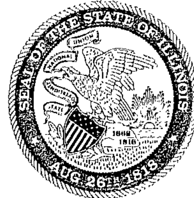


STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PROGRAM AUDIT

OFFICE OF THE INSPECTOR GENERAL

DEPARTMENT OF MENTAL HEALTH
AND DEVELOPMENTAL DISABILITIES

APRIL 1993

WILLIAM G. HOLLAND

AUDITOR GENERAL

STATE OF ILLINOIS
JOHN W. KUNZEMAN
DEPUTY AUDITOR GENERAL

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 Mental Health and Developmental Disabilities.

We conducted this audit at the direction of Section 8 of Public Act 87-1158, effective September 18, 1992. 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.

JOHN W. KUNZEMAN
Deputy Auditor General

Springfield, Illinois
April 1993

OFFICE OF THE AUDITOR GENERAL • 509 SOUTH SIXTH STREET • SPRINGFIELD, ILLINOIS 62701 • 217/782-6046

509 SOUTH SIXTH STREET, ROOM 151
SPRINGFIELD, ILLINOIS 62701-1878
PHONE: 217/782-6046
FAX: 217/785-8222

100 WEST RANDOLPH STREET, SUITE 4-100
CHICAGO, ILLINOIS 60601-3219
PHONE: 312/814-4000
FAX: 312/814-4006

OFFICE OF THE AUDITOR GENERAL

REPORT DIGEST

Program Audit of the OFFICE OF THE INSPECTOR GENERAL

Department of Mental Health and Developmental Disabilities

SYNOPSIS

This is the second audit of the Office of the Inspector General's (OIG) effectiveness in investigating allegations of resident abuse and neglect at the 21 facilities of the Department of Mental Health and Developmental Disabilities. The first audit was released in May 1990.

This audit reports the following:

- Abuse allegations have increased from Fiscal Years 1989 to 1992, but the number of abuse cases substantiated by investigations has steadily decreased over this period;

- The thoroughness in documenting case investigations and tracking of recommended administrative actions has improved since our 1990 audit. The OIG has implemented case documentation requirements and follows up on recommended administrative actions to facilities;

- The OIG's timeliness in completing investigations has improved since our 1990 audit, but further improvements are still needed. About 30 percent of the cases sampled in Fiscal Year 1992 took more than 60 days to complete. Also, 24 cases we sampled were still open with ongoing investigations ranging from 161 days old to 491 days old. In addition, OIG supervisors did not consistently monitor the status of cases over 60 days old.

RECYCLED PAPER - SOYBEAN INKS

INTRODUCTION

Section 8 of Public Act 87-1158, effective September 18, 1992, directed the Auditor General to conduct a program audit of the Office of the Inspector General (OIG) in relation to its compliance with this Act. The Act states 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 of Mental Health and Developmental Disabilities (DMHDD) and in making recommendations for sanctions to DMHDD and the Department of Public Health.

Two related audits have been completed by the Office of the Auditor General. In May 1990, the Auditor General released a program audit on the reporting and investigation of resident abuse and neglect and reviewed the Office of the Inspector General's effectiveness in investigating reports of suspected abuse and neglect. In November 1992, a second program audit on facility reporting was released that reported trends of suspected abuse and neglect. (page 1)

REPORT CONCLUSIONS

About twelve percent of the 9,037 incidents reported to the OIG in Fiscal Year 1992 involved allegations of abuse and neglect. While abuse allegations increased from Fiscal Years 1989 to 1992 (826 to 1,079), the number of abuse cases substantiated by investigations steadily decreased over this period (Fiscal Year 1989 - 245; Fiscal Year 1990 - 209; Fiscal Year 1991 -114; Fiscal Year 1992 - 83). Changes in incident reporting guidelines in 1990 which expanded reporting requirements and an increased emphasis on reporting by the Department may account for the increase in incidents reported.

The reasons for the decrease in substantiated cases are not readily determinable. The following factors may be influencing the decrease in substantiated cases: the continued emphasis on abuse and neglect by the Department, including new training programs; administrative actions taken against employees who are found to have engaged in abuse toward residents; the timeliness of investigations; and increased investigator workloads. This audit found no conclusive evidence to explain the downward trend in substantiated cases.

The thoroughness in documenting case investigations and the tracking of recommended administrative actions has improved markedly since our 1990 audit. The OIG has implemented case documentation requirements and follows up on recommended administrative actions to facilities. Our testing showed that 95 percent of completed OIG investigation case files contained the required documentation and recommended administrative actions were tracked to final disposition.

The Inspector General's timeliness in completing investigations has improved since our 1990 audit but further improvements are still needed. About 30 percent of completed investigations in our sample of 284 cases took longer than 60 days to complete compared to about 37 percent in our 1990 audit. Also, 24 of our sample cases were still open, with ongoing investigations ranging from 161 days old to 491 days old. In addition, OIG supervisors did not consistently monitor the status of cases over 60 days old. (pages 1-2)

BACKGROUND

The General Assembly established the Office of the Inspector General (OIG) within DMHDD (Public Act 85-233, effective August 26, 1987) to investigate alleged incidents of abuse and neglect at DMHDD operated facilities. 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 March 1992. She was formerly the Executive Director of the Alliance for the Mentally Ill of Illinois.

