STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PROGRAM AUDIT

OFFICE OF THE INSPECTOR GENERAL

DEPARTMENT OF HUMAN SERVICES

DECEMBER 2000

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AUDITOR GENERAL

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WILLIAM G. HOLLAND

To the Legislative Audit Commission, the Speaker and Minority Leader of the House of Representatives, the President and Minority Leader of the Senate, the members of the General Assembly, and the Governor:

This is our report of the Program Audit of the Office of the Inspector General, Department of Human Services.

The audit was conducted pursuant to Section 30/6.8 of the Abused and Neglected Long Term Care Facility Residents Reporting Act. This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

The audit report is transmitted in conformance with Section 3-14 of the Illinois State Auditing Act.

WILLIAM G. HOLLAND
Auditor General

Springfield, Illinois
December 2000

REPORT DIGEST

Program
Audit of

THE DEPARTMENT OF HUMAN SERVICES

OFFICE OF THE INSPECTOR GENERAL

Released: December 2000

State of Illinois
Office of the Auditor General

WILLIAM G. HOLLAND
AUDITOR GENERAL

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SYNOPSIS

This is our sixth audit of the Office of the Inspector General's (OIG's) effectiveness in investigating allegations of abuse or neglect.

- In FY 2000, the OIG substantiated abuse or neglect in 490 cases, 450 of which were related to an allegation of abuse or neglect. Of the 450 cases, 129 occurred at State facilities and 321 involved community agencies. In FY 2000, 19 State facilities served 12,858 individuals and 535 community agencies in Illinois served 145,000 individuals with developmental disabilities or mental illness. While the number of abuse and neglect allegations reported by State facilities has remained fairly consistent over the past four years, the number reported by community agencies has been increasing.

- The OIG continued to have problems completing timely investigations. In FY 2000, only 25 percent of investigations were completed within 60 days as required in OIG administrative rules. This is an improvement from FY 1998 when only 14 percent of cases were completed within 60 days. However, 23 percent of the cases in FY 2000 took longer than 200 days to complete.

- OIG case reports were generally thorough and addressed the allegation. There were some instances where documentation could be improved. While in 70 of 83 (84 percent) injury cases sampled the case file did not contain required photographs, only 2 percent of injury cases lacked other required documentation of an injury. Progress notes were not collected in 19 of 181 (10 percent) cases sampled.

- In general, community agency conducted investigations we reviewed were more complete and thorough than in our 1998 audit. Of the 1,195 investigations conducted by community agencies in FY 2000, 1,071 were conducted by community agencies without an OIG approved investigative protocol. OIG staff stated that until a community agency has an approved protocol, the investigation method approval is granted on a case-by-case basis.

- Training of OIG investigators improved since our last audit. Only one investigator had not obtained all of the required investigation-related courses.

REPORT CONCLUSIONS

The Office of the Inspector General (OIG) investigates allegations of abuse and neglect that occur in facilities operated by the Department of Human Services (DHS), as well as community agencies licensed, certified, or funded by DHS. In FY 2000, the OIG substantiated abuse or neglect in 490 of 5,095 closed investigations of incidents reported to the OIG. Of the 490 substantiated cases, 450 were related to investigations of 2,365 specific abuse or neglect allegations; the remaining 40 were found in investigations of the 2,730 incidents not classified as abuse or neglect at intake.

Of the 450 substantiated cases, 129 occurred at State facilities and 321 involved community agencies. In FY 2000, State facilities served 12,858 individuals while approximately 15,000 individuals with developmental disabilities and 130,000 individuals with mental illness were served at 535 community agencies in Illinois, according to DHS officials.

While the number of abuse and neglect allegations reported by State facilities has remained fairly consistent over the past four years (fluctuating between 1,114 in FY 1997 and 1,313 in FY 2000), the number of abuse and neglect allegations reported by community agencies has been increasing. In FY 1997, community agencies reported 365 allegations of abuse and neglect; by FY 2000, the number of allegations reported by community agencies increased to 898. OIG officials attributed this increase to an enhanced awareness of the responsibility to report such allegations by community agencies. The overall number of abuse and neglect cases closed by the OIG has increased steadily over the past four years -- from 1,116 in FY 1997 to 2,365 in FY 2000.

Problems cited in prior audits concerning untimely OIG investigations continued in FY 1999 and FY 2000. OIG administrative rules require investigations be completed within 60 days, absent extenuating circumstances. In FY 2000, only 25 percent of OIG investigations were completed within 60 days; 23 percent of the investigations took longer than 200 days to complete. Timeliness has improved slightly from FY 1998 when only 14 percent of investigations were completed within 60 days. An investigation's effectiveness is diminished if it is not conducted in a timely manner. With the passage of time, memories fade and witnesses may become unavailable for interviews.

Interviews with investigative staff and reviews of case files identified numerous factors contributing to cases taking more than 60 days to complete:

- Cases for which State Police conducted a criminal investigation were returned to the OIG approximately 6 months after they had been initially received by the State Police (as compared to 6 days for cases where State Police determined no criminal investigation was necessary).

- Cases referred to DHS Clinical Services for medical review on average took approximately five months longer than investigations not sent to Clinical Services.

- Investigator caseloads varied significantly among the OIG's four investigative bureaus. The average number of cases assigned annually per investigator varied significantly, with the highest in the South bureau (92 cases annually) and the lowest in the Central bureau (51 cases annually). There are many factors that impact the significance of investigator caseloads such as the nature of the allegation and level of investigator involvement required.

OIG case reports generally were thorough and addressed the allegation. All case files sampled contained a case report. OIG Investigative Guidelines allow investigators to determine what evidence will be collected based on the circumstances of the case. Instances where documentation could be improved included: photographs of injuries and progress notes. While in 70 of 83 (84 percent) injury cases in our sample the case file did not contain required photographs, only 2 percent of injury cases lacked other required documentation of an injury. In addition, progress notes were not collected in 19 of 181 (10 percent) cases sampled.

The required explanations as to why the case took longer than 60 days to complete were missing in 76 of 113 (67 percent) case files reviewed. The timeliness of case file review by OIG management improved from the last audit, with the median number of 19 days for review in FY 2000, down from 33 days in FY 1998.

Of the 1,195 investigations conducted by community agencies in FY 2000, 1,071 were conducted by community agencies without an approved investigative protocol. OIG administrative rules allow the OIG to delegate investigation responsibility in certain cases only to community agencies with an "approved method of investigation." OIG staff stated that until a community agency has an approved protocol, the investigation method approval is granted on a case-by-case basis. The OIG has been

working with community agencies to develop protocols to guide the agencies' investigations of abuse or neglect. As of August 4, 2000, the OIG had approved 16 community agency investigation protocols and was reviewing 24 others. In general, community agency conducted investigations were more complete and thorough in our sample of cases from FY 2000 than community agency cases sampled in FY 1998.

Not all community agencies are reporting incidents of abuse and neglect to the Department of Public Health as required by the Abused and Neglected Long Term Care Facility Residents Reporting Act (Act). In addition, 64 of 99 (65 percent) of the alleged incidents of abuse or neglect in sampled cases were not reported by community agencies within one hour of discovery as required by OIG administrative rules. At State facilities, 21 of 63 (33 percent) abuse or neglect allegations in our sample were not reported to the OIG within the one-hour requirement.

State facilities and community agencies took administrative action, such as suspension or termination, against employees in 366 (75 percent) of the 490 substantiated cases closed in FY 2000. Other actions taken against employees included: staff retraining, policy/procedure issues, treatment/program change, structural change, and legal review.

The OIG closed 53 of the 490 substantiated cases even though facilities or community agencies had not yet provided a response, such as a corrective action plan, to the OIG's finding of substantiated abuse or neglect. The OIG’s Investigative Log did not contain information regarding what, if any, corrective action facilities or community agencies took in these cases. Statutorily, it is the Secretary of the Department of Human Services' responsibility to accept or reject the facility or community agency response to OIG reports. DHS currently monitors the approval of written responses and the actions taken. However, since corrective action taken to address issues identified in substantiated cases of abuse or neglect is a critical element of an effective investigatory process, the OIG should also track all actions taken in response to its investigations.

As recommended in past audits, the OIG established a protocol in December 1999 that defines when sanctions should be recommended to the Department of Public Health and the Department of Human Services. OIG officials stated they found it unnecessary to recommend any sanctions against State-operated facilities during FY 2000. In FY 2000 the OIG also conducted unannounced site visits at all of the State-operated facilities as required by statute.

Training of OIG investigators has improved since our last audit. Our review of the training database noted that only one of the OIG investigators had not obtained all of the required investigation-related courses.

BACKGROUND

The Abused and Neglected Long Term Care Facility Residents Reporting Act (Act) established the Office of the Inspector General within the Department of Human Services. The Act requires the OIG to investigate allegations of abuse or neglect within State-operated facilities and community agencies (funded, certified, or licensed by DHS) that serve the mentally ill and developmentally disabled. The Inspector General is appointed by the Governor and confirmed by the Senate for a four-year term. The current Inspector General was appointed in July 2000.

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As of June 30, 2000, the OIG had 59 staff. This represents an increase of seven investigatory positions over staffing levels reported in our 1998 OIG audit. The largest organizational unit within the OIG is the Bureau of Investigations. The Bureau of Investigations is responsible for conducting investigations of allegations of abuse and neglect and is divided into four regional bureaus of investigations. Each regional bureau has a Bureau Chief, a Network Team Leader who is responsible primarily for case file review, and additional investigatory staff.

In FY 2000, the Department of Human Services operated 19 facilities Statewide which served 12,858 individuals. In addition, DHS licenses, certifies, or provides funding for approximately 535 separate community agency programs that provided services to 15,000 individuals with developmental disabilities and 130,000 individuals with mental illness in community settings within Illinois in FY 2000.

In FY 2000, a total of 2,211 allegations of abuse or neglect were reported to OIG (1,313 from State facilities and 898 from community agencies). As shown in Digest Exhibit 1, the number of abuse or neglect allegations at State facilities remained fairly consistent over the past four years (fluctuating between 1,114 in FY 1997 and 1,313 in FY 2000). However, the number of abuse and neglect allegations reported at community agencies has increased each year since FY 1997. In FY 1997,

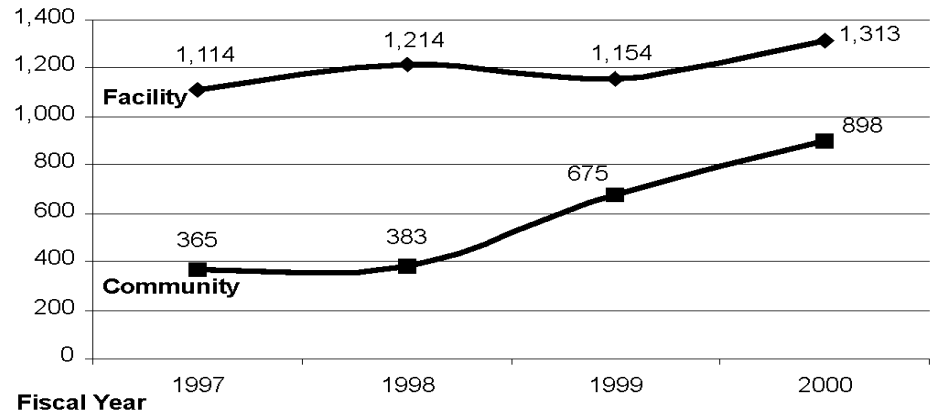
In FY 1997, abuse and neglect allegations involving community agencies totaled 365; by FY 2000, the number of incidents reported for community agencies increased to 898.

abuse and neglect allegations involving community agencies totaled 365; by FY 2000, the number of incidents reported for community agencies increased to 898. OIG officials stated that this increase is attributable to increased awareness of the responsibility to report such allegations by community agencies.

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

In the past, the Office of the Auditor General has conducted five audits of the OIG to assess the effectiveness of their investigations into allegations of abuse and neglect, as directed under 210 ILCS 30/6.8. These audits were released in 1990, 1993, 1994, 1996, and 1998. (Pages 4-6, 9, 14)

Digest Exhibit 1
TOTAL ABUSE AND NEGLECT ALLEGATIONS REPORTED TO OIG



Note: State facilities served 12,858 individuals in FY 2000. Community agencies served 15,000 individuals with developmental disabilities, and 130,000 individuals with mental illness in FY 2000.

Source: OAG analysis of OIG data.

INVESTIGATION TIMELINESS

The OIG continued to have problems completing investigations in a timely manner. OIG administrative rules require that, absent extenuating circumstances, investigations be completed within 60 days. Digest Exhibit 2 shows the number of investigations completed in terms of ranges of the number of days to completion. In FY 2000, only 25 percent of OIG investigations were completed within 60 days. While this is an improvement from FY 1998 and FY 1999, when only 14 percent and 21 percent of cases, respectively, were completed within 60 days, additional improvement is necessary.

The number of cases taking more than 200 days to complete increased from 13 in FY 1997 to 211 in FY 1998 and to 547 in FY 2000.

The number of cases taking more than 200 days to complete has also increased the past four

years. In FY 1997, only 13 cases took longer than 200 days to complete. By FY 2000, that number had increased to 547. An investigation's effectiveness is diminished if it is not conducted in a timely manner because with the passage of time, memories fade and witnesses may become unavailable for interviews.

Interviews with investigative staff and reviews of case files identified numerous possible factors contributing to cases taking more than 60 days to complete:

In FY 2000 only 25% of OIG investigations were completed within 60 days.

Digest Exhibit 2
DAYS TO COMPLETE ABUSE AND NEGLECT INVESTIGATIONS
FY 1997-2000

Days Taken to Complete Cases	FY 1997		FY 1998		FY 1999		FY 2000	
	# of Cases	%	# of Cases	%	# of Cases	%	# of Cases	%
0-60	396	41%	187	14%	313	21%	594	25%
61-90	262	27%	242	19%	144	10%	414	18%
91-120	161	17%	212	16%	165	11%	337	14%
121-180	115	12%	384	29%	342	23%	367	16%
181-200	17	2%	72	6%	90	6%	82	4%
>200	13	1%	211	16%	453	30%	547	23%
Total > 60 days	**568**	**59%**	**1,121**	**86%**	**1,194**	**79%**	**1,747**	**75%**
Totals	**964**	**100%**	**1,308**	**100%**	**1,507**	**100%**	**2,341**	**100%**

Note: Some totals due not add due to rounding. Analysis excludes cases investigated by the Illinois State Police. "Completed cases" shown in this Exhibit are cases where the OIG issued a Preliminary Report to the State facility or community agency in the fiscal year. "Closed cases", referred to later in this digest, are cases where the OIG sent the final report to the Secretary of DHS in the fiscal year.
Source: OAG Analysis of OIG Data

- Cases for which State Police conducted a criminal investigation were returned to the OIG approximately 6 months after they had been initially received by the State Police (as compared to 6 days for cases where State Police determined no criminal investigation was necessary).

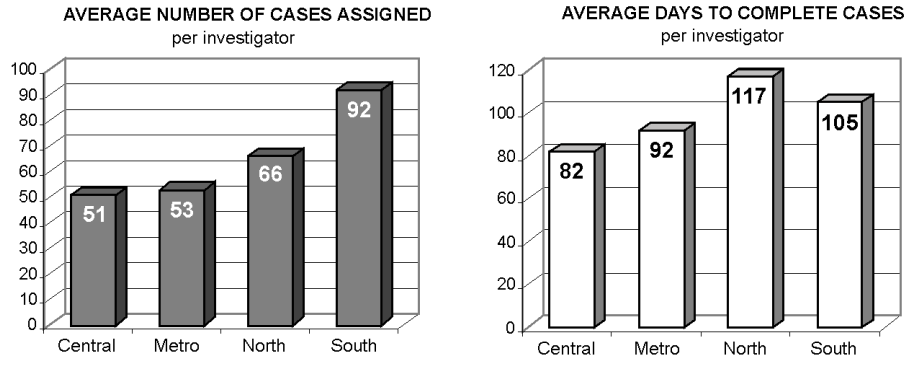
- Cases referred to DHS Clinical Services for medical review on average took approximately five months longer than investigations not sent to Clinical Services.

There are many factors that impact the significance of investigator caseloads. However, investigator caseloads varied significantly among the four investigative bureaus.

- Investigator caseloads varied significantly among the four investigative bureaus. The average number of cases assigned annually per investigator varied significantly, with the highest in the South bureau (92 cases annually) and the lowest in the Central bureau (51 cases annually). There are many factors that impact the significance of investigator caseloads, such as the nature of the allegation or level of investigator involvement required. Digest Exhibit 3 shows that the average number of cases assigned per investigator

and the average time to complete those cases varied by OIG bureau for FY 2000.

Digest Exhibit 3
AVERAGE NUMBER OF CASES ASSIGNED TO AN INVESTIGATOR AND AVERAGE TIME FOR AN INVESTIGATOR TO COMPLETE CASES BY BUREAU FY 2000



Source: OAG analysis of OIG data.

We recommended that the OIG continue to improve the timeliness of investigations. We recommended that efforts be directed in the areas of case referrals to Illinois State Police and Clinical Services, investigator caseloads, and interview and case review timeliness. (Pages 17 – 24)

INVESTIGATION THOROUGHNESS

OIG case reports generally were thorough, comprehensive, and addressed the allegation.

OIG case reports generally were thorough, comprehensive, and addressed the allegation. All case files in our sample contained a case report. We did identify instances where documentation could be improved. While in 70 of 83 (84 percent) injury cases in our sample the case file did not contain required photographs, only 2 percent of injury cases lacked other required documentation of an injury. In 19 of 181 OIG cases sampled (10 percent), progress notes were not collected.

