STATE OF ILLINOIS
OFFICE OF THE
AUDITOR GENERAL
Frank J. Mautino, Auditor General

REPORT DIGEST

PERFORMANCE AUDIT

Release Date: January 2021

Audit performed in accordance with **The Department of Human Services Act (20 ILCS 1305/1-17(w))**

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EXECUTIVE SUMMARY

Illinois Department of Human Services Office of the Inspector General

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

For FY20, there were a total 518 community agencies with 4,401 program sites that were under the investigative jurisdiction of the OIG. In addition, there were also 14 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 14 State-operated facilities.

In this audit we reported that:

- There is an overall correlation between the increase in the total number of allegations and the worsening of case completion timeliness.
- From FY10 to FY18 the total number of allegations reported at community agencies has increased by 1,200 (1,500 to 2,700) or 80 percent. During the same time period, the total allegations at State-operated facilities has increased at a much slower rate. From FY10 to FY18 the total number of allegations reported at State-operated facilities increased by 205 (967 to 1,172) or 21 percent.
- For FY18, FY19 and FY20, community agency allegations accounted for 70 percent, 68 percent, and 67 percent of all reported allegations of abuse or neglect, respectively.
- According to OIG data, during FY20 it took an average of 117 working days (or 170 calendar days) to complete an investigation.
- For FY18, FY19, and FY20, the percentage of cases completed within 60 working days was 44 percent, 38 percent, and 45 percent, respectively.
- There are no investigative completion timeliness standards for the OIG in statute or administrative rule. Only OIG's directives contain a 60 working day completion requirement for investigations.
- OIG case reports we reviewed generally were thorough, comprehensive, and addressed the allegation.

This audit report contains a total of 16 recommendations to the OIG and DHS. The OIG and DHS generally agreed with the recommendations in the report.

AUDIT SUMMARY AND RESULTS

The Department of Human Services Act (Act) (20 ILCS 1305/1-17(w)) directs the Auditor General to conduct a program audit of the Department of Human Services (DHS), Office of the Inspector General (OIG) on an as-needed basis. The Act specifically requires the audit to include the Inspector General's compliance with the Act and effectiveness in investigating reports of allegations occurring in any facility or agency. This is the 13th audit the Auditor General has conducted of the OIG since 1990.

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

During FY20, OIG investigators were responsible for investigating allegations at 14 State-operated facilities, and 4,401 program sites.

For FY20, there were a total of 14 State-operated facilities, and 518 community agencies with 4,401 program sites that were under the investigative jurisdiction of the OIG. In our FY17 audit we reported that there were 421 agencies operating 4,552 programs. OIG investigators in many cases are responsible for hundreds of program sites covering large areas of the State. (page 1)

Digest Exhibit 1 summarizes the five OIG Bureaus and the number of counties, facilities, community agencies, program sites, and square mileage each is responsible for investigating. (page 9)

Digest Exhibit 1
SUMMARY OF OIG BUREAUS AND RESPONSIBILITIES
As of June 30, 2020

OIG Bureau	Number of Investigators	Counties	Sq. Mileage by Bureau	State Facilities	Community Agencies[1]	Program Sites[2]
Cook County	8	1	946	2	197	1,573
North	7	20	10,628	3	97	875
Chicago Metro	9	5	3,391	2	44	402
Central	9	47	28,588	3	98	995
South	8	29	12,040	4	82	548
Totals	**41**	**102**	**55,593**	**14**[1]	**518**	**4,401**[3]

Notes:
[1] Choate is a dual facility located in the South Bureau.
[2] Some community agencies operate program sites in multiple OIG bureaus. Therefore, the count of agency and program sites by bureau includes some duplication. Column totals may not add.
[3] There were 8 program sites in our data that did not contain a location.

Source: OAG analysis and OIG data.