The primary mission of the OIG is to investigate reports of suspected abuse or neglect of residents in any facility operated by DMHDD. The OIG also establishes criteria for reportable incidents, monitors investigations conducted by facilities, and reviews facility compliance with abuse policies and procedures. The OIG staff reviews reported incidents and refers potential criminal cases to the State Police for investigation. The OIG may also recommend sanctions to the Department of Public Health or DMHDD. These sanctions, which may be imposed to protect the residents, include the appointment of on-site monitors or receivers, the transfer or relocation of residents, and the closure of units. (pages 2-5)

ABUSE AND NEGLECT REPORTING

The facilities reported 9,037 incidents to the OIG in Fiscal Year 1992. Allegations of abuse totaled 1,079 (12 percent). While the total number of abuse allegations increased each year, the number of substantiated cases of abuse has decreased each year since Fiscal Year 1989. Digest Exhibit 1 illustrates these numbers.

DIGEST EXHIBIT 1
ABUSE ALLEGATIONS AND SUBSTANTIATED ABUSE CASES

Fiscal Year	Total Abuse Allegations	Substantiated Cases	Percentage Substantiated
1989	826	245	30%
1990	860	209	24%
1991	957	114	12%
1992	1079	83	8%

Note: Substantiated cases are those closed in the stated fiscal year even though they may have been reported in prior periods.

Source: OAG Analysis of OIG Data

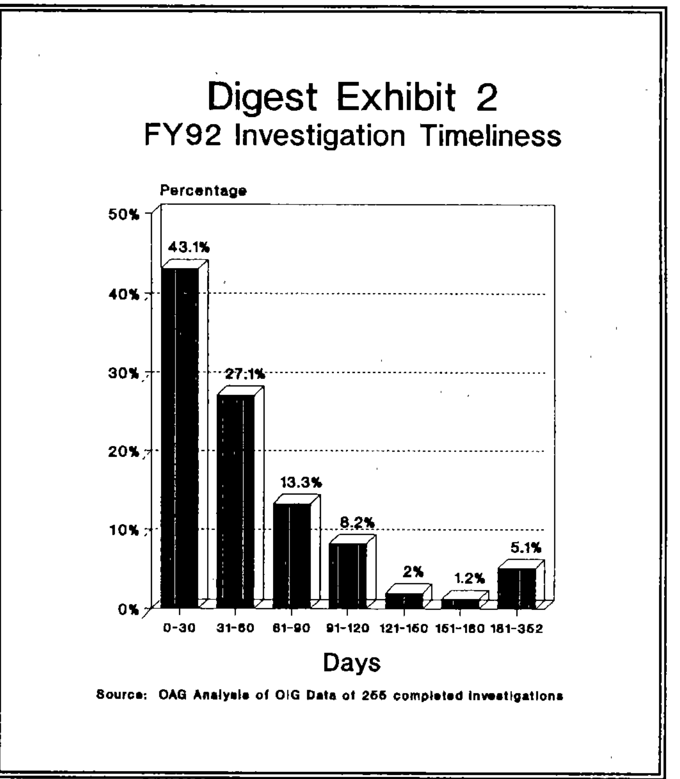
The reasons for an increase in abuse allegations and a decrease

in substantiated cases are not readily determinable. According to the Inspector General, the decline in substantiated cases along with the rise in the number of allegations may be due to the implementation of a Department-wide training program on the prevention and identification of abuse and neglect. Also, in the OIG Fiscal Year 1992 State of Care Report, the Inspector General credits some problems with the substantiation of cases to the reluctance of facility personnel to report other employees. (pages 9-16)

OIG INVESTIGATIONS

In June 1990, the OIG established documentation requirements for investigation case files and for verification that facilities have taken corrective actions. These actions were in response to recommendations in the 1990 performance audit.

We sampled 284 case files from the abuse allegations made in Fiscal Year 1992. The majority of the closed cases (95 percent) contained the required documentation. We also found that the OIG follows up on recommended administrative actions to facilities.



Although investigation timeliness has improved since the OIG implemented timeliness guidelines following our 1990 audit, some problems with the length of investigations still exist. The number of investigations completed within 30 days increased from 29 percent of the sample cases in the 1990 audit to 43 percent in our current sample. The number of investigations completed within 60 days also increased, from 63 percent to 70 percent. In our sample of 284 OIG investigations in Fiscal Year 1992, 257 were completed. Two of these cases did not contain sufficient documentation to enable us to determine the length of the investigation. Therefore, the timeliness data presented is based on 255 completed investigations. Investigation times ranged from 3 to 352 days. Over 80 percent of investigations were completed within 90 days. However, 16 investigations (6 percent) took over 150 days to complete. Digest Exhibit 2 illustrates the timeliness of the 255 completed investigations.

In our sample of 284 cases, two were facility investigations that were mistakenly coded as OIG investigations and one was a State Police investigation. Our sample also contained 24 OIG investigations that were still open at the time of our review. Only 22 had

sufficient documentation to allow us to determine how long they have been open. These open cases ranged from 161 days old to 491 days old. Five of these cases were over 270 days old. (pages 19-23)

Caseloads and Case Review Process

Investigator caseloads and average times to complete investigations vary. Investigators are assigned to specific facilities and investigate all abuse cases at those facilities. Fiscal Year 1992 caseloads varied from 45 to 156. One of the reasons for the uneven caseloads is that some facilities have more complaints than others. The average investigation times also varied widely, from 29 days to 96 days. Timeliness may vary due to the complexity of the cases and the workloads of the investigators.