For cases that take over 60 days to complete, OIG Investigative Guidelines require the Network Team Leader (case reviewer) to document in the investigation case file a "barrier to completion." The barrier to completion notation is to document the extenuating circumstances that caused the case to exceed the 60-day requirement.

Of 113 cases reviewed that exceeded the 60-day completion timeline, 76 (67 percent) case files did not contain the required notation. Digest Exhibit 4 shows the reasons for delay cited for cases exceeding the 60-day completion requirement.

In 76 of 113 investigations sampled, the case file did not contain the required "barrier to completion" notation.

Digest Exhibit 4
REASONS FOR CASE COMPLETION DELAY
FY 2000 SAMPLE OF CASES

Reason for Delay	Number of Cases	Percent of Cases
No Reason Documented	76	67%
Investigator Caseload	11	10%
Investigator Caseload and Low Priority	7	6%
Case Reassigned	7	6%
Low Priority	6	5%
Death Case	2	2%
Clinical Review	2	2%
Subpoenaed Records	1	1%
Complexity of Case	1	1%
TOTAL	**113**	**100%**

Source: Sample of FY 2000 OIG Investigations exceeding 60 days.

Community Agency Investigations

Of the 1,195 investigations conducted by community agencies in FY 2000, 1,071 were conducted by community agencies without an approved investigative protocol. In these cases, OIG staff approved investigation methods on a case-by-case basis.

In general, community agency conducted investigations were more complete and thorough in our sample of cases from FY 2000 than the community agency investigations sampled in FY 1998.

OIG administrative rules allow the OIG to delegate investigation responsibility in certain cases only to community agencies with an "approved method of investigation." The rules require community investigations to meet the same investigation standards and methodologies as used in OIG investigations. The OIG has been working with community agencies to develop protocols to guide the agencies' investigations of abuse or neglect. As of August 4, 2000, the OIG approved 16 community agency investigation protocols and was reviewing 24 others.

Of the 1,195 investigations conducted by community agencies in FY 2000, 1,071 were conducted by community agencies without an approved investigative protocol. OIG officials stated that until a community agency has an approved protocol, the investigation method approval is granted on a case-by-case basis.

Reporting of Abuse or Neglect Allegations

Not all community agencies are reporting incidents of abuse and neglect to the Department of Public Health (DPH) as required by the Abused and Neglected Long Term Care Facility Residents Reporting Act

(Act). In addition, 64 of 99 (65 percent) of the alleged incidents of abuse or neglect in sampled cases were not reported by community agencies within one hour of discovery as required by OIG administrative rules. At State facilities, 21 of 63 (33 percent) abuse or neglect allegations in our sample were not reported to the OIG within the one-hour requirement.

In 65% of cases sampled at community agencies and 33% of cases at State facilities, allegations of abuse or neglect were not reported within one hour.

According to DPH staff, community agencies who call the DPH hotline with an allegation of abuse or neglect are told that in the future they should call the OIG hotline if they are funded by the Department of Human Services (DHS), and have eight or less Medicaid certified beds. Such a practice is not consistent with the requirements of the Abused and Neglect Long Term Care Facility Residents Reporting Act. The Act requires that all allegations of abuse or neglect be reported to a central registry established and operated by DPH. We recommended that the OIG and DPH work with community agencies to ensure they are reporting allegations of abuse or neglect as required by statutes. (Pages 27, 30, 32 – 35)

ACTIONS, SANCTIONS, AND RECOMMENDATIONS

OIG substantiated abuse or neglect in 450 of 2,365 allegations of abuse or neglect in FY 2000.

In FY 2000, the OIG substantiated abuse or neglect in 490 of 5,095 closed investigations of incidents reported to the OIG. Of the 490 substantiated cases, 450 were related to investigations of 2,365 specific abuse or neglect allegations; the remaining 40 were found in investigations of the 2,730 incidents not classified as abuse or neglect at intake. Of the 450 substantiated cases, 129 occurred at State facilities and 321 involved community agencies.

In FY 2000, the OIG closed 53 cases for which State facilities or community agencies had not yet provided a written response to the Inspector General's finding of substantiated abuse or neglect. State law requires that the Secretary of the Department of Human Services accept or reject community agency and State facility written responses. The Divisions of Mental Health and Developmental Disabilities within DHS monitor the approval of written responses and the actions taken. They also follow-up with facilities and community agencies which do not respond to OIG timely. OIG does not always update its Investigative Log to reflect the actions taken as stated in the written response. Closing these

OIG should track the actions taken in all substantiated cases.

cases while lacking a system to ensure that appropriate responses are received and recorded can limit the effectiveness of OIG investigations.

Digest Exhibit 5 shows the 490 substantiated cases by the type of action taken and the investigating agency. There are 4 cases where an action was recommended but no action was taken. In these cases, no action was taken for the following reasons: the perpetrator resigned before the action could be taken, action was taken prior to case closure, or the action was overturned in the grievance process.

Digest Exhibit 5
ACTIONS TAKEN ON SUBSTANTIATED CASES
FY 2000

Action	Investigated By OIG	Investigated by Community Agency	TOTAL
Administrative Action	165	201	366
General Retraining	9	5	14
Policy Creation/Revision	12	4	16
Procedural Clarification	5	1	6
Specific Staff Retraining	11	11	22
Facility Structural Change	3	0	3
Treatment/Program Change	5	0	5
Legal Review	0	1	1
No Action	4	0	4
No Response	49	4	53
TOTAL	**263**	**227**	**490**

Source: OAG Analysis of OIG Data.

Sanctions and Site Visits

As recommended in past audits, the OIG developed a protocol that defines when sanctions should be recommended to DPH and DHS.

As recommended in past audits, the OIG established a protocol that defined when sanctions should be recommended to the Department of Public Health and the Department of Human Services. OIG officials stated they found it unnecessary to recommend any sanctions against State-operated facilities during FY 2000. Over the past five years, the OIG has not recommended any sanctions against facilities. In FY 2000 the OIG also conducted unannounced site visits at all of the State-operated facilities.

The OIG has not conducted any unannounced site visits at community agencies. OIG officials stated they do not have statutory authority to conduct site visits at community agencies. (Pages 39 - 48)

OTHER ISSUES

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

Training of OIG investigators has improved since our last audit. Our review of the training database noted that all but one of the OIG investigators had obtained all of the required investigation-related courses. Our last audit noted that 12 employees were lacking one or more of the required courses. OIG also began maintaining data on training provided to community agency employees who attend OIG sponsored courses. (Page 47)

All but one OIG investigator had received required investigation-related training.

RECOMMENDATIONS

The audit report contains seven recommendations related to the Office of the Inspector General and one recommendation to both the Office of the Inspector General and the Department of Public Health. The OIG and Public Health agreed with all of the recommendations. Appendix F to the audit report contains the Inspector General's and Public Health's complete responses.

WILLIAM G. HOLLAND
Auditor General

WGH:KJM

December 2000

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Chapter One

INTRODUCTION AND BACKGROUND

REPORT CONCLUSIONS

The Office of the Inspector General (OIG) investigates allegations of abuse and neglect that occur in facilities operated by the Department of Human Services (DHS), as well as community agencies licensed, certified, or funded by DHS. In FY 2000, the OIG substantiated abuse or neglect in 490 of 5,095 closed investigations of incidents reported to the OIG. Of the 490 substantiated cases, 450 were related to investigations of 2,365 specific abuse or neglect allegations; the remaining 40 were found in investigations of the 2,730 incidents not classified as abuse or neglect at intake. Of the 450 substantiated cases, 129 occurred at State facilities and 321 involved community agencies. In FY 2000, State facilities served 12,858 individuals and approximately 15,000 individuals with developmental disabilities and 130,000 individuals with mental illness were served at 535 community agencies, according to DHS officials.

While the number of abuse and neglect allegations reported by State facilities has remained fairly consistent over the past four years (fluctuating between 1,114 in FY 1997 and 1,313 in FY 2000), the number of abuse and neglect allegations reported by community agencies has been increasing. In FY 1997, community agencies reported 365 allegations of abuse and neglect; by FY 2000, the number of allegations reported by community agencies increased to 898. OIG officials attributed this increase to an enhanced awareness of the responsibility to report such allegations by community agencies. The overall number of abuse and neglect cases closed by the OIG has increased steadily over the past four years-- from 1,116 in FY 1997 to 2,365 in FY 2000.

Problems cited in prior OIG audits concerning untimely investigations continued in FY 1999 and FY 2000. OIG administrative rules require investigations be completed within 60 days, absent extenuating circumstances. In FY 2000, only 25 percent of OIG investigations were completed within 60 days; 23 percent of the investigations took longer than 200 days to complete. Timeliness has improved slightly from FY 1999 when only 21 percent of investigations were completed within 60 days and 30 percent of the investigations took longer than 200 days to complete.

The majority of cases (59 percent) taking longer than 200 days to complete were from the OIG's North bureau. Cases at Elgin Mental Health Center and Kiley Developmental Center, both in the North bureau, accounted for 40 percent of all cases

taking more than 200 days to complete. An investigation's effectiveness is diminished if it is not conducted in a timely manner. With the passage of time, memories fade and witnesses may become unavailable for interviews.

Interviews with investigative staff and reviews of case files identified numerous possible factors contributing to delayed investigations. These included cases referred to State Police for possible criminal investigation, cases referred to Clinical Services for review of medical issues, and investigator caseloads.

Cases for which State Police determined that a criminal investigation was not warranted were returned to the OIG, on average, 6 days after they had been forwarded by the OIG to the State Police. Cases where State Police conducted an investigation were returned to the OIG approximately 6 months after they had been initially received by the State Police. In addition, cases referred to Clinical Services for medical review on average took approximately five months longer than investigations not sent to Clinical Services. The average number of cases assigned annually per investigator varied significantly, with the highest in the South bureau (92 cases annually) and the lowest in the Central bureau (51 cases annually). There are many factors that impact the significance of investigator caseloads such as the nature of the allegation and level of investigator involvement required.

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Also, the required explanations as to why the case took longer than 60 days to complete were missing in 76 of 113 (67 percent) case files reviewed. The timeliness of case file review by OIG management improved from the last audit, with the median number of 19 days for review in FY 2000, down from 33 days in FY 1998.

Of the 1,195 investigations conducted by community agencies in FY 2000, 1,071 were conducted by community agencies without an approved investigative protocol. OIG officials stated that until a community agency has an approved protocol, the investigation method approval is granted on a case-by-case basis. The OIG has been working with community agencies to develop protocols to guide the agencies' investigations of abuse or neglect. As of August 4, 2000, the OIG had approved 16 community agency investigation protocols and was reviewing 24 others. In general, community agency conducted investigations were more complete and thorough in our sample of cases from FY 2000 than the same type of investigations in our sample from FY 1998.

Not all community agencies are reporting incidents of abuse and neglect to the Department of Public Health as required by the Abused and Neglected Long Term Care Facility Residents Reporting Act (Act). In addition, 64 of 99 (65 percent) of the alleged incidents of abuse or neglect in our sample of cases were not reported by community agencies within one hour of discovery as required by OIG administrative rules. At State facilities, 21 of 63 (33 percent) abuse or neglect allegations in our sample were not reported to OIG within the one-hour requirement.

We identified some instances where the four bureaus which comprise the Bureau of Investigations were not conducting investigations in a consistent manner. Internal reviews conducted by the OIG have also identified, and OIG has taken action on, some inconsistencies. We also found that changes in OIG policy (temporary or permanent) were not formally communicated in a consistent manner to all staff conducting investigations.

Facilities and community agencies took administrative action, such as suspension or termination, against employees in 366 (75 percent) of the 490 substantiated cases closed in FY 2000. Other actions taken against employees included: staff retraining, policy/procedure issues, treatment/program change, structural change, and legal review.

The OIG closed 53 of 490 substantiated cases even though facilities or community agencies had not yet provided a response, such as a corrective action plan, to the OIG's finding of substantiated abuse or neglect. The OIG's Investigative Log did not contain information regarding what, if any, corrective action facilities or community agencies took in these cases. Statutorily, it is the Secretary of the Department of Human Services' responsibility to accept or reject the facility or community agency responses to OIG reports. DHS currently monitors the approval of written responses and the actions taken. However, since corrective action taken to address issues identified in substantiated cases of abuse or neglect is a critical element of an effective investigatory process, the OIG should also track all actions taken in response to its investigations.

As recommended in past audits, the OIG established a protocol in December 1999 that defines when sanctions should be recommended to the Department of Public Health and the Department of Human Services. OIG officials stated they found it unnecessary to recommend any sanctions against State-operated facilities during FY 2000. In FY 2000 the OIG also conducted unannounced site visits at all of the State-operated facilities as required by statute.

Training of OIG investigators has improved since our last audit. Our review of the training database noted that only one of the OIG investigators had not obtained all of the required investigation-related courses.

BACKGROUND

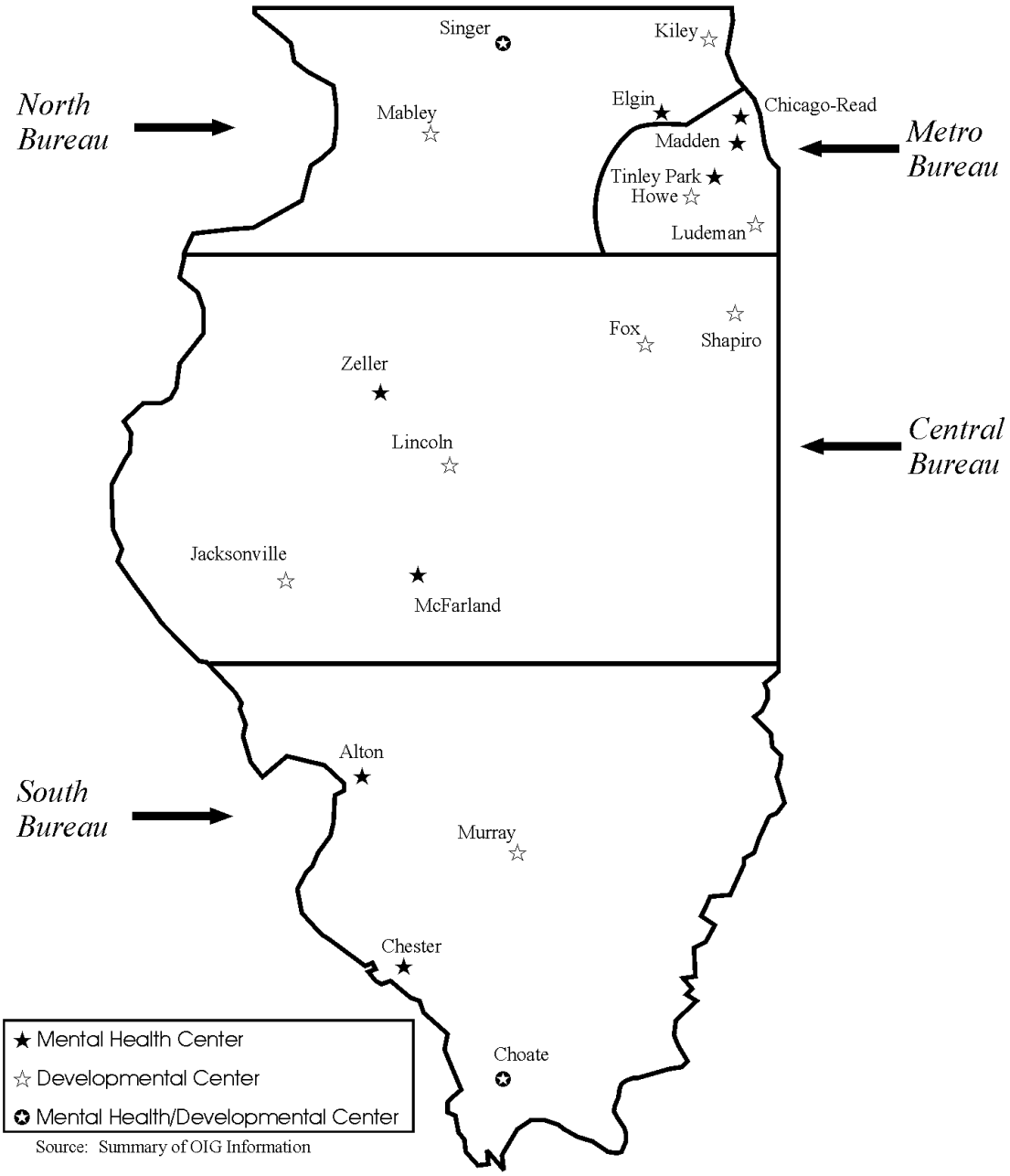
The Office of the Inspector General (OIG) was established by Public Act 85-223 in 1987 which amended the Abused and Neglected Long Term Care Facility Residents Reporting Act [Act] (210 ILCS 30/*et seq.*). The Act requires the Inspector General to investigate allegations of abuse and neglect within State-operated facilities serving the mentally ill and developmentally disabled. In 1995, the role of the Office of the Inspector General was clarified and expanded to include the authority to investigate reports of abuse or neglect at facilities or programs not only operated by the Department of Human Services (DHS) [State facilities], but also those licensed, certified or funded by DHS [community agencies]. This gave the OIG the authority to conduct investigations at community agencies.

The 1995 amendment also required the OIG to promulgate rules to establish requirements for investigations that delineate how the OIG would interact with the licensing unit of DHS. These Administrative Rules (59 Ill. Adm. Code 50) were adopted October 19, 1998. The rules require that facilities and community agencies report incidents of alleged abuse or neglect to the OIG.