An OIG investigator is often responsible for covering hundreds of program sites over large areas of the State

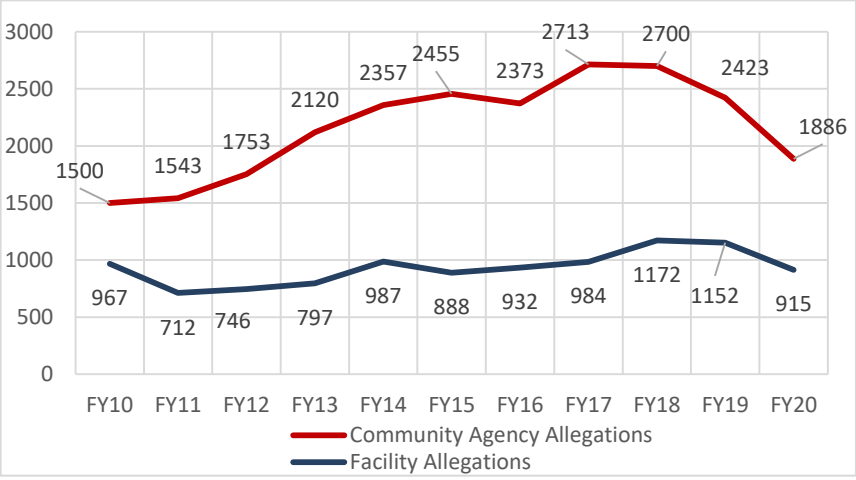
The total number of allegations increased from 2,467 in FY10 to 3,872 in FY18 before decreasing to 3,575 in FY19. For FY20 the total number of allegations declined to 2,801. This overall increase is due primarily to the increase in allegations reported at community agencies. **From FY10 to FY18 the total number of allegations reported has increased by 1,200 or 80 percent**. For FY18, FY19 and FY20, community agency allegations accounted for 70 percent, 68 percent, and 67 percent of all reported allegations of abuse or neglect, respectively. (page 1)

FY20 Decrease in Allegations
(Potential Impact of Covid-19 Restrictions)

For FY20 the total number of allegations declined to 2,801. Beginning in March of 2020 a stay-at-home order due to COVID-19 was issued by Governor Pritzker, which mandated employees deemed non-essential to remain at home. OIG officials stated that when compared to the same time period from the previous year, March 1, 2020 through June 30, 2020 allegations were down by 45.7 percent. Based on these numbers COVID-19 played a large factor in these reductions. The closing of the day programs and restricting individuals to their residences during COVID-19 is likely responsible for some of the drop in complaints. However, at the community agencies, the reduced presence of supervisory/administrative staff at the CILAs/homes may have resulted in a reduction of complaints. (pages 1-2)

Digest Exhibit 2 shows the allegation reporting trends by community agency and facility from FY10 through FY20, and also shows the FY20 overall drop in allegations reported. (page 14)

Digest Exhibit 2
ABUSE AND NEGLECT ALLEGATIONS REPORTED TO OIG BY TYPE OF FACILITY
FY10 through FY20



Source: OIG data summarized by OAG.

Community Agency allegations increased by 80% (1,200 allegations), compared to a 21% (205 allegations) increase at State-operated facilities from FY10 through FY18.

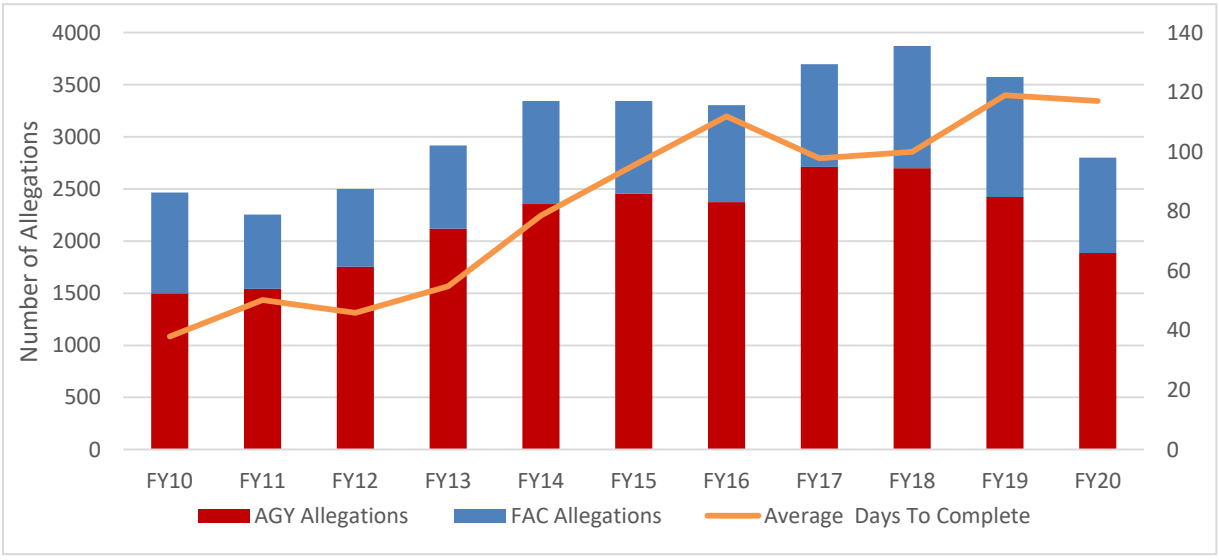
Increase in Allegations and Time to Complete Investigative Cases