The OIG did not maintain documentation of training received by all investigators. Documentation was available for most training received by the downstate investigators, but was not available for some training received by Chicago investigators.

Improvements are needed in the case review process. For example, we noted that no action was taken on one case for several months because it was misfiled, 78 cases lacked status reports, and no documentation was available to show any work was done on four cases for six months because they were transferred from one investigator to another. The OIG implemented the use of a status report to provide for an interim review of overdue cases. When an investigation takes longer than 60 days, the investigator is required to fill out a status report at 60 days and every 30 days thereafter. However, status reports were often not filled out or not reviewed. According to an OIG official, there are occasional spot checks done to determine if status reports were being filled out, but this is not done systematically. (pages 24-27)

Sanctions and Administrative Actions

The OIG is authorized to make recommendations for administrative actions against employees and sanctions to DMHDD and to the Department of Public Health based on investigations or for other reasons. Sanctions include appointment of on-site monitors or receivers, transfer or relocation of residents, and closure of units. An OIG official stated there have never been instances where they have closed a facility, a unit, or transferred all residents from a unit as a result of an abuse allegation investigation, but in the Spring of 1992, the OIG appointed on-site monitors at two facilities as a result of visits to the facilities.

Of the 243 closed cases in our sample, 19 (eight percent) were substantiated cases of abuse and administrative actions were recommended by the OIG. The cases substantiated varied and included cases of verbal abuse such as an employee calling a recipient ugly, a neglect case where a recipient fell to the floor and dislocated a shoulder but was not examined by a doctor until 17.5 hours had elapsed, and a physical abuse case where a recipient was grabbed by an employee and dragged to a chair. The 19 substantiated cases were classified as follows:

- Ten (52.6 percent) physical abuse;
- Seven (36.8 percent) verbal/psychological abuse; and,
- Two (10.5 percent) neglect. (pages 28-29)

Corrective Actions by Facilities

When allegations of abuse are substantiated, various corrective actions are taken against the facility employees. These corrective actions range from informal counseling or retraining to suspension and/or discharge. After an investigation is completed, the OIG will usually make a general recommendation to the facility. The facilities determine the actual corrective action to be taken on a case-by-case basis. The OIG evaluates the action taken and either returns the case to the facility for further action or closes the case.

In our sample of completed cases, there were nine cases in which the facilities took some actions even though no action was recommended by the OIG and 47 cases where the facility took action per recommendation by the OIG. These actions included counseling, training, suspensions, and terminations. Four employees were discharged after abuse allegations were substantiated. (pages 29-32)

OTHER ISSUES

The report disclosed other issues related to the Inspector General that were not central to this audit. These issues include the Quality Care Board and the annual report. (pages 33-36)

RECOMMENDATIONS

This audit contains five recommendations related to the Office of the Inspector General. The Inspector General concurred with the five recommendations. See Appendix G for the Inspector General's complete response.

JOHN W. KUNZEMAN
Deputy Auditor General

JT
April 1993

TABLE OF CONTENTS

Auditor General's Transmittal Letter i
Report Digest iii
Glossary xv

CHAPTER 1: INTRODUCTION 1

Report Conclusions 1
Background 2
The Office of the Inspector General 2
Investigative and Reporting Process 4
Prior Audits 5
Scope and Methodology 7
Disclosure Requirements 7
Report Organization 8

CHAPTER 2: ABUSE AND NEGLECT REPORTING 9

Incident Reporting 9
Abuse Allegations 12
Investigations of Resident Abuse 13
Substantiated Abuse Allegations 14
Allegations of Abuse by Demographic Characteristics 16

CHAPTER 3: OIG INVESTIGATIONS 19

Improvements in Case Documentation 19
Corrective Action Documentation 19
Case File Documentation Requirements 20
Agency Recommendation # 1 21
Investigation Timeliness and Guidelines 21
OIG Timeliness Requirements 21
Investigation Timeliness 22
Agency Recommendation # 2 24
Case Review Process 24
Status Reports 25
Agency Recommendation # 3 25
Investigator Caseloads and Training 26
Investigator Caseload 26
Training 27

Agency Recommendation # 4 . . . 28
Sanctions and Administrative Actions . . . 28
OAG Sample Cases Substantiated . . . 29
Corrective Actions by Facilities . . . 29
Timeliness of Facility Response and Case Closures . . . 31

CHAPTER 4: OTHER ISSUES . . . 33

Quality Care Board . . . 33
Annual Report . . . 33
Agency Recommendation # 5 . . . 34
Facility Access . . . 34
Other Issues . . . 35
Abuse Allegations in Community-Based Programs . . . 35
Resident to Staff Incidents . . . 35

EXHIBITS

EXHIBIT 1-1 DMHDD Facility Population . . . 2

EXHIBIT 1-2 DMHDD Resident Facilities . . . 3

EXHIBIT 1-3 Types of Incidents Reportable to the Inspector General . . . 5

EXHIBIT 2-1 Incidents Reported to OIG by Type Fiscal Year 1992 . . . 10

EXHIBIT 2-2 Number of Incident Occurrences by Facility Comparison of Percent Change in Total Incidents Fiscal Years 1989 through 1992 . . . 11