The Inspector General is located within the Department of Human Services and is appointed by the Governor and confirmed by the Senate for a four-year term. The current Inspector General was appointed by the Governor in July 2000.

In FY 2000, the Department of Human Services operated 19 facilities Statewide which served 12,858 individuals. Nine facilities served the developmentally disabled, eight facilities served the mentally ill, and two facilities served both. Exhibit 1-1 shows the location of the 19 facilities and indicates whether the facilities are part of the OIG's North, Metro, Central, or South investigative bureaus.

Exhibit 1-1
DHS OPERATED RESIDENT FACILITIES AND OIG BUREAUS



Source: Summary of OIG Information

In addition, the Department licenses, certifies, or provides funding for at least 535 separate community agency programs that provide services to the developmentally disabled and the mentally ill in community settings within Illinois. These community agency programs provide transportation services, workshops, or community living arrangements. In FY 2000, approximately 15,000 individuals with developmental

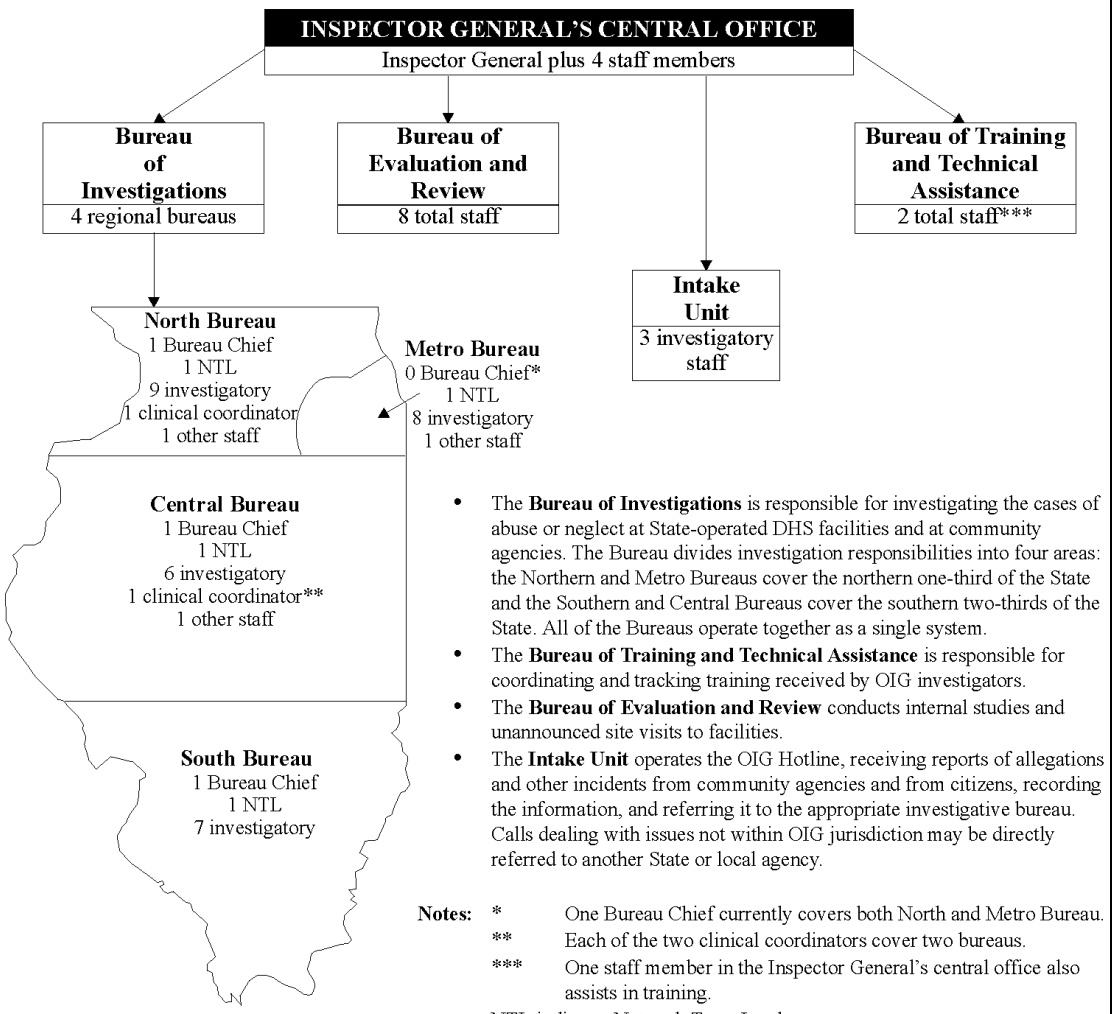
disabilities and approximately 130,000 individuals with mental illness were served in agencies required to report to the OIG.

OIG Organization

As of June 30, 2000, the OIG had 59 staff. This represents an increase of seven investigatory positions over staffing levels reported in our 1998 OIG audit. The largest organizational unit within the OIG is the Bureau of Investigations.

The Bureau of Investigations is responsible for conducting investigations of allegations of abuse and neglect. As shown on Exhibit 1-2, the OIG has established four regional bureaus within the Bureau of Investigations. Each regional bureau has a Bureau Chief, a Network Team Leader who is responsible primarily for case file review, and additional investigatory staff. As of June 30, 2000, the Bureau of Investigations had a total of 42 staff, 39 of whom had some investigatory responsibilities. Exhibit 1-2 shows the organizational structure of the OIG and the number of staff in each of the bureaus. In FY 2000, the OIG had an appropriation of $4.2 million.

Exhibit 1-2
OIG ORGANIZATIONAL CHART
As of June 30, 2000



- The **Bureau of Investigations** is responsible for investigating the cases of abuse or neglect at State-operated DHS facilities and at community agencies. The Bureau divides investigation responsibilities into four areas: the Northern and Metro Bureaus cover the northern one-third of the State and the Southern and Central Bureaus cover the southern two-thirds of the State. All of the Bureaus operate together as a single system.
- The **Bureau of Training and Technical Assistance** is responsible for coordinating and tracking training received by OIG investigators.
- The **Bureau of Evaluation and Review** conducts internal studies and unannounced site visits to facilities.
- The **Intake Unit** operates the OIG Hotline, receiving reports of allegations and other incidents from community agencies and from citizens, recording the information, and referring it to the appropriate investigative bureau. Calls dealing with issues not within OIG jurisdiction may be directly referred to another State or local agency.

Notes: * One Bureau Chief currently covers both North and Metro Bureau.
** Each of the two clinical coordinators cover two bureaus.
*** One staff member in the Inspector General's central office also assists in training.
NTL indicates Network Team Leader.

Source: OIG.

OIG MISSION, GOALS, AND PERFORMANCE MEASURES

During our last audit, the OIG developed a mission statement along with goals and objectives to guide future operations. However, according to OIG staff, the mission statement and goals were never formally communicated to the OIG employees. OIG has also not established performance measures against which they can measure the effectiveness of their investigations of allegations of abuse and neglect. According to

statutes, the primary purpose of the OIG is to investigate alleged incidents of abuse or neglect reported at facilities operated, licensed, certified, or funded by DHS.

We inquired how OIG currently defines its mission, goals, and objectives and what performance measures they have established to measure the effectiveness of their investigations. OIG officials responded that they initially attempted to develop performance measures for the Bureau of Investigations and ran into some difficulties. They then decided to start developing performance measures for the Bureau of Evaluation and Review. They felt that this might provide them with a model to develop performance measures for investigations. OIG officials have established performance measures for the Bureau of Evaluation and Review.

After completing its work on performance measures for the Bureau of Evaluation and Review, OIG then began working on performance measures for the Bureau of Investigations. Their efforts focused on research and strategic planning. Part of this strategic planning was the formation of internal work groups. OIG officials also indicated they researched various reports and studies on the topic of performance measures. From October 1999 through June 2000, OIG was awaiting a permanent appointment to the Inspector General (IG) position. During this period, long-term projects like performance measures were put on hold.

With the recent appointment of the new Inspector General, the concept of mission and goals is again being discussed. According to OIG officials, beginning in October 2000, a member of the State Police Training Academy is to act as a facilitator to the OIG in developing a mission statement, value statements, and at least three objectives for the OIG.

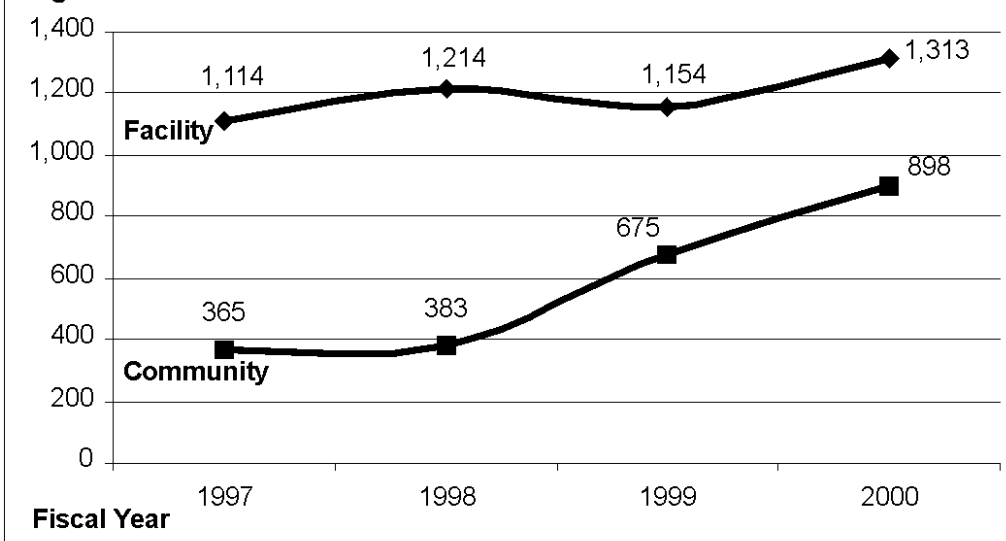
Clearly defined objectives and goals are necessary in order for the organization to establish performance measures. Performance measures provide the organization with a "yardstick" against which the organization can gauge whether the organization is meeting its goals and objectives and, ultimately, fulfilling its mission.

MISSION AND GOALS	
RECOMMENDATION **1**	***The Inspector General should develop and formally communicate the mission and goals of the Office of the Inspector General to its employees. The Inspector General should also continue efforts to establish and implement performance measures for the Bureau of Investigations.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree. An appointed committee developed new Mission and Vision statements, Strategic Goals, Core Values, and Core Competencies in October 2000. These will be used to further develop Strategic Plans for the Office and measurable performance objectives for OIG investigations by June 30, 2001.

TRENDS IN ALLEGATIONS OF ABUSE AND NEGLECT

In FY 2000, a total of 2,211 allegations of abuse or neglect were reported to OIG (1,313 from State facilities and 898 from community agencies). Exhibit 1-3 summarizes abuse and neglect allegations reported to OIG for FYs 1997 to 2000.

Exhibit 1-3
TOTAL ABUSE AND NEGLECT ALLEGATIONS REPORTED TO OIG



Note: State facilities served 12,858 individuals in FY 2000. Community agencies served 15,000 individuals with developmental disabilities, and 130,000 individuals with mental illness in FY 2000.

Source: OAG analysis of OIG data.

As shown in Exhibit 1-3, the number of abuse or neglect allegations at State facilities remained fairly consistent over the past four years (fluctuating between 1,114 in FY 1997 and 1,313 in FY 2000). However, the number of abuse and neglect allegations reported at community agencies has increased each year since FY 1997. In FY 1997, abuse and neglect allegations involving community agencies totaled 365; by FY 2000, the number of allegations reported for community agencies increased to 898. OIG officials stated that this increase is attributable to increased awareness of the responsibility to report such allegations by community agencies.

"Abuse" is defined in the statute as any physical injury, sexual abuse, or mental injury inflicted on a resident other than by accidental means. Statutorily, neglect is "a failure in a long term care facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition" (210 ILCS 30/3).

Prior to adopting administrative rules in October of 1999, the OIG through its Investigative Guidelines defined abuse more narrowly than the statutory definition. The

OIG limited its investigations to allegations of abuse or neglect of a resident by an employee. Three and one half months into FY 1999, the OIG adopted administrative rules, which expanded the OIG's definition of abuse to include both resident abuse or neglect by an employee and abuse with a serious injury by another person who is not an employee.

During FY 1999 and associated with the adoption of the OIG administrative rule, OIG began using a more detailed method of coding the different types of incidents reported to them by State-operated facilities and community agencies. Appendix D contains a listing of the new coding system and also includes a breakdown of the number of allegations reported in each of the categories. Appendix E shows the same breakdown using the OIG old coding system. These more detailed categories still make a distinction between allegations of mistreatment of residents by employees and incidents which are not necessarily attributable to staff.

OIG delegates certain investigations to facilities and the community agencies. OIG then reviews and accepts these investigations to fulfill its statutory responsibility to investigate all abuse and neglect.

OIG INVESTIGATION PROCESS

The OIG has developed four levels of OIG investigatory involvement in investigations: conducted, led, directed, and reviewed. OIG conducted investigations have the highest level of investigator involvement while reviewed investigations have the lowest.

The investigation process begins when an allegation is reported to the OIG Hotline or the field investigator and the OIG Incident Report Form is completed by OIG Intake staff. The case is then assigned to the investigator responsible for that facility or region (for community agencies). Depending on the allegation and the direction by the OIG investigator, the facility or agency personnel collect physical evidence and take initial statements from those involved in the incident about the alleged abuse or neglect. The investigator reviews case information, develops an investigative plan, and either conducts, directs, leads, or reviews the investigation at the facility or community agency. Exhibit 1-4 shows the number of investigations by level of involvement for FY 2000.

In death cases and cases with medical issues, the OIG clinical coordinator reviews the case and determines if the case needs to be further evaluated by DHS Clinical Services. At the conclusion of the investigation, the investigator prepares a "Preliminary Report" which describes the investigation methodology and its conclusion. This report is reviewed by Network Team Leaders and then by the Bureau Chief. Only substantiated cases are reviewed by the Inspector General.

Exhibit 1-4
OIG CASES CLOSED
(Includes abuse, neglect and all other incidents reported to OIG.)

Cases Closed in FY 2000
5,095 Total Cases

Community Agency 1,991 Total Cases		**State Operated Facility** 3,104 Total Cases
181	**OIG Conducted** The OIG investigator conducts every aspect of the investigation.	37
197	**OIG Led** The OIG investigator and the facility/agency staff conducts the on-site investigative work and the OIG investigator writes the Preliminary Report.	982
334	**OIG Directed** The OIG investigator gives the facility/ agency staff guidance regarding collection of evidence. The OIG investigator analyzes this evidence and writes the Preliminary Report.	537
1,279	**OIG Reviewed** The OIG investigator requests the facility/agency to conduct their own investigation and send the report to OIG. OIG reviews and analyzes evidence presented.	1,548

Note: This analysis includes referrals and cases referred to local law enforcement.
Source: OAG analysis of OIG data.

The OIG sends a Cover Memo to the facility or community agency stating the findings and recommendations in the case. The facility or community agency can request a reconsideration or clarification of the case findings if there is a disagreement. If abuse or neglect is substantiated, the facilities/agencies are required to submit a written response to the OIG that includes implementation dates for corrective action. OIG officials stated that statutes do not require OIG staff to review the written response or ensure that a written response is received for every substantiated case before the case is closed. Generally, once the written response deadline passes, OIG closes the case.

Other State Agencies

While the Act requires OIG to investigate abuse and neglect, other State agencies, including the Departments of Children and Family Services, Public Health, and State Police, also have statutory responsibility to investigate potential instances of abuse and neglect. The Act required OIG to promulgate rules that set forth instances where two or more State agencies could investigate an allegation so that OIG investigations do not duplicate other investigations. OIG administrative rules adopted in October 1998 state

that "when two or more State agencies could investigate an allegation of abuse or neglect at a community agency or facility, OIG shall not conduct an investigation that is redundant to an investigation conducted by another State agency unless another State agency has requested that OIG participate in the investigation".

Illinois State Police

State Police investigates all instances of criminal activity. The Act requires the OIG to notify State Police within 24 hours of receiving an allegation where a possible criminal act has been committed. State Police then decides if there is possible criminal activity. If so, they investigate the case; if not, the case is referred back to OIG to investigate.

However, even in cases investigated by the State Police, OIG may conduct a separate investigation after the State Police investigation is completed. State Police officials stated that this is because they only look at the criminal aspects of the incident; it is up to OIG to examine any administrative issues relating to the incident.

During the audit period, the OIG had an interagency agreement with State Police that was not signed by any of the required parties. According to OIG officials and inter-office memorandum from State Police, the agreement was in effect even though all parties had not yet signed. The State Police agreement does not address procedures for handling situations where investigations may be duplicated. The State Police agreement specifies the types of incidents that OIG should refer to them.

Department of Public Health

Public Health conducts investigations at any long-term care institution participating in the Medicare or Medicaid programs, including facilities operated by DHS. The Act requires all persons who provide direct care services or have direct contact with residents to report all incidents of suspected abuse and neglect to Public Health immediately. According to Public Health officials, their investigations focus on regulatory and licensure/certification issues, which include State Administrative Code, Medicare, and Medicaid. Public Health officials stated that their investigations are not duplicative of OIG investigations because they look for regulatory issues, not specific instances of personnel abuse and neglect. However, OIG investigations often examine the policies and procedures in place as well.

OIG currently has an interagency agreement with Public Health; however, a revised agreement is being developed. The Public Health agreement does not address procedures for handling situations where investigations may be duplicated. The agreement gives both OIG and Public Health the authority to investigate and requires that they share the results of completed investigations; it also allows Public Health to delegate its investigative authority to OIG.