The total number of allegations reported to the OIG has continued to increase overall since FY10. During FY10 the OIG reported 2,467 allegations of abuse and neglect. During FY18 the OIG reported 3,872 cases of abuse and neglect, an increase of 57 percent compared to FY10. **According to OIG data, during FY20 it took an average of 117 working days (or 170 calendar days) to complete an investigation. This is an increase of 208 percent from the average of 38 working days during FY10.**

During this same time period community agency allegations have increased drastically compared to State-operated facility allegations. **During FY18, community agency allegations reached 2,700, or an increase of 80 percent over the 1,500 FY10 community agency allegations**. Conversely, State-operated facility allegations have increased at a much slower rate. During FY18, there were 1,172 allegations, or a 21 percent increase over the 967 FY10 State-operated facility allegations.

As can be seen in **Digest Exhibit 3**, there is also an overall correlation between the increase in the total number of allegations and the increase in case completion timeliness. (pages 26-27)

Digest Exhibit 3
AVERAGE WORKING DAYS TO COMPLETE INVESTIGATIONS AND TOTAL ALLEGATIONS
FY10 through FY20



Source: OAG analysis of OIG data.

Timeliness of Investigations

Overall, timeliness issues involving investigations worsened compared to our previous FY17 audit. The following are areas with timeliness issues:

For FY18, FY19, and FY20, the percentage of cases completed within the required 60 working days was 44%, 38%, and 45%, respectively.

- **Case Completion** – The timeliness of completion for OIG investigations has worsened since our FY17 audit. For FY17, 50 percent of closed cases were completed within 60 working days. For FY18, FY19, and FY20, the percentage of cases completed within 60 working days was **44 percent, 38 percent, and 45 percent, respectively.** Timeliness of investigations has been an issue in all of the 12 previous OIG audits. (pages 21, 25-26)

- **Data Issues** – Timeliness could not be determined for 20 percent of facility allegations and 17 percent of community allegations for FY20. This was because the incident discovered time/date was reported as unknown, or was inaccurate, or the time/date recorded was not specific. (page 23)

- **Initial Reporting of Allegations** – Allegations of abuse and neglect not reported within the statutorily required four hours have increased since our FY17 audit. Late reporting of allegations at **State-operated facilities** increased from 5 percent in FY17 to 10 percent during FY20. For **community agencies**, late reporting has also increased, going from 11 percent during FY17 to 16 percent during FY20. (page 22)

- **Investigator Assignments** – OIG directives require that investigations be assigned to an investigator within one working day of the Bureau Chief or Investigative Team Leader receiving the allegation. For investigations closed during FY20, 97 percent (3,476 of 3,582) were initially assigned within one working day of the Bureau Chief or Investigative Team Leader receiving the allegation. However, when compared to the date reported, 45 percent (1,598 of 3,582) of allegations took two or more working days to be assigned to an investigator, indicating there was a delay in notifying the Bureau Chief or Investigative Team Leader. (page 24)

- **Supervisory Review** – OIG directives require the Investigative Team Leader or Bureau Chief to review completed cases within 15 working days of receipt absent extenuating circumstances. For cases closed in FY20, 70 percent (2,524 of 3,582) were approved within 15 working days of submission. (page 33)