EXHIBIT 2-3 Abuse Allegations as a Percentage of Resident Population and Total Incidents . . . 12

EXHIBIT 2-4 Completed Investigations of Abuse/Neglect . . . 13

EXHIBIT 2-5 Substantiated Abuse Cases . . . 14

EXHIBIT 2-6 Fiscal Year 1992 Abuse/Neglect Incidents at Facilities . . . 15

EXHIBIT 2-7 Race Characteristics of DMHDD Staff and Residents Alleging Abuse - Fiscal Year 1992 17

EXHIBIT 3-1 Fiscal Year 1992 Investigation Timeliness 23

EXHIBIT 3-2 Investigator Caseloads 26

EXHIBIT 3-3 Corrective Actions Taken by Facilities - Fiscal Year 1992 31

EXHIBIT 4-1 Resident to Staff Incidents 36

APPENDICES

APPENDIX A: Public Act 87-1158 39

APPENDIX B: Methodology 43

APPENDIX C: Number of Incidents and Allegations Reported to OIG by Facility and Type 47

APPENDIX D: Substantiated Reportable Incidents by Facility 51

APPENDIX E: Staff/Resident Direct Care Facility Ratios 55

APPENDIX F: Abuse Reporting and Oversight 61

APPENDIX G: Inspector General Responses 65

GLOSSARY

ABUSE and NEGLECT
Abuse is any physical injury, sexual abuse, or mental injury inflicted on a resident other than by accidental means. Neglect is a failure to provide adequate care or maintenance to a resident which results in physical or mental injury, or physical or mental deterioration (210 ILCS 30/3; formerly Ill.Rev.Stat.1991, ch. 111 1/2, par. 4163(d-e)).

DEVELOPMENTAL DISABILITY
A disability attributable to: (a) mental retardation, cerebral palsy, epilepsy or autism; or to (b) any other condition which results in impairment similar to that caused by mental retardation and which requires services similar to those required by mentally retarded persons. Such disability must originate before the age of 18 years, be expected to continue indefinitely, and constitute a substantial handicap (405 ILCS 5/1-106; formerly Ill.Rev.Stat. 1991, ch. 91 1/2, par. 1-106).

DEVELOPMENTAL DISABILITY FACILITY
A facility or a section thereof licensed or operated by or under contract with the State or a political subdivision thereof and which admits developmentally disabled persons for residential and habilitation services (405 ILCS 5/1-107; formerly Ill.Rev.Stat. 1991, ch. 91 1/2, par. 1-107).

MENTAL HEALTH FACILITY
Any licensed private hospital, institution, or facility or section thereof, and any facility, or section thereof, operated by the State or a political subdivision thereof for the treatment of persons who are mentally ill (405 ILCS 5/1-114; formerly Ill.Rev.Stat. 1991, ch. 91 1/2, par. 1-114).

MENTAL ILLNESS
Mental disease to such extent that a person so afflicted requires care and treatment for his/her own welfare, or the welfare of others, or of the community (45 ILCS 40/1; formerly, Ill.Rev.Stat. 1991, ch. 91 1/2, par. 50-1).

RESIDENT
A person residing in and receiving personal care from a long term care facility, or residing in a mental health facility or developmental disability facility (210 ILCS 30/3; formerly Ill.Rev.Stat.1991, ch. 111 1/2, par. 4163(b) as amended by Public Act 86-1013).

CHAPTER ONE
INTRODUCTION

Section 8 of Public Act 87-1158, effective September 18, 1992, directed the Auditor General to conduct a program audit of the Office of the Inspector General (OIG) in relation to its compliance with this Act. The Act states 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 of Mental Health and Developmental Disabilities (DMHDD) and in making recommendations for sanctions to DMHDD and the Department of Public Health.

Two related audits have been completed by the Office of the Auditor General. In May 1990, pursuant to Public Act 86-1013, the Auditor General released a program audit on the reporting and investigation of resident abuse and neglect and reviewed the Office of the Inspector General's effectiveness in investigating reports of suspected abuse and neglect. In November 1992, also pursuant to Public Act 86-1013, a second program audit on facility reporting was released that reported trends of suspected abuse and neglect.

The OAG will perform another audit, scheduled to be released no later than January 1, 1995, that will also review the Inspector General's effectiveness in investigating reports of suspected abuse and neglect. Appendix F provides a listing of audits and reports completed concerning the OIG and reporting statistics.

REPORT CONCLUSIONS

About twelve percent of the 9,037 incidents reported to the OIG in Fiscal Year 1992 involved allegations of abuse and neglect. While abuse allegations increased from Fiscal Years 1989 to 1992 (826 to 1,079), the number of abuse cases substantiated by investigations steadily decreased over this period (Fiscal Year 1989 - 245; Fiscal Year 1990 - 209; Fiscal Year 1991 - 114; Fiscal Year 1992 - 83). Changes in incident reporting guidelines in 1990 which expanded reporting requirements and an increased emphasis on reporting by the Department may account for the increase in incidents reported.