Department of Children and Family Services

The Abused and Neglected Child Reporting Act (325 ILCS 5/1 *et seq*.) mandates that many persons, including State employees, immediately report incidents of suspected abuse or neglect of all persons under the age of 18 to DCFS. DCFS then has 14 days to investigate and determine if the abuse or neglect is indicated and a total of 60 days to conduct the investigation. Officials at DCFS stated that they contact OIG or OIG contacts them for a joint investigation or a coordinated effort. DCFS officials described these investigations as separate efforts with distinct paperwork for DCFS and OIG. According to DCFS officials, the joint effort in the investigation is related to the sharing of information and the conduct of some joint interviews. There is currently no final agreement with DCFS, although an agreement has been drafted and both agencies are reviewing the document.

INTERAGENCY AGREEMENTS	
RECOMMENDATION 2	***The Inspector General should clarify the investigatory role of each agency through signed interagency agreements with other State agencies that conduct investigations of abuse and neglect.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree. The Inspector General has final agreements with the Illinois State Police, and the Department of Public Health. Pending signatures on agreement with the Department of Children and Family Services. This should receive final approval by the Secretary of DHS and DCFS Director by December 1, 2000.

AUDIT SCOPE AND METHODOLOGY

This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

Initial work began on this audit in March 2000 and fieldwork was concluded in October 2000. We interviewed representatives of the Inspector General's Office, the Department of Human Services, the Department of Public Health, Department of State Police, and the Department of Children and Family Services. We reviewed documents at the Inspector General's Office, State Police, DCFS, and Public Health, interagency agreements with State Police and Public Health, and a draft interagency agreement with DCFS. We examined the current OIG organizational structure, policies and procedures, investigations process, case review process, and documentation requirements. We also reviewed internal controls over the investigation process. We reviewed backgrounds for investigators hired since our last audit and reviewed data from the Investigations Log. Our audit work included follow-up on previous audit recommendations.

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

The Office of the Auditor General has conducted five prior audits of the OIG to assess the effectiveness of their investigations into allegations of abuse and neglect, as directed under 210 ILCS 30/6.8 (Appendix A). These audits were released in 1990, 1993, 1994, 1996, and 1998. Exhibit 1-5 summarizes the findings for each of these audits.

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

Our audit released in December 1998 included a recommendation that the OIG should develop a protocol which dictates responsibility for reporting licensed individuals to the Department of Professional Regulation when cases of abuse or neglect involve patient care. Current Investigative Guidelines include a section on reporting licensed

Exhibit 1-5
AUDITOR GENERAL PRIOR AUDIT RECOMMENDATIONS CONCERNING THE OIG

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

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

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

individuals to the Department of Professional Regulation. Our audit work also included a review of standards used to conduct investigations and training requirements of staff.

REPORT ORGANIZATION

Chapter Two examines the timeliness of OIG investigations.

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

Chapter Four reviews actions, sanctions, and recommendations.

Chapter Five discusses OIG investigator and facility staff training.

Chapter Two

TIMELINESS OF ABUSE OR NEGLECT INVESTIGATIONS

CHAPTER CONCLUSIONS

The OIG continued to have problems completing investigations in a timely manner. OIG administrative rules require that, absent extenuating circumstances, investigations be completed within 60 days. In FY 2000, only 25 percent of OIG investigations were completed within 60 days. While this is an improvement from FY 1998 and 1999, when only 14 percent and 21 percent of cases, respectively, were completed within 60 days, additional improvement is necessary.

The number of cases taking more than 200 days to complete has also increased the past four years. In FY 1997, only 13 cases took longer than 200 days to complete. By FY 2000, that number had increased to 547. An investigation's effectiveness is diminished if it is not conducted in a timely manner because with the passage of time, memories fade and witnesses may become unavailable for interviews.

The majority of cases (59 percent) taking longer than 200 days to complete were from the OIG's North bureau. Cases at Elgin Mental Health Center and Kiley Developmental Center, both in the North bureau, accounted for 40 percent of all cases taking more than 200 days to complete.

Interviews with investigative staff and reviews of case files identified numerous possible factors contributing to delayed investigations. These included cases referred to State Police for possible criminal investigation, cases referred to DHS Clinical Services for review of medical issues, and investigator caseloads.

Cases for which State Police determined that a criminal investigation was not warranted were returned to the OIG, on average, 6 days after they had been forwarded by the OIG to the State Police. Cases for which State Police conducted an investigation were returned to the OIG approximately 6 months after they had been initially received by the State Police. In addition, cases referred to Clinical Services for medical review on average took about five months longer than investigations not sent to Clinical Services. The average number of cases assigned annually per investigator varied significantly, with the highest in the South bureau (92 cases annually) and the lowest in the Central bureau (51 cases annually). There are many factors that impact the significance of investigator caseloads such as the nature of the allegation or level of investigator involvement required.

The timeliness of case file review by OIG management improved from the last audit, with the median number of 19 days for review in FY 2000, down from 33 days in FY 1998.

INVESTIGATION TIMELINESS

The effectiveness of an investigation is diminished if it is not conducted in a timely manner. In our last audit we noted that timely completion of investigations is critical for an effective investigation, because as time passes, injuries heal, memories fade, or witnesses may not be located. Department of Human Services (DHS) policy, OIG administrative rules, and Investigative Guidelines require that investigations be completed as expeditiously as possible and should not exceed 60 days absent extenuating circumstances.

Overall timeliness of OIG investigations has been an issue in the previous five audits, and is again in FY 2000. Overall it took an average of 152 days and a median of 121 days to complete an investigation of abuse or neglect in FY 1999 and FY 2000.

In FY 2000, the OIG completed only 25 percent of its investigations within the 60 days required by administrative rules, as shown in Exhibit 2-1. FY 2000 represented a slight improvement over FY 1999 when only 21 percent of the cases were completed within 60 days. The number of cases open for more than 60 days has also increased over the past four fiscal years.

Exhibit 2-1
DAYS TO COMPLETE ABUSE AND NEGLECT INVESTIGATIONS
FY 1997-2000

Days Taken to Complete Cases	FY 1997		FY 1998		FY 1999		FY 2000	
	# of Cases	%	# of Cases	%	# of Cases	%	# of Cases	%
0-60	396	41%	187	14%	313	21%	594	25%
61-90	262	27%	242	19%	144	10%	414	18%
91-120	161	17%	212	16%	165	11%	337	14%
121-180	115	12%	384	29%	342	23%	367	16%
181-200	17	2%	72	6%	90	6%	82	4%
>200	13	1%	211	16%	453	30%	547	23%
Total > 60 days	**568**	**59%**	**1,121**	**86%**	**1,194**	**79%**	**1,747**	**75%**
Totals	**964**	**100%**	**1,308**	**100%**	**1,507**	**100%**	**2,341**	**100%**

Note: Some totals due not add due to rounding. Analysis excludes cases investigated by the Illinois State Police, Division of Internal Investigations. "Completed cases" shown in this Exhibit are cases where the OIG issued a Preliminary Report to the State facility or community agency in the fiscal year. "Closed cases," referred to later in this report, are cases where the OIG sent the final report to the Secretary of DHS in the fiscal year.
Source: OAG Analysis of OIG Data

Exhibit 2-1 shows the number of cases completed in terms of ranges of the number of days to completion. Case completion is measured from the date the allegation

of abuse or neglect is reported to OIG to the date the Preliminary Report is sent to the facility or agency notifying them of the investigation outcome. Data analysis was conducted on the entire population of cases closed in each of the fiscal years.

The number of cases taking more than 200 days to complete has increased significantly from FY 1997 to FY 2000. In FY 1997, only 13 cases took longer than 200 days to complete. By FY 2000, the cases taking longer than 200 days to complete increased to 547. Exhibit 2-2 shows the types of allegations taking more than 200 days to complete in FY 2000.

Exhibit 2-2
TYPES OF ALLEGATIONS FOR CASES OVER 200 DAYS TO COMPLETE
FY 2000

Type of Allegation	FY 2000
Neglect	192
Physical abuse not requiring emergency medical treatment	154
Verbal abuse	84
Death	59
Recipient injury requiring emergency medical treatment	29
Sexual abuse	28
Unauthorized resident absence from a facility	1
TOTAL	**547**

Source: OAG Analysis of OIG Data.

Investigations at State facilities completed during FY 2000 accounted for 69 percent of the cases that took longer than 200 days to complete; investigations at community agencies accounted for the remaining 31 percent. In FY 2000, of the four OIG Investigation bureaus, the North bureau accounted for the majority of cases taking longer than 200 days to complete (59 percent). The other three bureaus accounted for a smaller proportion of the cases taking longer than 200 days to complete: Metro (23 percent); Central (8 percent); and South (11 percent).

Certain DHS facilities accounted for a large proportion of the State facility cases over 200 days old. The following three facilities comprised almost half of the abuse and neglect investigations at State facilities taking more than 200 days to complete: Elgin Mental Health Center (28 percent); Kiley Developmental Center (12 percent); and Chicago Read Mental Health Center (7 percent).

Our prior audit also noted that Elgin Mental Health Center had the largest number of cases over 200 days old. We noted instances in our review of Elgin cases where the OIG cited the facility for untimely interviews.

Open Cases

Exhibit 2-1 also shows that the number of cases completed each year has steadily increased over the past four fiscal years. Our analysis of open OIG investigated cases in the OIG Investigative Log showed that overall, the average age of cases open at the end of FY 2000 (149 days) has increased over FY 1999 (100 days). However, the number of

open cases has decreased. Exhibit 2-3 displays the average age of open cases and the number of open cases at the end of FY 1999 and FY 2000 by investigative bureau. In FY 1999, 69 percent of the open cases were from the North and Metro bureaus while in FY 2000, 46 percent of the cases were from these two bureaus. The South bureau almost doubled the number of open cases between FY 1999 and FY 2000. The average age of cases in all bureaus was higher in FY 2000 than it was in FY 1999. In FY 2000, the 268 investigations conducted by community agencies in the Investigative Log were on average 128 days old.

Exhibit 2-3
AVERAGE AGE & NUMBER OF OPEN OIG INVESTIGATED CASES BY BUREAU
FY 1999 & 2000

	FY 1999		FY 2000	
Bureau	**Average Age in Days**	**# Open**	**Average Age in Days**	**# Open**
Metro	130	277	178	46
North	99	263	189	163
Central	69	131	128	24
South	63	111	115	221
Totals	**100**	**782**	**149**	**454**

Source: OAG Analysis of OIG Data.

POSSIBLE REASONS FOR DELAYS IN CASE COMPLETION

We asked OIG staff in varying investigative positions to identify the reasons for cases exceeding the 60-day completion requirement. Their responses often pointed to cases required to be referred to State Police's Division of Internal Investigations and cases referred to DHS Clinical Services.

OIG officials also offered a variety of other responses for the possible cause of delays in completing cases. Staffing and caseload were the most common responses. Other factors cited included availability of witnesses, the timeliness of documents being provided to OIG, and how well facilities or community agencies handled the initial phases of investigations.

Case Referrals

There are aspects of some investigations into abuse and neglect allegations (i.e., those referred to Illinois State Police (ISP) or Clinical Services) that are outside the direct control of OIG. For these types of cases the average case completion time is greater than for cases not referred to State Police or Clinical Services.

Illinois State Police

Statutes require that OIG notify State Police within twenty-four hours of all reports when criminal activity may have occurred or is suspected. According to an interagency agreement with the State Police, certain types of cases are required to be submitted to State Police, Division of Internal Investigations. The following incidents must be reported to State Police for possible criminal investigation:

- physical abuse or neglect with a serious injury;
- sexual abuse with either credible evidence or injury;
- criminal activity within 14 days of discharge;
- transactions where an employee receives personal gain or profit;
- all deaths (other than those occurring in community agencies, or any death of natural causes at State-operated facilities); and
- any other allegation of abuse or neglect by an employee that the DHS/OIG may determine warrants reporting due to either credible evidence or injury.

State Police can then either conduct an investigation or refer the case back to OIG for investigation. In some instances, the OIG will conduct an investigation in a case even if State Police conducted an investigation. The State Police investigation is a criminal investigation and the OIG investigation is administrative. According to OIG's Investigative Guidelines, OIG conducts no further investigatory activity when ISP accepts a case unless requested to do so by ISP.

Exhibit 2-4
NUMBER OF DAYS CASES REFERRED BY OIG WERE AT ISP
FY 2000

	Average Number of Days at ISP
Cases not investigated by ISP	6
Cases investigated by ISP	188

Source: OAG Analysis of OIG Data.

As shown in Exhibit 2-4, cases where ISP decided not to conduct an investigation were returned to the OIG, on average, 6 days after the OIG had forwarded them to ISP. Sixty-eight percent of these cases (94 of 139) were returned by ISP to the OIG within 3 days of receipt.

At the conclusion of an ISP conducted investigation, ISP sends a letter of finding to OIG. Exhibit 2-4 shows that ISP took on average approximately six months to send this letter. As shown in Exhibit 2-5, of the 20 cases where the ISP conducted an investigation, the prosecutor declined to prosecute the case in 12. A conviction was obtained in two of these cases.

Exhibit 2-5
DISPOSITION OF CASES REFERRED TO ISP IN FY 2000

Disposition	**Number of Cases**
Referred back to OIG	139
CASES INVESTIGATED BY ISP	
Declined by Prosecutor	12
Not Sustained	3
Conviction	2
Other	3
TOTAL	159

Note: Due to data limitations, we analyzed 159 of the 190 cases OIG referred to ISP in FY 2000.
Source: OIG analysis of Illinois State Police data.

The Inspector General discussed with ISP ways in which the OIG can help reduce the amount of time ISP has cases. According to an ISP official, the discussion focused on the OIG having staff designated at both their north and south locations with the authority to refer cases to ISP. In many instances, past practice allowed only the Inspector General the authority to make the referrals. The ISP concluded this arrangement would help ISP get to the scene of the incident more quickly and avoid loss of evidence or witnesses.

Clinical Services Cases

Cases with medical issues that are referred to Clinical Services may also impact the timeliness of investigations. Officials at OIG indicated that in some cases a review by Clinical Services could take a minimum of 6-8 weeks. The 157 cases referred to Clinical Services in FY 1999 and 2000 took an average of 302 days and a median of 297 days to complete as shown in Exhibit 2-6. Of the 157 cases referred to Clinical Services, 111 (71 percent) were death cases, and 30 (19 percent) were neglect cases. The remaining 16 cases were other physical abuse, sexual abuse, verbal/psychological abuse or other allegation cases. Only four community agency cases were referred to Clinical Services and all were death cases. By comparison, OIG investigated cases for the same two-year period which were not referred to Clinical Services took an average of 138 and a median of 109 days to complete.

Exhibit 2-6
COMPLETION TIMES FOR OIG CASES REFERRED TO CLINICAL SERVICES
FYs 1999 & 2000

	Average	Median
Referred to Clinical Services	302	297
Not Referred to Clinical Services	138	109

Source: OAG Analysis of OIG Data.

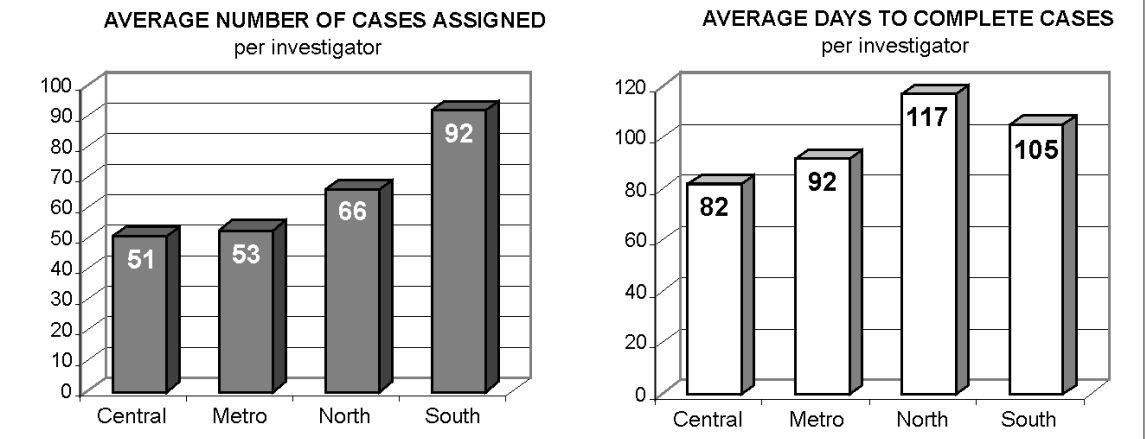
Investigator Caseloads

High investigation caseloads were cited as a reason for not completing cases in a timely manner by both the investigative staff interviewed and in case files. Our review of the number of cases assigned per investigator found a large variation in the average number of cases assigned between the four OIG bureaus.

Exhibit 2-7 shows the average number of cases assigned per investigator and the average time to complete those cases by bureau for FY 2000. The Exhibit shows that the Central Bureau had the lowest average number of cases assigned per investigator (51) and had the lowest average number of days to complete those cases (82). The South Bureau had the highest average number of cases assigned per investigator (92) and the second highest average number of days to complete those cases (105). The North and Metro Bureaus had the second and third highest average number of cases assigned per investigator respectively (66 North and 53 Metro) and the first and third highest average number of days to complete (117 days North and 92 days Metro).