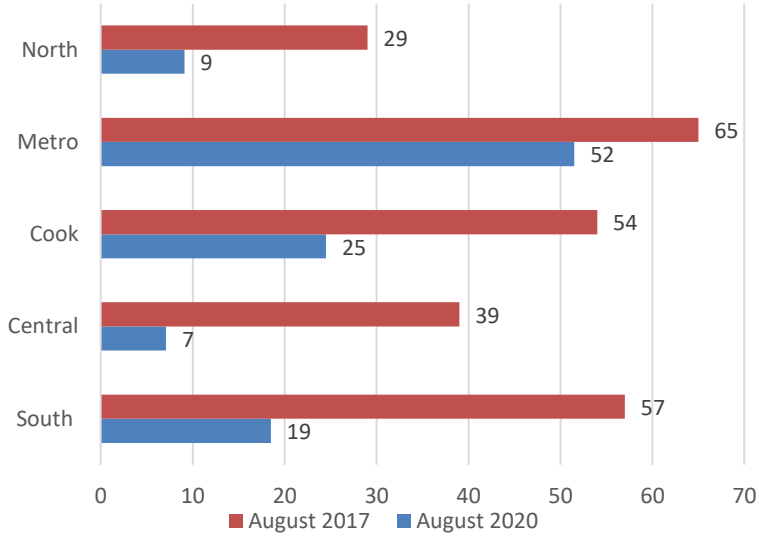
- **Obtaining Interviews or Statements from Victims** – The OIG's timeliness to obtain interviews or statements from victims has worsened by 77 percent since the last audit. For the FY20 cases sampled where a victim was interviewed and/or a statement was taken, it took an average of 46 days from the assignment date for the victim to have a statement taken or

interviews to be performed, compared to an average of 26 days during our FY17 audit. Within the FY20 sample there were 12 cases which took between 119 and 574 days to interview the victim, which impacted the average time significantly. (page 31)

- **Obtaining Interviews or Statements from Perpetrators** – For FY20 cases sampled it took an average of 45 days from the assignment date for the alleged perpetrator to be interviewed and/or a statement to be taken, which equaled the average of 45 days during our FY17 audit. Within the sample, there were 13 cases that took between 108 and 428 days to interview the alleged perpetrator, which impacted the average time significantly. (page 31)

- **Open Cases and Average Caseloads** – As shown in **Digest Exhibit 4**, open cases and average caseloads have decreased significantly since our FY17 audit. Overall, open cases decreased from 1,797 total cases as of August 2017 to 1,093 as of August 2020. The average investigator caseload for each bureau has also improved since our last audit. (page 35)

Digest Exhibit 4
AVERAGE INVESTIGATOR CASELOADS
By Bureau as of August 2017 and 2020



Source: OIG data summarized by OAG (unaudited).

Thoroughness of Investigations

OIG case reports we reviewed generally were thorough, comprehensive, and addressed the allegation. Case files contained interviews and witness statements, injury reports, pertinent medical records and treatment plans, and photographs.

All 100 cases we reviewed contained a Case Tracking Form and a Case Closure Checklist. Although all of the cases sampled contained these forms, for 27 of 100 (27%) case files reviewed, the Case Tracking Form was not complete. For 16 of 100 (16%) case files reviewed, the Case Closure Checklist was incomplete. The Case Closure Checklist requires two separate reviews. In all 16 cases, it appeared the Bureau Chief did not review the form as required. Instead the initial reviewer either signed off or initialed for the Bureau Chief, which circumvents the purpose of the second review. In addition, OIG's bureaus did not consistently use the same version of the Case Closure Checklist. (pages 37, 39-40)

There are no investigative completion timeliness standards for the OIG in statute or administrative rule. Only OIG's directives contain a 60 working day completion requirement for investigations.

Case Completion Timeliness Standards

It is crucial when dealing with the vulnerable population within State-operated facilities and community agencies that investigations are started and completed as expeditiously as possible in order to have the most accurate outcome, and to ensure the safety and well-being of the residents.

There are no investigative completion timeliness standards for the OIG in statute or administrative rule. Prior to 2002, the OIG was required to complete investigations within 60 calendar days. Since that time, the OIG has gradually relaxed the requirement within the rules to 60 working days (which is generally the equivalent of 80 calendar days), and during the FY17 audit, the requirement was removed from the administrative rules. The only place that contains the 60 working day timeliness requirement for completing investigations is within the OIG's directives. Because completing investigations in a timely manner is crucial to conducting effective investigations, auditors decided to review the timeliness standards of another investigative agency with a similarly vulnerable population, the Department of Children and Family Services (DCFS).

In both statute and rule, the DCFS Child Protective Service Unit is required to determine within 60 calendar days whether the report is 'indicated' or 'unfounded'.