The reasons for the decrease in substantiated cases are not readily determinable. The following factors may be influencing the decrease in substantiated cases: the continued emphasis on abuse and neglect by the Department, including new training programs; administrative actions taken against employees who are found to have

engaged in abuse toward residents; the timeliness of investigations; and increased investigator workloads. This audit found no conclusive evidence to explain the downward trend in substantiated cases.

The thoroughness in documenting case investigations and the tracking of recommended administrative actions has improved markedly since our 1990 audit. The OIG has implemented case documentation requirements and follows up on recommended administrative actions to facilities. Our testing showed that 95 percent of completed OIG investigation case files contained the required documentation and recommended administrative actions were tracked to final disposition.

The Inspector General's timeliness in completing investigations has improved since our 1990 audit but further improvements are still needed. About 30 percent of completed investigations in our sample of 284 cases took longer than 60 days to complete compared to about 37 percent in the 1990 audit. Also, 24 of our sample cases were still open, with ongoing investigations ranging from 161 days old to 491 days old. In addition, OIG supervisors did not consistently monitor the status of cases over 60 days old.

BACKGROUND

The Department of Mental Health and Developmental Disabilities provides care and treatment to Illinois citizens who are mentally ill or developmentally disabled. As of June 30, 1992, there were 7,642 residents in the 21 residential facilities.

Exhibit 1-1
DMHDD Facility Population

Fiscal Year	Pop.
1988	8057
1989	8097
1990	7961
1991	7722
1992	7642

Source: DMHDD Annual Reports

Nine State-operated residential facilities serve the developmentally disabled, eight facilities serve the mentally ill, and four facilities serve both groups. Exhibit 1-2 shows the location of DMHDD's 21 residential facilities.

The Office of the Inspector General

The General Assembly established the Office of the Inspector General (OIG) within DMHDD (Public

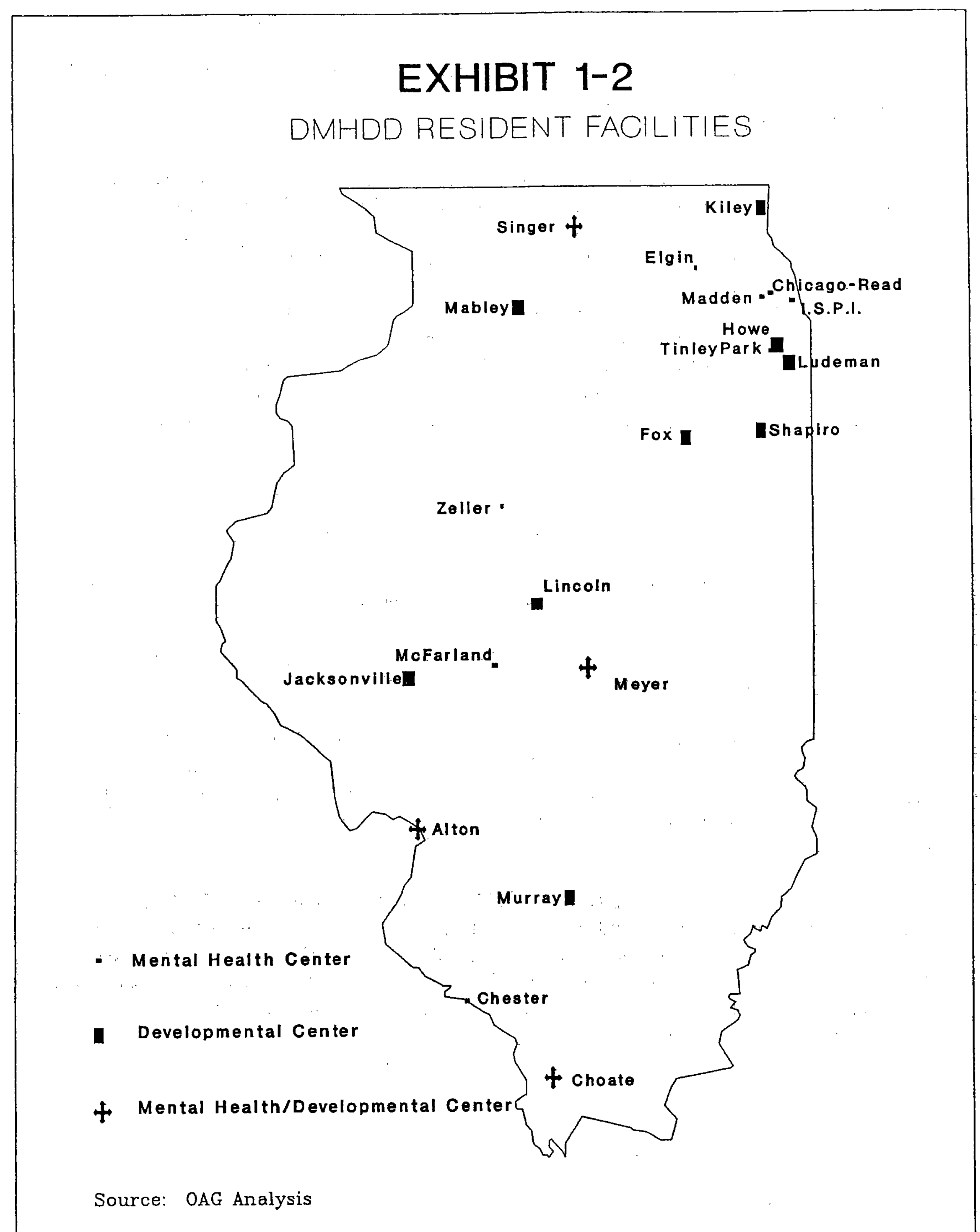


EXHIBIT 1-2
DMHDD RESIDENT FACILITIES
Kiley
Singer
Elgin
Madden
Chicago-Read
I.S.P.I.
Mabley
Howe
TinleyPark
Ludeman
Fox
Shapiro
Zeller
Lincoln
McFarland
Jacksonville
Meyer
Alton
Murray
Chester
Choate
Mental Health Center
Developmental Center
Mental Health/Developmental Center
Source: OAG Analysis