There are, however, many factors that can impact the significance of these differences in caseloads, such as the nature of the allegation and the investigator level of involvement in the case. However, since both investigators interviewed and case files reviewed cited high caseloads as a factor impacting the timeliness of investigations, the level and distribution of OIG investigator case assignments should be reviewed by OIG management.

Exhibit 2-7
AVERAGE NUMBER OF CASES ASSIGNED TO AN INVESTIGATOR AND AVERAGE TIME FOR AN INVESTIGATOR TO COMPLETE CASES BY BUREAU
FY 2000



Source: OAG analysis of OIG data.

Time to Initiate the Investigation

A contributing factor for investigations exceeding the 60-day time requirement may be delays in initiating the OIG portion of the investigation. Timely initiation of the investigation is important because memories may fade or witnesses may become unavailable for follow-up interviews. According to an OIG internal audit, the timeliness of the investigation often depends on the timeliness of interviews. Therefore, one possible way to help determine the timeliness, and ultimately the effectiveness of an investigation, is to measure the length of time it took to initiate the investigation. Delays in getting accounts from those involved, especially from the alleged victim, increases the risk of losing information and weakening the evidence obtained.

Improvement is needed in the timeliness of the OIG investigator's first interview. In 56 of 105 (53 percent) investigations sampled, the first OIG interview was not conducted for more than one month after the incident was reported to the OIG and took an average of 69 days overall. In our 1998 OIG audit, in 38 percent of the cases sampled, the first OIG interviews did not take place for over one month after the allegation report and the average was 51 days overall. Investigative Guidelines do not contain specific time requirements for conducting a first OIG interview and new classifications of investigator level of involvement in the cases (conducted, led, directed and reviewed) may affect the length of time to the first OIG interview.

Timeliness of Case File Reviews

Timeliness requirements for supervisory review have been eliminated over the last two audit periods. In FY 1996, OIG supervisors were required to review each investigation within three working days of receipt. Guidelines during the current audit period included a three level supervisory review with no mention of a timeline. The only specific time requirement concerned the amount of time the OIG had to send the report to the DHS facility or community agency after all reviews were complete.

Once the investigator completes the investigation and writes the Preliminary Report, the report is submitted for review. During the audit period, Guidelines stated that the investigative case file (including the preliminary report) is reviewed by the Network Team Leader (NTL), Bureau Chief, and if necessary (substantiated cases), the Inspector General. However, the Guidelines did not mention a specific time requirement to complete these reviews (NTL or Bureau Chief).

The timeliness of case file review by OIG management improved from the last audit. Our analysis of the OIG Investigative Log showed that the median number of days cases were being reviewed decreased from 21 days in FY 1999 to 19 days in FY 2000. In FY 1998 and FY1997, the median number of days in review were 33 days and 22 days respectively.

TIMELINESS OF CASE COMPLETION	
RECOMMENDATION **3**	***The Inspector General should continue to improve the timeliness in investigations of abuse and neglect in order to comply with OIG administrative rules. Efforts could be directed in the areas of:*** • ***Case referrals to Illinois State Police;*** • ***Case referrals to Clinical Services;*** • ***Investigator caseloads;*** • ***Interview timeliness; and*** • ***Case review timeliness.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree. OIG has considered each of these areas and others in its efforts over the past year to decrease the length of time to completion of investigations. The investigative time line will be reviewed and changed beginning January 1, 2001. Average time has already dropped by a third in the first quarter of FY 2001. Investigative managers will be held responsible for prompt completion of investigative and review work.

FACILITY NOTIFICATION AND RESPONSE

After the Preliminary Report review process is completed and the report has been accepted by the Inspector General, the facility/agency needs to be notified of the investigation results. Substantiated cases of abuse or neglect also must be reported to the Secretary of the Department of Human Services.

Notifying Facilities or Agencies

Investigative Guidelines state that the Inspector General or designee must submit a copy of the "Preliminary Report" to the Authorized Representative (Facility Director or community agency Executive Director) within five working days of acceptance of the report. This time frame is measured from the date all reviews were completed (indicating the Inspector General's acceptance), to the date the notification letter was sent to the facility/agency. In our sample of cases, we did not note any problems meeting this requirement.

Facility or Agency Requests for Reconsideration or Clarification of Findings

Once the facility or agency receives the investigation results, the OIG Investigative Guidelines establish a detailed reconsideration/clarification process that allows the authorized representative 30 days to submit a written response. In substantiated cases, the response must be written and include the steps that will be taken to protect the individual(s) from abuse or neglect, including implementation dates. However, if the facility or agency disagrees with the outcome of the investigation, they may request, in the same 30 days, that the Inspector General further explain the findings, or request the Inspector General to reconsider the findings based on additional information submitted by the community agency or facility.

The Inspector General has 15 working days to notify the facility or agency as to whether their request for clarification or reconsideration was approved or disapproved. If no clarification or reconsideration is requested, the Preliminary Report becomes final 30 days from the date on the cover memorandum that is attached to the Preliminary Report. The OIG Investigative Log showed that in FY 1999 and FY 2000 there were 40 and 31 formal requests for reconsideration respectively.

Of the eight cases in our sample where reconsideration or clarification was requested, 38 percent (3 of 8) of the community agencies or facilities did not request a reconsideration or clarification within the required 30 days. Even though their requests were submitted after the 30 days, the request was granted. The Inspector General's response to the request for reconsideration or clarification was timely in 63 percent (5 of 8) of the cases sampled.

Chapter Three

THOROUGHNESS OF ABUSE OR NEGLECT INVESTIGATIONS

CHAPTER CONCLUSIONS

OIG case reports generally were thorough, comprehensive, and addressed the allegation. All case files in our sample contained a case report. We did identify instances where documentation could be improved. While in 70 of 83 (84 percent) injury cases in our sample the case file did not contain required photographs, only 2 percent of injury cases lacked other required documentation of an injury. In 19 of 181 OIG cases sampled (10 percent), progress notes were not collected.

All files reviewed contained the required "Library Sheet" which is used to document key aspects of a case. In only 37 of the 113 (33 percent) cases taking more than 60 days to complete did the Library Sheet contain an explanation describing why a case wasn't completed within 60 days, as required by OIG policy.

Of the 1,195 investigations conducted by community agencies in FY 2000, 1,071 (90 percent) were conducted by community agencies without an approved protocol for the community agency. OIG officials stated that until a community agency has an approved protocol, the investigation method approval is granted on a case-by-case basis. The OIG has been working with community agencies to develop protocols to guide the agencies' investigations of abuse or neglect. As of August 4, 2000**,** the OIG approved 16 community agency investigation protocols and was reviewing 24 others. In general, community agency conducted investigations were more complete and thorough in our sample of cases from FY 2000 than the same type of investigations in our sample from FY 1998.

Not all community agencies are reporting incidents of abuse and neglect to the Department of Public Health as required by the Abused and Neglected Long Term Care Facility Residents Reporting Act (Act). In addition, 64 of 99 (65 percent) of the alleged incidents of abuse or neglect in our sample of cases were not reported by community agencies within one hour of their discovery as required by OIG administrative rules. At State facilities, 21 of 63 (33 percent) abuse or neglect allegations in our sample were not reported to OIG within the one-hour requirement.

We identified some instances where the four bureaus that comprise the Bureau of Investigations were not conducting investigations in a consistent manner. Internal reviews conducted by the OIG have also identified, and OIG has taken action on, some inconsistencies. We also found that changes in OIG policy (temporary or permanent) were not formally communicated in a consistent manner to all staff conducting investigations.

INVESTIGATION THOROUGHNESS

In addition to timeliness, essential components of an abuse or neglect investigation include thoroughness in the collection of evidence, adequate supervisory review, and a clear and comprehensive final case report.

Collection of Evidence

For most types of evidence, the OIG Investigative Guidelines give the investigator the responsibility to determine what evidence needs to be collected:

> *"Depending on the nature of the allegation, the following considerations should be used as a GUIDE for each investigation to determine what evidence should be sought, collected, and when relevant, made part of the investigative case file."*

Consideration of what evidence to collect is part of the investigative plan, which the investigator is responsible for developing for each investigation. However, Guidelines do not require the investigative plan to be documented.

Guidelines do require that certain evidence be collected for specific types of cases. This evidence includes: photographs, progress notes, documentation concerning injuries (including documentation that no injury occurred), and restraint/seclusion records.

- **Photographs:** Photographs were missing in 70 of the 83 cases (84 percent) with injuries in our sample from FY 2000. OIG Investigative Guidelines state that photographs are required in all instances where an injury has been sustained as a result of an incident. When injuries have been inflicted as a result of an alleged incident of abuse or neglect, the investigator should ensure that they are photographed. Photographs of injuries serve as demonstrative evidence to document the size, location and severity of the injury and can indicate when the injury may have been inflicted (e.g., discoloration of bruises).

- **Progress Notes:** There were 19 of 181 cases (10 percent) sampled that did not contain progress notes, other unit notes, or hospital or other records as

required by Guidelines. According to OIG Guidelines, copies of relevant progress notes are required for every investigation.

- **Documentation of Injury:** In 2 of 83 cases (2 percent) involving an alleged injury, case files did not contain any documentation for an injury. OIG Investigative Guidelines require investigators to obtain copies of relevant documentation concerning injuries, including documentation that no injury was sustained. Documentation may include an Injury Report, physician/nurse examination, results of body check, nursing notes, medical progress notes, and other relevant progress notes, treatment records, and physician orders.

- **Restraint/Seclusion Records:** All five cases sampled which met the criteria requiring that a restraint/seclusion record be included contained the appropriate documentation.

CASE MONITORING AND SUPERVISORY REVIEW

Supervisory review is another essential element in an effective investigation. It is the responsibility of the OIG's supervisory staff to ensure that criteria for effective investigations are being met. Without adequate supervisory review and feedback, the quality of the investigations may suffer, and as a result, the effectiveness may be diminished.

Each OIG investigation is to be thoroughly reviewed, and the reviewer at each level is to complete a standardized case review form for each case indicating questions, comments or instructions for the investigator that were noted during the review. A typical case will move through two and possibly three levels of review (for substantiated cases) before being sent to the facility/agency.

Documentation of Case Monitoring and Review

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

Library Sheet

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

For cases that take over 60 days to complete, the Investigative Guidelines require the Network Team Leader (first level of review) to document on the Library Sheet in the investigation case file a "barrier to completion." The barrier to completion notation is to document the extenuating circumstances that caused the case to exceed the 60-day requirement.

Of 113 cases reviewed which required a notation of the barrier to completion (because the case exceeded the 60-day completion timeline), 76 (67 percent) did not contain the required notation. Exhibit 3-1 shows that of the 37 cases with a barrier to completion, the Network Team Leader often noted acceptable reasons for delay contained in Investigative Guidelines.

Exhibit 3-1
REASONS FOR CASE COMPLETION DELAY
FY 2000 SAMPLE OF CASES

Reason for Delay	Number of Cases	Percent of Cases
No Reason Documented	76	67%
Investigator Caseload	11	10%
Investigator Caseload and Low Priority	7	6%
Case Reassigned	7	6%
Low Priority	6	5%
Death Case	2	2%
Clinical Review	2	2%
Subpoenaed Records	1	1%
Complexity of Case	1	1%
TOTAL	**113**	**100%**

Source: Sample of FY 2000 OIG Investigations exceeding 60 days.

Investigative Guidelines and OIG officials noted the following examples of acceptable barriers to completion:

- the unavailability of witness(es);
- a non-serious, low priority case;
- the case was sent for other internal/external consultation (such as an expert in a particular field, or the Department's clinical physicians); or
- the case was initially investigated by the ISP, local law enforcement, or other investigative entity.

Case File Review Action Slip

After a case is submitted for review, the review progress is documented through a Case File Review Action Slip. After each level of review, the reviewer signs and dates the form to indicate that the review has taken place and sends the case to the next level of review. The form also has a section where the reviewer can note when the case was sent to special review, clinical, legal, consultant, or another office.

We noted an inconsistency in the use of the Case File Review Action Slip between the four investigation bureaus. In community agency investigations conducted by the community agency and reviewed by OIG, the Case File Review Action Slip was not included in the majority of case files in the North and Metro bureaus. The same type of cases in the Central and South bureaus did have the Case File Review Action Slip. OIG officials noted the inconsistency before our sample testing took place (June 2000) and set a consistent policy for using the Case File Review Action Slip.

Our sample of cases showed that almost all other types of cases contained the Case File Review Action Slip; however, it was not always complete. Nine of 180 case files sampled (5 percent) contained an incomplete Case File Review Action Slip. In one file the Case File Review Action Slip was missing.

Review Sheet

The OIG Review Sheet is used by case file reviewers at each level to document their comments on the case and to suggest further instructions for investigators. Reviewers should complete a Review Sheet on every case even if they have no comments. Our sample of cases showed that 39 of 303 cases (13 percent) did not contain a review sheet. However, all of these cases were reviewed prior to January 2000 and in all cases there was an indication on the Case File Review Action Slip that there were no review comments. OIG officials stated that they were accepting cases with only an indication "no comments" on the Case File Review Action Slip before the middle of January 2000. All other case files in our sample included the Review Sheets.

SUPERVISORY REVIEW	
RECOMMENDATION **4**	***The Inspector General should ensure that supervisory review provides assurance that:*** • ***All relevant documentation has been collected and analyzed by the investigator;*** • ***Library sheets contain the required "barrier to completion" notation explaining why cases took longer than 60 days to complete; and*** • ***All investigation bureaus consistently use and complete***

	the same case monitoring and review forms in case files.
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree. OIG has begun the process of revising the Investigative Guidelines to be more specific as to what documentation is necessary, including how barriers to completion are to be identified. This process should be completed by June 30, 2001. All investigative bureaus currently use the same case review forms in all case files.

FINAL CASE REPORTS

A well-written final case report is also essential to an effective investigation because it often provides a basis for management's decision on the action warranted in the case. At the OIG, the investigator's final report is reviewed by up to three levels of management who must "sign off" on the case before a recommendation is sent to the facility. Therefore, it is important that the final case report be clear and convincing to anyone who reads it. The report should address all relevant aspects of the investigation and reveal what the investigation accomplished. All case files in our sample contained a case report. OIG case reports generally were thorough, comprehensive, and addressed the allegation.

COMMUNITY AGENCY INVESTIGATIONS DELEGATED BY THE OIG

In general, the investigations completed by the community agencies were more complete and thorough in our sample of cases from FY 2000 than the same type of investigations sampled in our 1998 audit. However, we identified one area regarding community investigations where additional attention is warranted. Many community agencies have conducted investigations without approved protocols.

Community Agency Protocols

OIG rules allow the community agency to investigate the following types of allegations:

- Physical or mental abuse without injury or with an injury not requiring medical treatment by a physician;
- Neglect without injury or with an injury not requiring medical treatment by a physician; and

- Deaths from accidents or natural causes.

OIG administrative rules allow the OIG to delegate investigation responsibility in certain cases only to community agencies with an "approved method of investigation." The rules require community investigations to meet the same investigation standards and methodologies as used in OIG investigations.

The FY 1999 OIG Annual Report notes that the Bureau of Evaluation and Review has the function of reviewing these "protocols." The protocols are reviewed to determine compliance with the requirements of OIG administrative rules, as well as the OIG Investigative Guidelines.

Our analysis of cases in the Investigative Log showed that 1,071 of the 1,195 (90 percent) investigations delegated by the OIG and conducted by community agencies did not have an approved investigation protocol for the community agency. OIG officials stated that until a community agency has an approved investigation protocol for all investigations, investigation method approval is granted on a case-by-case basis. In community agency investigated cases sampled, we noted instances where OIG case reviewers conducted follow-up (e.g. called the agency for further documentation) to ensure that the documented evidence was sufficient to meet OIG standards.

As of August 4, 2000, the OIG had approved 16 protocols for investigations at the 535 community agencies and had received 24 additional protocols for review. OIG staff has been working with the community agencies to help guide them in developing abuse or neglect investigation protocols. Staff involved in this process stated the OIG had mailed protocol templates to a list of community agencies that are the most active in investigations and who do not have an approved protocol. Given the increasing number of incidents being reported by community agencies and the increased level of agency involvement in investigations, it is important the OIG continue to work with community agency personnel and develop formal investigative policies or protocols to ensure that their investigations are done in a proper and effective manner.

COMMUNITY AGENCY INVESTIGATIONS	
RECOMMENDATION 5	***The Inspector General should continue its efforts to work with community agencies in their conduct of investigations, including the protocol approval process.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree. OIG will be requiring all agencies to submit either a protocol or request that OIG conduct all of the investigations; the first set of letters was mailed on November 17, 2000 to all agencies that had reported to OIG.

COMMUNITY AGENCY AND FACILITY REPORTING OF ALLEGATIONS

Not all community agencies are reporting incidents of abuse and neglect to the Department of Public Health as required by the Abused and Neglected Long Term Care Facility Residents Reporting Act (Act). In addition, 64 of 99 (65 percent) of the alleged incidents of abuse or neglect in our sample of cases were not reported by community agencies within one hour of their discovery as required by OIG administrative rules. At State facilities, 21 of 63 (33 percent) abuse or neglect allegations were not reported to OIG within the one-hour requirement.

Of the 21 incidents not reported timely at State facilities, 9 of the allegations were reported within 3 hours of discovering the incident and 4 additional allegations were reported within 6 hours of discovery. The remaining 8 were reported 7 or more hours after discovery, the longest taking almost 3 days. Of the 64 untimely incidents at community agencies, 22 allegations were reported within 3 hours and 6 additional allegations were reported within 6 hours. The remaining 36 were not reported for more than 6 hours of discovering an incident.

