstantiated	Unscheduled Hospitalization
24	12/03/20	12/03/20	Physical Abuse	Unsubstantiated *	Unscheduled Hospitalization
25	04/09/21	04/19/21	Neglect	Unfounded	Unscheduled Hospitalization
26	10/10/22	10/10/22	Physical Abuse	Unsubstantiated	Known Injury
27	08/08/20	08/27/20	Physical Abuse	Unfounded	Unscheduled Hospitalization
28	08/19/20	08/21/20	Physical Abuse	Unfounded	Unscheduled Hospitalization
29	Unknown	09/11/20	Physical Abuse	Unfounded	911 Call
30	04/25/22	04/25/22	Neglect	Unfounded	Unscheduled Hospitalization
31	08/28/22	08/29/22	Physical Abuse	Unsubstantiated	Unscheduled Hospitalization

Note: * Unsubstantiated with issues.

Source: OAG developed from DHS OIG information.

Case 21 from Digest Exhibit 12 illustrates the **under-reporting of incidents in CIRAS**. In this case:

- OIG received a **neglect allegation** call on November 11, 2022, relative to a resident of Broadstep Academy-IL.
- The resident got up, took medications around 7:00 a.m., and then rested in a recliner.
- Around 10:00 a.m., a direct service provider told the resident it was time to get dressed.
- The resident lifted an arm and began to cry.
- The resident was taken to the hospital emergency room for a medical assessment.

- The diagnosis was a dislocated elbow, which was reset and placed in a soft cast.
- Since the incident was reported to OIG, **there was no reporting of the unknown injury into CIRAS**.
- The OIG investigation concluded the allegation was **unsubstantiated**.

Case 3 from Digest Exhibit 12 also illustrates the **under-reporting of incidents in CIRAS**. In this case:

- OIG received a **neglect allegation** call on October 6, 2022, relative to a resident of Avancer Homes.
- The resident has limited verbal skills, uses a wheelchair for mobility, and a lift for transfers.
- On September 27, 2022, on the way to the doctor, the resident complained of shoulder pain.
- The resident received an x-ray of the shoulder.
- On October 5, 2022, the doctor called the provider, provided the diagnosis of a dislocated shoulder, and referred the resident to an orthopedic doctor for treatment.
- Since the incident was reported to OIG, **there was no reporting of the unknown injury into CIRAS**.
- The OIG investigation concluded the allegation was **unsubstantiated**.

To determine how much the under-reporting may affect monitoring of CILAs we summarized the OIG database provided by DHS. During the period FY21-FY23, the database showed 3,348 **cases that were closed** by the OIG. **Seventy-six percent** (2,558 of 3,348) of the closed case allegations were **proven by OIG to be unfounded or unsubstantiated**. If CILA providers and ISCs utilized the CIRAS criteria developed by DHS, there could have been a substantial number of incidents missing from the CIRAS database.

On November 21, 2023, a DHS official reported, *"Incidents reported to OIG are not reported in the CIRAS system. This is the policy as we don't want even the perception that we are interfering in the investigation being conducted by OIG."*

Under reporting of incidents to CIRAS does not protect the health and well-being of residents in the CILA program, residents DHS is charged with protecting. (pages 61-66)

Audit Recommendations

The audit report contains 15 recommendations directed to DHS. DHS accepted the recommendations. The complete response from DHS is included in this report as Appendix G.

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:MAZE