Act 85-223, effective August 26, 1987) to investigate alleged incidents of abuse and neglect at DMHDD-operated facilities. 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 March 1992. She was formerly the Executive Director of the Alliance for the Mentally Ill of Illinois.

The primary mission of the OIG is to investigate reports of suspected abuse or neglect of residents in any facility operated by DMHDD. As of March 1993, the OIG has 9 investigators and one person who is classified as an Executive III who performs investigations along with other duties. Five of the people doing investigations are headquartered in Chicago and five are headquartered downstate. The OIG also establishes criteria for reportable incidents, monitors investigations conducted by facilities, and reviews facility compliance with abuse policies and procedures. The OIG staff reviews reported incidents and refers potential criminal cases to the State Police for investigation. The OIG may also recommend sanctions to the Department of Public Health or DMHDD. These sanctions, which may be imposed to protect the residents, include the appointment of on-site monitors or receivers, the transfer or relocation of residents, and the closure of units.

Investigative and Reporting Process

"Abuse" is any physical injury, sexual abuse, or mental injury inflicted on a resident other than by accidental means. "Neglect" occurs when the failure to provide adequate medical or personal care or maintenance results in physical or mental injury or causes the resident's physical or mental condition to deteriorate. Abuse and neglect are referred to collectively as "abuse" in this report.

Facility staff are required to report a variety of incidents to the OIG. Prior to January 15, 1990, facilities were also required to report incidents and allegations to the Department of State Police. Since January 1990, facilities send all reported incidents to the OIG and the OIG reviews them and refers potential criminal cases to State Police for investigation.

Exhibit 1-3 summarizes the types of incidents reported to the OIG. The OIG investigates allegations of abuse and neglect (1a-1e). These categories involve mistreatment of residents by employees and not resident-to-resident incidents. Until October 1992, the OIG also investigated all cases of resident death. Resident death cases that are the result of a known medical condition are now investigated by each facility with oversight and closure activities carried out by the OIG.

Exhibit 1-3 TYPES OF INCIDENTS REPORTABLE TO THE INSPECTOR GENERAL	
1. Mistreatment of Residents by Employees: a. Physical abuse requiring emergency medical treatment b. Other physical abuse c. Sexual abuse d. Verbal/psychological abuse e. Neglect which results in an injury f. Other improper employee conduct	2. Resident Death 3. (a) Injuries requiring emergency medical treatment or (b) non-accidental injuries inflicted by another person 4. Unauthorized resident absence from a facility 5. Certain sexual incidents between residents 6. Theft of resident property 7. Employee misconduct, malfeasance, misfeasance or other occurrences serious enough to warrant reporting.
Source: DMHDD Policy and Procedures Directive 01.05.06.03	

PRIOR AUDITS

In May 1990, the Auditor General released a program audit on the reporting and investigation of resident abuse and neglect. This program audit established a base for reviewing future trends in reporting resident abuse at DMHDD facilities. It also reviewed the OIG's effectiveness in investigating reports of suspected abuse and neglect in DMHDD facilities. The audit found:

- The OIG had no formal program to test for underreporting of resident abuse, even though wide variations in reporting existed among facilities. The audit recommended that the OIG establish a program to inspect facility files to identify instances of underreporting.

  OIG Comment: *In response, OIG established a formal audit process to test for under-reporting at each facility twice a year.*

- The facilities did not report incidents in a timely manner. The audit recommended that the OIG monitor facility incident reporting for timeliness.

  OIG Comment: *In response, OIG began tracking timeliness in January 1991 and included data on timeliness in its FY91 and FY92 annual reports.*

- Seventy-one percent of the investigations sampled took longer than the then-established 30-day guideline. This guideline was revised in January 1990 to state only that investigations be completed as expeditiously as possible. The audit recommended that the OIG take steps to ensure investigations are conducted in a timely fashion and to consider establishing time guidelines.

  OIG Comment: *In response, OIG revised its policy to include a time guideline.*

- The OIG did not require documentation of corrective actions taken by facilities. The audit recommended that the OIG verify corrective actions taken by facilities and ensure the actions are documented in employee personnel files.

  OIG Comment: *In response, OIG established specific documentation requirements for corrective actions.*

- Investigative case file documentation needs improvement. The audit recommended the OIG adopt case file documentation policies and ensure the files contain required documentation before the case is closed.

  OIG Comment: *In response, OIG established investigative file documentation requirements for all OIG case files.*

In November 1992, a second program audit on facility reporting was released that reported trends of suspected resident abuse and neglect using the data in the May 1990 audit as a base. The audit found that DMHDD facilities reported an increasing number of

incidents from Fiscal Year 1988 through 1991 and stated that changes in reporting requirements may have accounted for increases during Fiscal Years 1990 and 1991. The audit also found improvement in the areas of the facilities' timeliness of incident reporting and compliance with reporting policies.