The Abused and Neglected Long Term Care Facility Residents Reporting Act requires that State facilities and community agencies report all incidents of abuse and neglect to the Department of Public Health (DPH). However, OIG rules also require that within one hour after the discovery of an incident of alleged abuse or neglect or a death, the authorized representative or his or her designee of the community agency or facility shall report to the OIG hotline.

According to an OIG official, all allegations of abuse or neglect at State facilities are being reported to DPH as required in statutes. According to DPH staff, however, community agencies who call the DPH hotline with an allegation of abuse or neglect and are funded by Department of Human Services (DHS) and who have eight or less Medicaid certified beds are told that in the future they should call the OIG hotline. Such a practice is not consistent with the requirements of the Abused and Neglect Long Term Care Facility Residents Reporting Act.

If community agencies are unclear where to report alleged incidents of abuse or neglect, there is the potential that allegations may go unreported or be reported untimely. The Abused and Neglected Long Term Care Facility Residents Reporting Act requires that all allegations of abuse or neglect be reported to a central registry established and operated by DPH. Community agencies not reporting incidents to DPH are not in compliance with the Act.

REPORTING	
RECOMMENDATION	***The Office of the Inspector General and the Department of Public Health should work with community agencies to***

6	***ensure they are reporting allegations of abuse and neglect as required by the Abused and Neglected Long Term Care Facility Residents Reporting Act.*** ***The Inspector General should also work with State facilities and community agencies to ensure that allegations of abuse or neglect are reported within the timeframe specified in State law and OIG administrative rules.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree. Illinois Administrative Rule 50 requires community agencies to report to OIG. The above Act requires the Department of Public Health to refer to OIG any complaints they receive regarding community agencies. Both requirements result in allegations getting to OIG, and no problems have been found in getting these to OIG. Some problems have been identified in getting allegations of abuse and neglect reported within the strict time frames in Rule 50. OIG continues to cite agencies and facilities for failure to report timely, and will explore time frames scaled to seriousness of the allegation.
DEPARTMENT OF PUBLIC HEALTH RESPONSE	The Department of Public Health will seek legislation to revise the definition of long-term care facility in the Abused and Neglected Long-Term Care Facility Residents Reporting Act such that community facilities for the developmentally disabled, not licensed or certified by the Department, would not be required to report incidents of abuse or neglect to the Department's hotline. Current reporting practices, while not in strict compliance with the Act, do result in the reporting of incidents of abuse and neglect to the appropriate regulatory agency. Modifying current procedure to assure strict compliance with the Act would result in a redundancy in that community facilities for the developmentally disabled would be required by the Act to report to the IDPH hotline and, per OIG administrative rules, simultaneously report the same incidents to the OIG hotline. In addition, mandating that all community facilities also report to the IDPH hotline would result in a significant workload increase for IDPH and necessitate increased staffing to process the increased number of reports. The Department believes that a revision to the Act will avoid the unnecessary duplication of services
DEPARTMENT OF PUBLIC HEALTH RESPONSE CONTINUED	between state agencies while still assuring that the agencies meet their regulatory mandates.

CONSISTENCY OF BUREAU OPERATIONS

As discussed in Chapter One, each of the four investigative bureaus (North, Metro, Central, and South) has a bureau chief, each of whom reports to the Inspector General (see Chapter 1 for the organizational chart).

We found some instances where the various bureaus were not conducting investigations in a consistent manner. Internal reviews conducted by the OIG have also identified, and OIG has taken action on, some inconsistencies. Inconsistencies we identified included:

- In the North and Metro bureaus, the case files for investigations conducted by the community agency generally did not contain the Case File Review Action Slip, whereas case files in the Central and South bureaus did.

- Most of the cases in the North and Metro bureaus in our sample did not contain the required notation on the Library Sheet explaining why a case exceeded the 60-day completion requirement. In the Central and South bureaus the notation was present in most of the sample.

- Data entry into the Investigative Log for the "date completed" field was inconsistent between the North and Metro bureaus and the South and Central bureaus. The North and Metro bureaus used the "to processing" date contained on the Case File Review Action Slip for this field and the South and Central bureaus used the date on the cover memorandum sent to the agency or facility.

During our review of files in our sample of FY 2000 cases we also noted that changes in the investigation policy resulted in inconsistencies in how or if certain monitoring forms were to be completed between the different bureaus. The policy changes also affected certain aspects of the investigation process, such as the number of reviews required on a particular case. Policy changes were communicated to investigative staff in the form of electronic mail messages, a memorandum discussing the results of facilitator groups, or a Final Project Report: Case Review of Backlogged Serious Injuries.

Changes in OIG policy (temporary or permanent) need to be formally communicated in a consistent manner to all staff conducting investigations. Formal, consistent communication of changes in investigation policy would help ensure that all investigative staff conduct investigations in the same way and according to the current OIG policy.

CONSISTENCY OF BUREAU OPERATIONS	
RECOMMENDATION	***The Inspector General should examine ways to ensure the consistency of investigatory policies and practices among***

7	***the four investigative bureaus.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree. As already noted, OIG is in the process of revising its Investigative Guidelines to be more specific in requirements. This process should be completed by June 30, 2001.

Chapter Four

ACTIONS, SANCTIONS AND RECOMMENDATIONS

CHAPTER CONCLUSIONS

In FY 2000, the OIG substantiated abuse or neglect in 490 of 5,095 closed investigations of incidents reported to the OIG. Of the 490 substantiated cases, 450 were related to investigations of 2,365 specific abuse or neglect allegations; the remaining 40 were found in investigations of the 2,730 incidents not classified as abuse or neglect at intake. Of the 450 substantiated cases, 129 occurred at State facilities and 321 involved community agencies.

Facilities and community agencies took administrative action, such as suspension or termination, against employees in 366 (75 percent) of the 490 substantiated cases closed in FY 2000. Other actions taken included: staff retraining, policy/procedure issues, treatment/program change, structural change, and legal review.

The OIG closed 53 of 490 substantiated cases even though facilities or community agencies had not yet provided a written response to the OIG's finding of substantiated abuse or neglect. Its Investigative Log did not contain information regarding what, if any, corrective action facilities or community agencies took in these cases. Statutorily, it is the Secretary of the Department of Human Services' responsibility to accept or reject the facility or community agency responses to OIG reports. DHS currently monitors the approval of written responses and the actions taken. However, since corrective action taken to address issues identified in substantiated cases of abuse or neglect is a critical element of an effective investigatory process, the OIG should also track all actions taken in response to its investigations.

As recommended in past audits, the OIG established a protocol that defined when sanctions should be recommended to the Department of Public Health and the Department of Human Services. OIG officials stated they found it unnecessary to recommend any sanctions against State-operated facilities during FY 2000. Over the past five years, the OIG has not recommended any sanctions against facilities.

In FY 2000 the OIG conducted unannounced site visits at all of the State-operated facilities using a site visit protocol adopted in January 1997 and revised in October 1999. The OIG has not conducted any unannounced site visits at community agencies. OIG

officials stated they do not have statutory authority to conduct site visits at community agencies.

SUBSTANTIATED ABUSE AND NEGLECT CASES

In FY 2000, the OIG closed a total of 5,095 investigations of incidents reported to them. Of these, 2,365 were investigations of allegations of abuse or neglect. The OIG substantiated 450 of the abuse or neglect allegations, resulting in a 19 percent substantiation rate. The OIG also substantiated abuse or neglect in an additional 40 other incidents that were not alleged to be abuse or neglect at intake, for a total of 490 substantiated cases.

Exhibit 4-1 shows the past five years' substantiation rates for allegations classified as abuse and neglect. These numbers and percentages include substantiated cases investigated by OIG and, for FY 2000, include only the 450 allegations of abuse and neglect that were substantiated and classified as abuse or neglect at intake. Exhibits 4-2 and 4-3 reflect the total 490 substantiated cases regardless of category at intake.

Exhibit 4-1 shows that the number of cases of substantiated abuse and neglect declined at State facilities, as compared to FY 1999, but increased significantly at community agencies in FY 2000. The

Exhibit 4-1

ABUSE & NEGLECT CASES
CLOSED AND SUBSTANTIATED
(Allegations Categorized as Abuse or Neglect at Intake)
FY 1996 - FY 2000

	Cases Closed	Substantiated Cases	Percentage Substantiated
FY 1996			
Facility	1,001	76	8%
Community	75	33	44%
TOTAL	**1,076**	**109**	**10%**
FY 1997			
Facility	850	73	9%
Community	266	106	40%
TOTAL	**1,116**	**179**	**16%**
FY 1998			
Facility	1,129	128	11%
Community	337	148	44%
TOTAL	**1,466**	**276**	**19%**
FY 1999			
Facility	1,159	152	13%
Community	445	179	40%
TOTAL	**1,604**	**331**	**21%**
FY 2000			
Facility	1,426	129	9%
Community	939	321	34%
TOTAL	**2,365**	**450**	**19%**

Note: State facilities served 12,858 individuals and community agencies served 15,000 individuals with developmental disabilities and 130,000 individuals with mental illness in FY 2000.

Source: OAG 1998 Program Audit and 1999 and 2000 OIG Investigative Logs.

Exhibit also shows that the OIG closed more cases for both community agencies and the facilities each year from FY 1996 through FY 2000, with the exception of FY 1997 when less facility cases were closed than in 1996.

Part of the decrease in the substantiation rates in FY 2000 for facility and community agency cases was due to a special project involving serious injury cases. For a period of time in FY 2000 the OIG was investigating all serious injuries from State-operated facilities and community agencies whether or not there was an allegation or suspicion of abuse or neglect. This amounted to 448 additional serious injury cases to be investigated. Also, during the last part of FY 1999 and into FY 2000 the OIG was also investigating all complaints from third parties, such as families, friends, IDPH inspectors and the public at large.

RECOMMENDATIONS AND ACTIONS

At the conclusion of the investigation, the OIG Network Team Leader determines whether the evidence in the case indicates that the allegation of abuse or neglect is substantiated, unsubstantiated, or unfounded. The case is reviewed and a letter is sent to the facility or agency notifying them of the results of the investigation. If the allegation is substantiated or the OIG had other findings, the letter recommends what type of action the OIG thinks should be taken.

Some examples of recommendations for actions in substantiated cases include:

- Policy revision or creation;
- Medical/Clinical review;
- Legal review;
- Administrative action against staff;
- Specific retraining of employee; and
- Treatment/programmatic changes.

In addition, there were 53 substantiated cases where the OIG Investigative Log did not show an action taken because the agency or facility had not yet submitted their written response to the OIG.

Exhibit 4-2 shows the type of allegation, who investigated the allegation, and the actions taken in the 490 substantiated cases closed in FY 2000. Administrative action was taken in 75 percent of the cases and was the most frequently used action in both OIG and community agency investigations. Administrative actions include, but are not limited, to suspension, termination, reprimand, and retraining. Appendix C shows the number of cases closed and a substantiation rate by facility in FY 1999 and FY 2000.

Exhibit 4-2
SUBSTANTIATED CASES BY TYPE OF ALLEGATION AND ACTIONS TAKEN
(Based on all Allegations Regardless of Category at Intake)
FY 2000

TYPE OF ALLEGATION	INVESTIGATED BY		TOTAL	ACTIONS TAKEN
	OIG	Community Agency		
Physical Abuse - Emergency Medical Treatment	1	0	1	Administrative Action
Other Physical Abuse	60	69	129	Administrative Action, None, Retraining, Policies/procedures, Structural Change, Legal Review, No written response
Sexual Abuse	5	5	10	Administrative Action, No written response
Verbal/Psychological Abuse	25	62	87	Administrative Action, Retraining, Policies/procedures, No written response
Neglect	139	84	223	Administrative Action, Retraining, None Policies/procedures, Treatment change, Structural change, No written response
Other Improper Employee Conduct	0	2	2	Administrative Action
Resident Death	19	2	21	Administrative Action, No written response, Policies/procedures, Retraining
Injury – Emergency Medical Treatment	13	3	16	Administrative Action, No written response, Policies/Procedures, Retraining
Other Incidents	1	0	1	Retraining
TOTAL	**263**	**227**	**490**	

Source: OAG Analysis of OIG Data.
* Does not include investigations conducted by State Police or the facilities.

Exhibit 4-3 in turn, shows the 490 substantiated cases by the type of action taken and by the investigating agency. There are 4 cases where an action was recommended but no action was taken. In these cases, no action was taken for the following reasons: the perpetrator resigned before the action could be taken, action was taken prior to case closure or the action was overturned in the grievance process.

Exhibit 4-3
ACTIONS TAKEN ON SUBSTANTIATED CASES
FY 2000

Action	Investigated By OIG	Investigated by Community Agency	TOTAL
Administrative Action	165	201	366
General Retraining	9	5	14
Policy Creation/Revision	12	4	16
Procedural Clarification	5	1	6
Specific Staff Retraining	11	11	22
Facility Structural Change	3	0	3
Treatment/Program Change	5	0	5
Legal Review	0	1	1
No Action	4	0	4
No Response	49	4	53
TOTAL SUBSTANTIATED	**263**	**227**	**490**

Source: OAG Analysis of OIG Data.

Exhibit 4-4 shows the same 490 substantiated cases classified by the OIG's new coding system. The new system further defines the types of cases within their categories. A complete listing and description of the new codes can be found in Appendix D. The new coding system provides a more detailed description of the type of case and serves as one tool the investigative staff can use to prioritize cases.

Exhibit 4-4
SUBSTANTIATED CASES BY TYPE OF ALLEGATION AND ACTIONS TAKEN
(Based on all Allegations Regardless of Category at Intake)
FY 2000

TYPE OF ALLEGATION	INVESTIGATED BY		TOTAL	ACTIONS TAKEN
	OIG	Comm. Agency		
Abuse Cases	**91**	**137**	**228**	
A-1—Physical Abuse w/ Imminent Danger	2	0	2	Administrative Action, Procedure Clarification
A-2—Physical Abuse w/ Serious Injury	1	0	1	Administrative Action
A-3—Other Physical Abuse	59	69	128	Administrative Action, None, Structural Change, Retraining, Programmatic Change, Legal Review, No written response
A-4—Sexual Abuse	5	5	10	Administrative Action, No written response
A-5—Verbal Abuse	12	42	54	Administrative Action, No written response, Policy Revision, Retraining
A-6—Psychological Abuse	11	20	31	Administrative Action, No written response, Retraining
A-7—Exploitation	1	1	2	Administrative Action
Neglect Cases	**139**	**84**	**223**	
N-1—Neglect w/ Imminent Danger	7	0	7	Administrative Action, No written response, Retraining
N-2—Neglect in Serious Injury Cases	27	9	36	Administrative Action, No written response, Retraining, Policy Revision, None
N-3—Neglect in Non-serious Injury Cases	20	12	32	Administrative Action, No written response, Retraining, Policy Revision
N-4—Neglect in an individual's absence	16	9	25	Administrative Action, No written response, Retraining, Policy Revision, None
N-5—Neglect in recipient sexual activity	1	0	1	Administrative Action
N-7—Neglect w/ no harm / injury	68	54	122	Administrative Action, No written response, Retraining, Policy Revision, Procedure Clarification, Structural Change, Programmatic Changes
Death Cases	**19**	**2**	**21**	
D-1—Death due to suicide within residential program	2	0	2	Procedural Clarification, No written response
D-3—All other suicides	15	1	16	Administrative Action, No written response, Retraining, Policy Revision, Procedural Clarification
D-4—Death due to other than suicide in a residential program	1	0	1	Programmatic Changes
D-6—Death due to natural causes	1	1	2	Administrative Action, Policy Revision
Other Reportable Incidents	**1**	**1**	**2**	
R-7—Other reportable incidents	1	1	2	Administrative Action, Retraining
Serious and Other Injuries	**13**	**3**	**16**	
S-1—Non-Accidental Serious Injury Inflicted by Non-Staff	2	0	2	Administrative Action, No written response
S-4—Serious Injury From Accidental Means	11	3	14	Administrative Action, Policy Revision, No written response, Procedural Clarification, Retraining
TOTAL	**263**	**227**	**490**	

* Does not include investigations conducted by State Police or the facilities.
Source: OAG Analysis of OIG Data.

OIG CASE CLOSURE PROCESS

In our prior audit we recommended that the Inspector General clarify the State facility or community agency notification policies so that the statutory requirements could be met. The OIG clarified language in the Cover Memo describing when the Secretary of Human Services would receive the final report.

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

OIG Investigative Guidelines state that at the end of the reconsideration/ clarification process, the preliminary report becomes the final report. The investigation is considered “completed” when the Inspector General sends the “final” report to the persons copied on the preliminary report cover and/or when a letter notifies the community agency or facility that the investigative findings remain unchanged and the determination is final.

OIG Case Closure

In FY 2000, the OIG closed 53 cases for which State facilities or community agencies had not yet provided a written response to the Inspector General's investigation report. The Divisions of Mental Health and Developmental Disabilities within DHS monitor the approval of written responses and the actions taken. They also follow-up with facilities and community agencies who do not respond to OIG timely. OIG does not always update its Investigative Log to reflect the actions taken as stated in the written response. Closing these cases while lacking a system to ensure that appropriate responses are received and recorded can limit the effectiveness of OIG investigations.

The OIG gives facilities or community agencies 30 days in which to provide a response to the investigative report or to request a reconsideration of the findings in the report. If no response is received by the end of 30 days, the OIG closes the case on its Investigative Log and forwards the final case report to the Secretary of DHS. Statutorily, the OIG is required (in substantiated cases) to provide a "complete report" to the Secretary of Human Services that includes agency or facility written responses. In cases where no response has been received, a blank written response form is included in the final report. Statutorily, it is the Secretary of the Department of Human Services' responsibility to review the appropriateness of facility or community agency responses to OIG reports. The Secretary has the statutory responsibility to accept or reject the written responses.