The Abused and Neglected Child Reporting Act (325 ILCS 5), and the DCFS Administrative Code (89 Ill Adm Code 300) set forth timeliness requirements for DCFS investigations in Illinois. Both the statute and rule require that the DCFS Child Protective Service Unit shall determine within 60 calendar days whether the report is "indicated" or "unfounded". The Administrative Code also contains timeliness requirements for making initial contact with the victim, alleged perpetrator, and caretaker. (pages 28-29)

Actions, Sanctions, and Recommendations

The substantiation rate for abuse and neglect investigations closed has decreased in FY20 from FY17 (from 13 percent in FY17 to 9 percent in FY20); however, the number of investigations closed has remained consistent. The number of abuse and neglect investigations closed for FY20 was 3,582, while it was 3,601 for FY17. (page 42)

DHS, in some cases, still takes an extended amount of time to receive and approve the actions taken by the community agencies or State-operated facilities. State-operated facilities and community agencies are required to submit a written response to DHS for all substantiated cases of abuse and neglect, or cases with other administrative issues, within 30 calendar days from receipt of the investigative report. In our sample of 100 investigations, there were 31 cases where a written response was required; OIG could not provide the written response for two of these cases. For the remaining 29 cases, the average time for DHS to receive the response after sending out the case report to the facility or agency was 42 days. About half of the responses (15) were received within the 30 days required by statute. Six cases (19%) took 90 days or longer for DHS to receive and approve the response. All six cases that took 90 days or longer were community agency cases. (page 46)

During FY18, the OIG recommended sanctions regarding one community agency, after determining that lack of care had directly contributed to the deaths of two individuals

During FY18, the OIG recommended sanctions regarding one community agency, after it determined that lack of care had directly contributed to the deaths of two individuals. The Secretary of DHS eventually fully adopted one and partially adopted two more of the Inspector General's four recommended actions, but the letter notifying the OIG was dated nearly a year after the original letter recommending sanctions. **Because of the lack of communication from the Secretary of DHS to the OIG during this time, it is unclear if the residents at this agency were continuing to live in unsafe conditions.** (pages 50-51)

Other Issues

The Quality Care Board (Board) did not have seven members during the audit period as required by statute. The Board did not meet quarterly as required by statute in FY18 and FY19, and it did not have a quorum during FY18. During the majority of FY20, the Board had five members and was able have a quorum during meetings. The Board cannot fulfill its statutory responsibilities "to monitor and oversee the operations, policies, and procedures of the Inspector General" with continued vacancies. (pages 54-56)

DHS was not able to provide documentation that community agency employees were in compliance with the required abuse and neglect prevention and reporting training (Rule 50).

The OIG could not provide documentation to show that investigators had received the required initial and continuing training courses delineated in OIG directives. Training information provided by the DHS Division of Mental Health and the Division of Developmental Disabilities showed that some employees at State-operated facilities did not receive training in prevention and reporting of abuse and neglect (Rule 50 training). DHS was unable to provide documentation that community agencies complied with these training requirements. The majority of community agencies did not have at least one employee who is certified in Rule 50.30(f). The purpose of Rule 50.30(f) is to outline preliminary investigative steps that secure and preserve statements, photographs, the scene of the allegation, and other sources of evidence before an OIG investigator can reasonably begin to conduct an investigation. (pages 57-62)

The Act requires the Inspector General to conduct unannounced site visits to each State-operated facility at least annually (20 ILCS 1305/1-17(i)). OIG directives require that the site visit report be sent to OIG and DHS staff, including the DHS Secretary and Assistant Secretary, the Directors of Mental Health or Developmental Disabilities, and the OIG leadership team members. None of the reports were sent to the DHS Secretary or Assistant Secretary, and three reports in FY20 were also not sent to the OIG leadership team. Additionally, the OIG does not currently conduct unannounced site visits at community agencies. Although not required to do so, it would be beneficial to consider conducting unannounced site visits at community agencies because of the increased risk of noncompliance with the Act or Rule 50. (pages 63-66)

Although the data provided by the OIG was generally complete and reliable for our analysis and sample selection for testing, we identified several instances in which the OIG could improve the quality of its data. The issues identified include inaccurate discovery dates and times, a lack of report dates to law enforcement, substantiated cases with no associated recommendations, and an absence of reviewer dates. There were also issues with the OIG's training database, including incorrect or missing training dates and changes to training classes not being updated. (pages 67-69)

RECOMMENDATIONS

The audit report contains a total of 16 recommendations to the Office of the Inspector General and the Department of Human Services. The OIG and DHS generally agreed with the recommendations in the report. Appendix F to the audit report contains the agency responses.

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

SIGNED ORIGINAL ON FILE

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