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 on this audit began in August 1992 and fieldwork was substantially concluded in January 1993. We interviewed representatives of DMHDD, the Inspector General's Office, the Department of Public Health, the Department of State Police, the Federal Department of Health and Human Services, and Protection and Advocacy, Inc., a not-for-profit organization. We reviewed documents at the Inspector General's Office, State Police, and Public Health. We reviewed DMHDD policies and procedures. We reviewed investigator backgrounds, caseloads, and statistics. Internal controls over OIG procedures were assessed in relation to the investigation process. We conducted a survey of 12 states concerning their investigations of abuse and neglect at mental health facilities. The states were New Jersey, New York, Ohio, Pennsylvania, Wisconsin, California, Indiana, Iowa, Massachusetts, Michigan, Minnesota, and Missouri.

We randomly sampled 284 abuse and neglect case investigations conducted by the OIG for Fiscal Year 1992 from DMHDD facilities to determine the adequacy and extent of the investigations. See Appendix B for sampling methodology. We also reviewed 10 death cases and 10 facility investigations. We tested selected personnel files at three facilities to determine if corrective actions were documented.

The issues of the timeliness of facility incident reporting and facilities' compliance with reporting policies are not examined in this audit. The Auditor General's two prior audits of DMHDD reviewed the timeliness of facility reporting and the facilities' compliance with reporting policies. The November 1992 audit found improvement in both areas.

Disclosure Requirements

Government Auditing Standards require the disclosure of all matters relating to the audit work, the audit organization, and the individual auditors concerning impairment of

audit independence, whether real or apparent. In accordance with these requirements, the Office of the Auditor General reports the following matter in regard to this audit: On or about August 31, 1992, the Office of the Auditor General began fieldwork on this audit, which was substantially completed by January 15, 1993. On January 19, 1993, the Office of the Auditor General learned that another bureau within the Department began functionally reporting to the Inspector General, the principal auditee, sometime earlier in January 1993. The wife of the Auditor General was under a service contract with that bureau. Effective January 26, 1993, all responsibilities for this audit were transferred to the Deputy Auditor General, including reviews of findings, conclusions, and recommendations, as well as report signature authority. Inasmuch as the auditors assigned to this engagement had substantially completed fieldwork and had only limited contact with the subject bureau as its functions were not within the primary scope of activities being audited, the auditors submit that no impairments to independence existed that would have limited their ability to conduct a fair and objective audit. This matter is noted here to comply with full disclosure requirements of relevant auditing standards.

REPORT ORGANIZATION

CHAPTER TWO reviews types and trends of incident reporting and abuse allegations. It also reviews the number of investigations performed by the OIG and reviews the number of substantiated abuse cases.

CHAPTER THREE reviews the documentation and timeliness of OIG investigations and discusses problems with the case review process. It compares investigator caseloads and investigation times and discusses corrective actions taken by facilities.

CHAPTER FOUR discusses the Quality Care Board, OIG's annual report, and other issues.

CHAPTER TWO
ABUSE AND NEGLECT REPORTING

About twelve percent of the 9,037 incidents reported to the OIG in Fiscal Year 1992 involved allegations of abuse and neglect. While abuse allegations have increased from Fiscal Years 1989 to 1992, the number of abuse cases substantiated by investigations has steadily decreased over this period. Changes in incident reporting guidelines in 1990 which expanded reporting requirements and an increased emphasis on reporting by the Department may account for the increase in incidents reported.

The reasons for the decrease in substantiated cases are not readily determinable. The following factors may be influencing the decrease in substantiated cases: the continued emphasis on abuse and neglect by the Department, including new training programs; administrative actions taken against employees who are found to have engaged in abuse toward residents; the timeliness of investigations; and increased investigator workloads.

INCIDENT REPORTING

Incident allegations are reported by each facility to the OIG. Normally, when an incident occurs at a facility, the staff person on duty who becomes aware of the incident will report to the facility director. The facility staff then reports the allegation to the OIG by telephone and by mail. The facilities have been directed to report all allegations to the OIG. Therefore, the incidents that are reported range from serious allegations to relatively minor incidents.

It should be noted that the scope of this audit did not extend to the issue of whether facilities were underreporting incidents to the OIG. The 1990 audit found some problems in underreporting and recommended the OIG monitor facility incident reporting and take corrective action if necessary. The November 1992 audit followed up on this issue and found substantial improvement in incident reporting, but recommended that DMHDD continue to require personnel to report incidents as required and take corrective actions where necessary. Because underreporting was so recently reviewed and improvements were noted, we did not reevaluate the issue.

Exhibit 2-1 shows the number and type of incidents reported to the OIG for Fiscal Year 1992. The facilities reported 9,037 incidents to the OIG. Allegations of abuse totaled 1,079 (12 percent). See Appendix C for the number of incidents reported by each facility. The "other" category includes theft of resident property as well as other types of misconduct.