Since corrective action taken to address issues identified in substantiated cases of abuse or neglect is a critical element of an effective investigatory process, the OIG should track actions in response to its investigations. In FY 2000, 53 of 490 (11 percent) substantiated cases were closed by the OIG without the facility (49) or community agency (4) submitting a written response. In an additional 13 cases, a response was received by the OIG from a facility or community agency but the action taken had not been recorded in the OIG's Investigative Log.

While it is statutorily the responsibility of the Secretary to accept or reject the written responses, if the OIG closes the case in the Investigative Log, OIG is not assured that the action they recommended was implemented at the agency or facility. If certain facilities or community agencies do not respond to substantiated findings of abuse or neglect, then these may be entities for which the OIG may want to follow-up in site visits or consider other types of enforcement actions.

OIG CASE CLOSURE	
RECOMMENDATION 8	***The Inspector General should establish a process to accurately track and follow-up on cases for which no response to a substantiated case of abuse or neglect has been received from a State facility or community agency.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	Agree. The Department will continue its statutorily required approval and monitoring process. OIG has been tracking receipt of Department-approved written responses and will conduct follow-up checks to ensure that these are in the OIG case file. In FY 2000, OIG began a more detailed tracking process for written responses from facilities as part of its site visit responsibilities.

APPEALS PROCESS IN SUBSTANTIATED CASES

During FY 1999, there were 40 of the 359 cases and in FY 2000, 31 of the 490 cases where the allegation of abuse or neglect was substantiated but the facility or community agency did not accept the recommendation of the OIG and requested reconsideration by the Inspector General. Of the 31 requests for reconsideration in FY 2000, 18 were from community agencies and 13 were from facilities. In FY 1999 and FY 2000, there were 15 agency cases and 4 facility cases that requested an appeal of OIG recommendations. Of these 19, 4 had filed requests for reconsideration and in all 4 cases the reconsideration request was made prior to filing the appeal.

A requirement of the Abused and Neglected Long Term Care Facility Residents Reporting Act (Act) (210 ILCS 30/6.2) is that there shall be an appeals process for any person or agency that is subject to any action based on a recommendation. Our prior audit noted that the OIG had not established an appeals process; however, the OIG

administrative rule adopted in October of 1998 includes a section that specifies the appeals process.

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

SANCTIONS

The Act (210 ILCS 30/6.2) gives the Inspector General broad authority to recommend sanctions. Sanctions are intended to ensure the protection of residents such as closing facility, transferring or relocating residents, or appointing on-site monitors. Protocols for these sanctions were established on December 8, 1999, that define those conditions that would warrant a sanction and the procedures the OIG is to follow when recommending sanctions to the Department of Public Health or the Department of Human Services. OIG officials stated they found it unnecessary to recommend any sanctions against State-operated facilities during FY 2000. Over the past five years, the OIG has not recommended any sanctions against facilities.

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

SITE VISITS

The OIG is conducting annual unannounced site visits of all State-operated facilities as required by 210 ILCS 30/6.2. In FY 2000, the OIG conducted unannounced site visits at all of the facilities using a site visit protocol adopted in January 1997 and revised in October 1999. The OIG developed the protocol using input from consumers, advocates, family members, facility and Department administrators, other Department staff, and OIG investigators.

Even though the protocol was general in nature, we reviewed the documentation from the FY 2000 site visits and noted that the protocol appeared to have been applied effectively to each of the facilities. The site visits focused on pertinent issues at each of the facilities, and they appeared to provide useful information to the facilities.

The purpose of the site visit is to review the systems and processes within a facility from the perspective of the individuals. The site visits involve meetings with various facility committees such as the Human Rights Committee, the Behavior Intervention Committee, and the Ethics Committee. The site visits also involve reviews of facility goals and objectives, restraint/seclusion data, treatment plans, and the nursing strategic plan. Site visit reports for FY 2000 contained observations relating to how the facility protects individuals from abuse or neglect, how the facility responds to the service needs of individuals, and how the facility includes input from the individuals.

The site visits usually last approximately three to five days. At the conclusion of the site visit, a memo is written to the network and facility administrators to document that the site visit took place, to indicate the activities of the site visit and to highlight issues discussed. There are no formal recommendations to the facilities and written responses are not required.

The OIG has not conducted any unannounced site visits at the community agencies. OIG officials stated that they do not conduct site visits at community agencies because they do not have the statutory authority to do them.

Chapter Five

OTHER ISSUES

CHAPTER CONCLUSIONS

Training of OIG investigators has improved since our last audit. Our review of the training database noted that all but one of the OIG investigators had obtained all of the required investigation related courses. Only two employees were lacking sexual harassment training and one additional employee did not receive one of the required courses within the first year of employment. Our last audit noted that 12 employees were lacking one or more of the required courses. Since our last audit, these 12 have received the required training. OIG also began maintaining data on training provided to community agency employees who attend OIG sponsored courses.

While the OIG monitors all the investigative training provided to facility investigators, its database did not contain training information for some of the facility staff who took initial statements in our sample of cases. Since facility investigators conduct investigative work on behalf of the OIG, it is important that the OIG has assurance that these staff are appropriately trained.

OIG INVESTIGATOR TRAINING

Training of OIG investigators has improved since our last audit. Our review of the training database noted that all but one of the OIG investigators had obtained all of the required investigation related courses. Only two employees were lacking sexual harassment training and one additional employee did not receive a course within the first year of employment as required by OIG Investigative Guidelines.

The Act requires the OIG to establish a comprehensive program to ensure that every person employed or newly hired to conduct investigations shall receive training on an on-going basis. This training should be in the areas of investigative techniques, communication skills, and the appropriate means of contact with persons admitted or committed to the mental health or developmental disabilities facilities under the jurisdiction of DHS.

To conduct an effective investigation, OIG investigators must be adequately trained. The criteria for OIG investigator training are clearly defined in OIG's Investigative Guidelines. As of January 13, 2000 all OIG investigators were required to receive 13 courses listed in Exhibit 5-1. "The Employee Assistance Program" and "The Challenge of Inclusion" courses are required only for supervisors.

In addition to the specific courses required in OIG policy, each investigator is required to obtain at least 10 hours per year of continuing training related to investigations, report writing, systems improvement, or the provision of services to those with mental illness or developmental disabilities. All investigatory employees met the continuing education requirement for FY 1999 and FY 2000 (through May 2000).

The list of required courses differs from that of the previous audit. The Drug Free Workplace course has been eliminated from the required course list and The Challenge of Inclusion has been added.

Some of these required courses are not conducted by OIG staff. Instead, each OIG investigator receives these courses at a facility or other location. The Bureau of Training and Technical Support tracks OIG employee training and notifies supervisors of the need for training. Fifty-nine training events were offered at State-operated facilities throughout the State during FY 1999 and FY 2000.

Exhibit 5-1
TRAINING COURSES REQUIRED FOR OIG INVESTIGATORS

ORIENTATION

Prevention and Identification of Abuse and Neglect
AIDS/HIV in the Workplace
Orientation to the Department
Sexual Harassment
Employee Assistance Program (if supervisor)
The Challenge of Inclusion (if supervisor)

OTHER ADDITIONAL COURSES REQUIRED

Basic Investigations Course
Advanced Investigations Course
Aggression Management
Communications
Hearing Impairment
Introduction to Developmental Disabilities
Introduction to Mental Illness
Legal Issues
Restraints

10 Hours Continuing Training Per Year

Source: OIG Investigative Guidelines

Exhibit 5-2
NUMBER OF INVESTIGATORY TRAINING DEFICIENCIES BY NEW OIG INVESTIGATORS

Number of Courses Needed	Number of Investigators
None	10
1	3

Source: OIG Training Data

Exhibit 5-2 shows the number of courses new investigators were lacking as of June 30, 2000. Our last audit noted that 12 employees were lacking one or more of the required courses. All of the employees with training deficiencies in our 1998 audit have received the required training.

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

TRAINING OF FACILITY STAFF

While the OIG monitors all the investigative training provided to facility investigators, its database did not contain training information for some of the facility staff who took initial statements in our sample of cases. Since these facility investigators conduct investigative work on behalf of the OIG, it is important that the OIG has assurance that these staff are appropriately trained.

OIG maintains training databases for OIG staff, and State-operated Facility staff (from any source). OIG also began maintaining data on training provided to community agency staff who attend OIG sponsored courses. The OIG administrative rules state that any person, community agency or facility may request training or technical assistance from the OIG in identifying, reporting, investigating, and preventing abuse or neglect or participation in applicable OIG sponsored training.

According to OIG officials, the OIG responds to these requests by providing the training events that were requested or by providing information about where training could be obtained. No separate log is maintained about the handling of these requests. During FY 1999 and FY 2000, the OIG provided training to facility staff at all 19 facilities encompassing 59 training events. This training included the following courses: Basic Investigative Skills, OIG Rule 50 and Statement Taking.

We asked OIG officials about their authority to require training for facility and community agency staff. OIG officials indicated that there is no express authority to require facilities or community agencies to participate in training. However, OIG officials did recognize that the rule requires them to provide the training if requested. Officials at OIG also indicated that management at DHS has sent out memos to community-based providers mandating training in the OIG administrative rule and in investigative skills. In addition, OIG officials stated that at least indirectly by reference, the Policies and Procedures Directive (PPD) requires that authorized representatives at State-operated Facilities (SOF) ensure that all staff are properly trained. In our sample of case files from FY 2000 (where we were able to identify the statement taker(s) name) we noted that 3 of the 45 statement takers lacked training in statement taking or in Basic Investigations. The OIG should ensure that only properly trained staff at facilities and community agencies conduct the initial steps of investigations for the OIG.

APPENDIX A
210 ILCS 30/6.8

Appendix A

210 ILCS 30/6.8

§6.8 Program Audit. The Auditor General shall conduct a biennial program audit of the Office of the Inspector General in relation to the Inspector General's compliance with this Act. The audit shall specifically include the Inspector General's effectiveness in investigating reports of alleged neglect or abuse of residents in any facility operated by the Department and in making recommendations for sanctions to the Departments of Human Services and Public Health. The Auditor General shall conduct the program audit according to the provisions of the Illinois State Auditing Act and shall report its findings to the General Assembly no later than January 1 of each odd-numbered year.

This Section is repealed on January 1, 2002.

APPENDIX B
Sampling and Analytical Methodology

Appendix B

Sampling and Analytical Methodology

We obtained the Investigative Log maintained by OIG of all cases reported to OIG for Fiscal Years 1999 and 2000. For information regarding the number of cases reported and closed, timeliness of case investigation, number of cases substantiated, and actions taken for those two years, we used the information contained in the Investigations Log.

To determine whether the information in the Log was complete, we randomly sampled files at the OIG's Springfield, Illinois office and compared these files to the Investigation Log database to determine if complete information was in the database. We compared information collected from sample case files to the Log to determine if information in the Log was accurate and, if discrepancies were noted, the differences were discussed with OIG management.

We also conducted a random sample of cases closed during FY 2000 to assess the quality of the investigation. We used this sample to determine whether investigators followed the OIG investigation guidelines in conducting investigations, including notifications to other agencies, collecting appropriate and relevant documentation, and documenting the investigative conclusions. Further, we determined whether there was evidence that the cases were reviewed according to OIG established procedures.

Using systematic random sampling with a confidence level of at least 90 percent and an acceptable error rate of 10 percent, we selected a total of 287 cases in four categories. Due to data misclassifications and some cases being selected in more than one category, our total number of unique cases was 282. This sample size allowed us to remain above our projected confidence level in each category, with the break down as follows:

76 cases investigated by OIG that occurred at State-operated facilities;
66 cases investigated by OIG that occurred at community agencies;
39 death cases investigated by OIG regardless of where the incident occurred;
101 cases investigated by the community agency where the incident occurred.

In addition to the systematic random sample, we selected 21 additional cases investigated by State-operated facilities in order to review case file thoroughness. These 21 cases were divided between the Northern and Southern Investigative Bureaus.

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

APPENDIX C
Rates of Substantiated Abuse or Neglect Cases by Facility for Investigations Closed

FY 1999 and FY 2000

Appendix C
Rate of Substantiated Employee Abuse or Neglect Cases by Facility
(Based on all Allegations Regardless of Category at Intake)
FY 1999 and FY 2000

	FISCAL YEAR 1999			FISCAL YEAR 2000		
Facility	**Number Closed**	**Number Substantiated by OIG**	**Substantiation Rate**	**Number Closed**	**Number Substantiated by OIG**	**Substantiation Rate**
Alton	317	10	3%	144	4	3%
Chester	400	13	3%	256	4	2%
Chicago-Read	217	2	1%	162	1	1%
Choate	545	16	3%	250	10	4%
Elgin	549	18	3%	393	21	5%
Fox	34	3	9%	19	0	0%
Howe	391	9	2%	345	13	4%
Jacksonville	373	9	2%	206	8	4%
Kiley	258	18	7%	276	32	12%
Lincoln	341	1	0%	187	1	1%
Ludeman	441	12	3%	240	6	3%
Mabley	122	1	1%	83	3	4%
Madden	174	2	1%	65	1	2%
McFarland	96	4	4%	50	4	8%
Murray	296	6	2%	67	7	10%
Shapiro	193	4	2%	158	3	2%
Singer	246	18	7%	139	12	9%
Tinley Park	152	8	5%	91	12	13%
Zeller	70	3	4%	26	0	0%
Community Agencies	844	201	24%	1956	348	18%
Special Cases	7	1	14%	5	0	0%
Totals	**6,066***	**359**	**6%**	**5,118***	**490**	**10%**

*The number of cases closed for FY99 and FY00 include cases investigated by the facilities and the Illinois State Police (DII). The number of cases substantiated only includes those cases substantiated by the OIG. There were 8-FY99 facility cases, 3-FY00 facility cases, 6-FY99 DII and 2-FY00 DII cases that were substantiated as abuse or neglect.

Source: OAG Analysis of OIG Data.

APPENDIX D
Allegations of Abuse or Neglect Using New Codes

FY 2000

Appendix D
Allegations by Facility Using New Code Definitions
FY 2000

Facilities	Abuse							
	A1	**A2**	**A3**	**A4**	**A5**	**A6**	**A7**	**Total**
DD Facilities								
Fox	0	0	0	1	0	0	0	**1**
Howe	1	0	44	2	16	2	0	**65**
Jacksonville	0	3	25	1	0	3	0	**32**
Kiley	0	0	30	0	8	8	0	**46**
Lincoln	0	2	17	0	1	0	1	**21**
Ludeman	0	1	27	1	1	3	0	**33**
Mabley	0	0	3	0	1	1	0	**5**
Murray	0	0	3	1	1	0	0	**5**
Shapiro	0	0	33	0	3	0	0	**36**
MH Facilities								
Alton	0	1	78	7	15	7	0	**108**
Chester	0	1	144	7	54	8	0	**214**
Chicago-Read	0	0	19	2	4	6	0	**31**
Elgin	0	1	55	14	29	27	4	**130**
Madden	0	0	16	3	8	0	0	**27**
McFarland	0	1	20	0	6	2	0	**29**
Tinley Park	0	1	11	4	9	2	0	**27**
Zeller	0	0	9	0	2	0	0	**11**
Dual Facilities								
Choate	0	0	135	10	17	8	0	**170**
Singer	0	0	42	10	9	10	0	**71**
Community Agencies	2	4	316	51	120	67	9	**569**
Special Cases	0	0	1	2	1	0	0	**4**
Totals	**3**	**15**	**1,028**	**116**	**305**	**154**	**14**	**1,635**

Source: OAG Analysis of OIG Data.

Appendix D
Allegations by Facility Using New Code Definitions
FY 2000

Facilities	Neglect							
	N1	**N2**	**N3**	**N4**	**N5**	**N6**	**N7**	**Total**
DD Facilities								
Fox	0	0	0	0	0	0	0	**0**
Howe	0	5	2	1	0	0	6	**14**
Jacksonville	1	2	2	3	0	0	4	**12**
Kiley	0	10	6	5	1	0	11	**33**
Lincoln	0	2	3	1	0	0	1	**7**
Ludeman	0	2	0	5	1	0	2	**10**
Mabley	0	2	1	0	0	0	0	**3**
Murray	0	0	2	0	0	0	5	**7**
Shapiro	0	2	3	0	0	0	2	**7**
MH Facilities								
Alton	0	1	1	0	3	0	7	**12**
Chester	0	0	9	0	0	1	8	**18**
Chicago-Read	0	2	3	1	1	0	7	**14**
Elgin	0	5	27	9	2	0	20	**63**
Madden	0	1	1	0	1	0	3	**6**
McFarland	0	0	0	1	0	0	3	**4**
Tinley Park	0	1	1	1	0	0	7	**10**
Zeller	0	0	0	0	1	0	1	**2**
Dual Facilities								
Choate	0	3	3	0	1	0	9	**16**
Singer	0	1	1	1	0	0	15	**18**
Community Agencies	21	54	48	13	5	0	192	**333**
Special Cases	0	0	0	0	0	0	0	**0**
Totals	**22**	**93**	**113**	**41**	**16**	**1**	**303**	**589**

Source: OAG Analysis of OIG Data.

Appendix D
Allegations by Facility Using New Code Definitions
FY 2000

Facilities	Deaths							
	D1	**D2**	**D3**	**D4**	**D5**	**D6**	**D7**	**Total**
DD Facilities								
Fox	0	0	2	0	0	1	0	**3**
Howe	0	0	1	0	0	1	0	**2**
Jacksonville	0	0	2	0	0	3	0	**5**
Kiley	0	0	1	0	0	0	1	**2**
Lincoln	0	0	4	0	0	4	0	**8**
Ludeman	0	0	2	0	0	0	0	**2**
Mabley	0	0	1	0	0	0	0	**1**
Murray	0	0	1	0	0	1	0	**2**
Shapiro	0	0	1	1	0	3	0	**5**
MH Facilities								
Alton	0	0	1	0	0	0	1	**2**
Chester	0	0	3	0	0	1	0	**4**
Chicago-Read	0	1	0	0	3	0	2	**6**
Elgin	1	0	0	0	0	0	0	**1**
Madden	1	0	0	0	3	0	0	**4**
McFarland	0	0	0	0	0	1	0	**1**
Tinley Park	0	0	0	0	0	0	0	**0**
Zeller	0	0	0	0	1	0	0	**1**
Dual Facilities								
Choate	0	0	1	0	0	0	0	**1**
Singer	0	0	1	0	0	0	0	**1**
Community Agencies	4	7	185	4	15	31	134	**380**
Special Cases	0	0	0	0	0	0	0	**0**
Totals	**6**	**8**	**206**	**5**	**22**	**46**	**138**	**431**

Source: OAG Analysis of OIG Data.

Appendix D
Allegations by Facility Using New Code Definitions
FY 2000

Facilities	Serious and Other Injuries							
	S1	**S2**	**S3**	**S4**	**S5**	**S6**	**S7**	**Total**
DD Facilities								
Fox	0	0	0	11	0	0	0	**11**
Howe	29	0	37	124	6	7	1	**204**
Jacksonville	5	0	1	50	12	19	0	**87**
Kiley	7	0	22	79	2	2	1	**113**
Lincoln	6	0	17	114	4	4	0	**145**
Ludeman	5	0	9	127	8	12	2	**163**
Mabley	5	0	1	32	15	0	0	**53**
Murray	3	0	2	31	16	0	0	**52**
Shapiro	6	0	6	77	0	4	2	**95**
MH Facilities								
Alton	7	0	4	10	3	2	5	**31**
Chester	11	0	9	17	4	4	0	**45**
Chicago-Read	2	1	0	16	9	1	0	**29**
Elgin	11	1	3	14	4	1	4	**38**
Madden	1	1	2	1	0	0	0	**5**
McFarland	0	2	1	5	0	2	0	**10**
Tinley Park	7	0	0	4	0	0	0	**11**
Zeller	1	1	3	5	0	3	0	**13**
Dual Facilities								
Choate	11	0	14	67	10	8	4	**114**
Singer	2	1	8	13	1	0	1	**26**
Community Agencies	34	4	13	408	7	3	0	**469**
Special Cases	0	0	0	0	0	0	0	**0**
Totals	**153**	**11**	**152**	**1,205**	**101**	**72**	**20**	**1,714**

Source: OAG Analysis of OIG Data.

Appendix D
Allegations by Facility Using New Code Definitions
FY 2000

Facilities	Other Reportable Incidents							
	R1	**R2**	**R3**	**R4**	**R5**	**R6**	**R7**	**Total**
DD Facilities								
Fox	0	0	0	0	0	0	1	**1**
Howe	1	0	0	6	6	0	7	**20**
Jacksonville	0	0	0	0	1	2	2	**5**
Kiley	0	0	0	2	1	0	4	**7**
Lincoln	0	0	0	1	0	1	2	**4**
Ludeman	0	0	0	1	0	0	0	**1**
Mabley	0	0	0	0	0	0	0	**0**
Murray	0	0	0	0	0	0	3	**3**
Shapiro	0	0	0	0	0	1	1	**2**
MH Facilities								
Alton	0	0	0	0	0	3	1	**4**
Chester	0	0	0	0	0	1	1	**2**
Chicago-Read	0	0	0	0	1	1	12	**14**
Elgin	0	0	0	3	4	3	21	**31**
Madden	0	0	0	1	0	1	2	**4**
McFarland	0	0	0	0	0	0	0	**0**
Tinley Park	0	0	0	1	4	1	4	**10**
Zeller	0	0	0	0	0	0	1	**1**
Dual Facilities								
Choate	0	0	0	0	0	0	9	**9**
Singer	0	0	0	0	0	1	5	**6**
Community Agencies	0	1	0	0	0	6	13	**20**
Special Cases	0	0	0	0	0	0	2	**2**
Totals	**1**	**1**	**0**	**15**	**17**	**21**	**91**	**146**

Source: OAG Analysis of OIG Data.

Appendix D
Allegations by Facility Using New Code Definitions
FY 2000

Facilities	Non-Reportable Incidents						
	X1	**X2**	**X3**	**X4**	**X5**	**X6**	**Total**
DD Facilities							
Fox	0	0	0	0	0	0	**0**
Howe	0	0	1	0	0	0	**1**
Jacksonville	1	0	0	0	0	0	**1**
Kiley	3	0	3	0	0	0	**6**
Lincoln	0	0	0	0	0	0	**0**
Ludeman	0	0	0	0	0	0	**0**
Mabley	0	0	0	0	0	0	**0**
Murray	0	1	0	0	0	0	**1**
Shapiro	0	0	0	0	0	0	**0**
MH Facilities							
Alton	1	1	1	0	0	0	**3**
Chester	0	0	0	0	0	0	**0**
Chicago-Read	0	0	14	0	0	1	**15**
Elgin	21	1	1	2	0	0	**25**
Madden	4	0	1	1	0	0	**6**
McFarland	0	0	0	0	0	0	**0**
Tinley Park	1	0	3	0	0	0	**4**
Zeller	0	0	0	0	0	0	**0**
Dual Facilities							
Choate	2	0	1	1	0	1	**5**
Singer	0	0	0	1	0	0	**1**
Community Agencies	2	0	3	4	0	0	**9**
Special Cases	0	0	0	0	0	0	**0**
Totals	**35**	**3**	**28**	**9**	**0**	**2**	**77**

Source: OAG Analysis of OIG Data.

APPENDIX E
Allegations of Abuse or Neglect Using Old Codes

FY 1999 and FY 2000

Appendix E
All Incidents and Allegations Reported by Incident Category
FY 2000

FACILITIES	Abuse/ Neglect	Other Employee Misconduct	Recipient Death	Serious Recipient Injury*	Minor Recipient on Recipient Injury	UA	Recipient Sexual Misconduct	Theft of Recipient Property	Other	Total Number Reported
DD FACILITIES										
Fox	1	0	3	11	0	0	0	0	1	**16**
Howe	79	0	2	197	7	0	1	0	20	**306**
Jacksonville	44	1	5	56	31	0	0	1	4	**142**
Kiley	79	7	2	108	5	2	0	0	4	**207**
Lincoln	28	0	8	136	9	0	0	1	3	**185**
Ludeman	43	0	2	142	21	0	0	0	1	**209**
Mabley	8	0	1	36	17	0	0	0	0	**62**
Murray	12	0	2	36	17	0	1	0	2	**70**
Shapiro	43	0	5	89	6	0	0	1	1	**145**
MH FACILITIES										
Alton	120	1	2	20	12	0	1	3	1	**160**
Chester	232	0	4	39	6	0	0	1	1	**283**
Chicago-Read	45	10	6	22	10	8	1	0	7	**109**
Elgin	189	33	1	31	8	1	2	2	21	**288**
Madden	33	5	4	5	0	0	0	0	5	**52**
McFarland	33	0	1	8	2	0	0	0	0	**44**
Tinley Park	36	2	0	11	1	1	0	2	9	**62**
Zeller	13	0	1	10	3	0	0	0	1	**28**
DUAL FACILITIES										
Choate	186	1	1	91	24	1	7	0	4	**315**
Singer	89	2	1	24	2	0	0	0	5	**123**
COMMUNITY AGENCIES	898	14	380	460	8	3	1	1	15	**1,780**
Special Cases	4	0	0	0	0	0	0	0	2	**6**
Totals	**2,215**	**76**	**431**	**1,532***	**189**	**16**	**14**	**12**	**107**	**4,592**

* Administrative Rule 50, which was adopted in October 1998, now requires reporting to OIG of minor injuries, absences, and resident-to-resident sexual activity only: if there is an allegation or reasonable suspicion of abuse or neglect by staff; if they occur multiple times or involve multiple people; or if they have serious implications. Therefore, the number of "Minor Recipient on Recipient Injury" allegations reported in FY 2000 decreased significantly from FY 1999.

Source: OAG Analysis of OIG Data.

Appendix E
All Incidents and Allegations Reported by Incident Category
FY 1999

FACILITIES	Abuse/ Neglect	Other Employee Misconduct	Recipient Death	Serious Recipient Injury	Minor Recipient on Recipient Injury	UA	Recipient Sexual Misconduct	Theft of Recipient Property	Other	Total Number Reported
DD FACILITIES										
Fox	4	0	2	12	13	0	0	0	0	**31**
Howe	65	2	8	52	208	9	10	0	23	**377**
Jacksonville	31	2	2	34	310	28	6	1	4	**418**
Kiley	75	6	1	60	127	10	3	1	11	**294**
Lincoln	28	1	8	87	213	3	1	0	5	**346**
Ludeman	44	1	6	52	259	5	4	0	4	**375**
Mabley	15	0	1	32	77	3	4	0	4	**136**
Murray	18	0	5	56	183	2	1	0	5	**270**
Shapiro	43	0	12	51	84	5	3	0	6	**204**
MH FACILITIES										
Alton	85	10	1	1	145	2	10	2	8	**264**
Chester	137	20	1	23	184	0	10	1	9	**385**
Chicago-Read	58	14	1	7	131	21	4	0	18	**254**
Elgin	199	51	3	20	266	13	8	2	34	**596**
Madden	25	2	2	10	95	15	4	1	7	**161**
McFarland	35	2	1	4	38	4	8	0	5	**97**
Tinley Park	35	10	1	11	68	8	3	0	10	**146**
Zeller	21	3	7	8	54	1	3	0	4	**101**
DUAL FACILITIES										
Choate	144	1	5	10	352	0	10	0	7	**529**
Singer	92	5	1	21	87	7	15	0	10	**238**
COMMUNITY AGENCIES	675	20	225	293	48	7	24	0	27	**1,319**
Special Cases	3	1	0	0	0	0	0	0	4	**8**
Totals	**1,832**	**151**	**293**	**844**	**2,942**	**143**	**131**	**8**	**205**	**6,549**

Source: OAG Analysis of OIG Data.

APPENDIX F
Agencies' Responses

George H. Ryan, *Governor*

Illinois Department of Human Services

Linda Reneé Baker, *Secretary*

Office of The Inspector General

November 28, 2000

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

Dear Auditor General Holland:

Thank you for the opportunity to respond to the recommendations in your draft audit report and for your willingness to include them in the body of the report. The responses are attached.

We would very much like to thank Audit Manager Kelly Mittelstaedt and her audit staff for an unbiased and thorough audit. We found them to be consistently open and objective, and we appreciated the efforts they made to understand and present a very complex system as accurately as possible.

I am also sending a copy of this letter and the responses by e-mail in MS Word 97 format. If you have any questions, please feel free to call me at (217) 786-6829.

Sincerely,

Odell Thompson, Jr.
Inspector General

App F

[redacted]

cc: Linda Reneé Baker, DHS Secretary
Jim Donkin, DHS Internal Auditor
Kelly Mittelstaedt, Office of the Auditor General

OIG RESPONSES TO THE FY 1999-2000 AUDITOR GENERAL AUDIT
November 28, 2000

Recommendation 1:
The Inspector General should develop and formally communicate the mission and goals of the Office of the Inspector General to its employees. The Inspector General should also continue efforts to establish and implement performance measures for the Bureau of Investigations.

OIG Response:
Agree. An appointed committee developed new Mission and Vision statements, Strategic Goals, Core Values, and Core Competencies in October 2000. These will be used to further develop Strategic Plans for the Office and measurable performance objectives for OIG investigations by June 30, 2001.

Recommendation 2:
The Inspector General should clarify the investigative role of each agency through signed interagency agreements with other State agencies that conduct investigations of abuse and neglect.

OIG Response:
Agree. The Inspector General has final agreements with the Illinois State Police, and the Department of Public Health. Pending signatures on agreement with the Department of Children and Family Services. This should receive final approval by the Secretary of DHS and DCFS Director by December 1, 2000.

Recommendation 3:
The Inspector General should continue to improve the timeliness in investigations of abuse and neglect in order to comply with OIG administrative rules. Efforts could be directed in the areas of: Case referrals to Illinois State Police; Case referrals to Clinical Services; Investigator caseloads; Interview timeliness; and Case review timeliness.

OIG Response:
Agree. OIG has considered each of these areas and others in its efforts over the past year to decrease the length of time to completion of investigations. The investigative time line will be reviewed and changed beginning January 1, 2001. Average time has already dropped by a third in the first quarter of FY 2001. Investigative managers will be held responsible for prompt completion of investigative and review work.

Recommendation 4:
The Inspector General should ensure that supervisory review provides assurance that:

- All relevant documentation has been collected and analyzed by the investigator;
- Library sheets contain the required "barrier to completion" notation explaining why cases took longer than 60 days to complete;
- All investigation bureaus consistently use and complete the same case monitoring and review forms in case files.

OIG Response:
Agree. OIG has begun the process of revising the Investigative Guidelines to be more specific as to what documentation is necessary, including how barriers to completion are to be identified. This process should be completed by June 30, 2001. All investigative bureaus currently use the same case review forms in all case files.

Recommendation 5:
The Inspector General should continue its efforts to work with community agencies in their conduct of investigations, including the protocol approval process.

OIG Response:
Agree. OIG will be requiring all agencies to submit either a protocol or request that OIG conduct all of the investigations; the first set of letters was mailed on November 17, 2000 to all agencies that had reported to OIG.

Recommendation 6:
The Office of the Inspector General and the Department of Public Health should work with community agencies to ensure they are reporting allegations of abuse and neglect as required by the Abused and Neglected Long Term Care Facility Residents Reporting Act.

The Inspector General should also work with State facilities and community agencies to ensure that allegations of abuse or neglect are reported within the time frame specified in State law and OIG administrative rules.

OIG Response:
Agree. Illinois Administrative Rule 50 requires community agencies to report to OIG. The above Act requires the Department of Public Health to refer to OIG any complaints they receive regarding community agencies. Both requirements result in allegations getting to OIG, and no problems have been found in getting these to OIG.

Some problems have been identified in getting allegations of abuse and neglect reported within the strict time frames in Rule 50. OIG continues to cite agencies and facilities for failure to report timely, and will explore time frames scaled to seriousness of the allegation.

Recommendation 7:
The Inspector General should examine ways to ensure the consistency of investigative policies and practices among the four investigative bureaus.

OIG Response:
Agree. As already noted, OIG is in the process of revising its Investigative Guidelines to more specific in requirements. This process should be completed by June 30, 2001.

Recommendation 8:
The Inspector General should establish a process to accurately track and follow-up on cases for which no response to a substantiated case of abuse or neglect has been received from a State facility or community agency.

OIG Response:
Agree. The Department will continue its statutorily required approval and monitoring process. OIG has been tracking receipt of Department-approved written responses and will conduct follow-up checks to ensure that these are in the OIG case file. In FY 2000, OIG began a more detailed tracking process for written responses from facilities as part of its site visit responsibilities.

Illinois Department of
Public Health

George H. Ryan, Governor • John R. Lumpkin, M.D., M.P.H., Director

525 535 West Jefferson Street • Springfield, Illinois 62761-0001

November 27, 2000

RECEIVED
AUDITOR GENERAL
SPFLD.
2000 NOV 29 A 8:16

Kelly Mittelstaedt
Audit Manager
Office of the Auditor General
740 East Ash
Springfield, Illinois 62703

Dear Ms. Mittelstaedt:

Attached is the written response to the audit finding pertaining to the Department of Public Health. If you have any questions regarding the response, please contact William A. Bell, Deputy Director, Office of Health Care Regulation at telephone 217-782-2913.

Sincerely,

John R. Lumpkin

John R. Lumpkin, M.D.
Director of Public Health

cc: Bill Bell
Darrell Balmer
Rick Dees
Tim Sledgister

REPORTING	
RECOMMENDATION 6	*The Office of the Inspector General and the Department of Public Health should work with community agencies to ensure they are reporting allegations of abuse and neglect as required by the Abused and Neglected Long Term Care Facilities Residents Reporting Act.* *The Inspector General should also work with State facilities and community agencies to ensure that allegations of abuse or neglect are reported within the timeframe specified in State law and OIG administrative rules.*
DEPARTMENT OF PUBLIC HEALTH RESPONSE	The Department of Public Health will seek legislation to revise the definition of long-term care facility in the Abused and Neglected Long-Term Care Facility Residents Reporting Act such that community facilities for the developmentally disabled, not licensed or certified by the Department, would not be required to report incidents of abuse or neglect to the Department's hotline. Current reporting practices, while not in strict compliance with the Act, do result in the reporting of incidents of abuse and neglect to the appropriate regulatory agency. Modifying current procedure to assure strict compliance with the Act would result in a redundancy in that community facilities for the developmentally disabled would be required by the Act to report to the IDPH hotline and, per OIG administrative rules, simultaneously report the same incidents to the OIG hotline. In addition, mandating that all community facilities also report to the IDPH hotline would result in a significant workload increase for IDPH and necessitate increased staffing to process the increased number of reports. The Department believes that a revision to the Act will avoid the unnecessary duplication of services between state agencies while still assuring that the agencies meet their regulatory mandates.