EXHIBIT 2-1
Incidents Reported to OIG By Type
Fiscal Year 1992

	Number	Percentage
Abuse/Neglect	1079	12%
Resident Death	99	1%
Improper Employee Conduct	298	3%
Serious Injury	301	3%
Resident to Resident Injury	6126	68%
Unauthorized Absence	521	6%
Sexual Conduct	345	4%
Other	268	3%
Total	9037	100%

Source: OAG Analysis of OIG/DMHDD data

Exhibit 2-2 compares the number of incidents reported from Fiscal Years 1989 to 1992 and the percentage change each year. As shown in the Exhibit, the total number of incidents reported increased 83 percent from Fiscal Years 1989 to 1990, and 46 percent from Fiscal Year 1990 to 1991 but decreased 2 percent from Fiscal Year 1991 to 1992.

Reasons for the significant increase in reported incidents from Fiscal Years 1989 to 1991, as discussed in the OAG 1992 performance audit, may be attributable to the following:

1) In January 1990, DMHDD broadened the definition of a reportable injury to include all injuries that "appear to have been inflicted by another person by other than accidental means." Following this change, there was an increase in the number of minor injuries reported. The previous definition required facilities to report injuries only if "the circumstances or nature of the injury indicate possible abuse or neglect by employees."

According to the 1992 audit, this change may have affected the number of injuries reported during Fiscal Years 1990 and 1991. For example, the audit states that 71 percent of the injuries reported during Fiscal Year 1990 were reported during the six months following the definition change. The number of reported injuries increased significantly again during the first six months of Fiscal Year 1991 and increased only slightly in the final six months of Fiscal Year 1991.

2) The Department put increased emphasis on incident reporting following our 1990 audit, which contained a recommendation concerning underreporting.

Exhibit 2-2

Number Of Incidents Reported By Facility
Comparison Of Percent Change In Total Incidents
Fiscal Years 1989 Through 1992

Facilities	FY89 Total Incidents	FY89 Facility Population	FY90 Total Incidents	FY90 Facility Population	FY89-FY90 % Change In Number Of Incidents	FY91 Total Incidents	FY91 Facility Population	FY90-FY91 % Change In Number Of Incidents	FY92 Total Incidents	FY92 Facility Population	FY91-FY92 % Change In Number Of Incidents
Alton	150	339	358	326	139%	536	305	50%	668	302	25%
Chester	66	292	191	322	189%	280	307	47%	243	315	-13%
Chgo-Read	649	613	528	493	-19%	924	527	75%	1,061	523	15%
Choate	209	455	451	420	116%	623	426	38%	622	439	-0%
Elgin	565	822	876	820	55%	1,143	794	30%	1,241	722	9%
Fox	9	194	14	195	56%	41	187	193%	51	184	24%
Howe	231	718	690	701	199%	869	630	26%	771	622	-11%
ISPI	37	156	64	181	73%	129	150	102%	150	152	16%
Jacksonville	97	328	326	326	236%	430	321	32%	487	321	13%
Kiley	102	478	364	476	257%	641	468	76%	511	468	-20%
Lincoln	115	499	173	485	50%	292	491	69%	327	490	12%
Ludeman	91	504	336	506	269%	488	494	45%	534	502	9%
Mabley	48	115	42	115	-13%	215	118	412%	155	110	-28%
Madden	86	262	184	248	114%	398	222	116%	330	177	-17%
McFarland	57	139	107	152	88%	122	161	14%	155	159	27%
Meyer	377	169	327	171	-13%	500	162	53%	415	189	-17%
Murray	41	363	184	369	349%	120	369	-35%	136	365	13%
Shapiro	292	810	480	817	64%	466	817	-3%	347	819	-26%
Singer	25	266	140	217	460%	230	237	64%	247	265	7%
Tinley Park	109	335	323	363	196%	463	306	43%	371	334	-20%
Zeller	77	240	124	258	61%	277	230	123%	215	184	-22%
Total	3,433	8,097	6,282	7,961	83%	9,187	7,722	46%	9,037	7,642	-2%

Population Figures Are As Of June 30 Of Each Fiscal Year.

Prior to May 1988, Choate Mental Health and Developmental Center was named Anna Mental Health and Developmental Center.
Prior to October 1988, Kiley Developmental Center was named Waukegan Developmental Center.

Source: OAG analysis of OIG/DMHDD Data

As stated earlier, the number and rate of incidents reported in Fiscal Year 1992 remained stable, decreasing only slightly from Fiscal Year 1991. This is in line with expectations noted in the 1992 performance audit. The 1992 audit stated that significant changes in the number of future reported incidents would not be expected: "Since facilities are now required to report almost all resident injuries, regardless of severity, and because the number of injury reports leveled off during the final six months of Fiscal Year 1991, we would not expect such significant changes in the future unless there were different reporting requirements, non-compliance with existing requirements, or unless the changes were due to some factor other than reporting, such as increased numbers of patients, decreased numbers of direct care staff, or a decrease in the quality of resident care."

Abuse Allegations

Allegations of abuse are one category of total reportable incidents. While the total number of reported incidents stabilized from Fiscal Year 1991 to 1992, the total number of abuse allegations has increased each year, as has the number of abuse allegations in proportion to facility populations. Exhibit 2-3 illustrates these numbers.

EXHIBIT 2-3
ABUSE ALLEGATIONS AS A PERCENTAGE OF RESIDENT POPULATION AND TOTAL INCIDENTS

Fiscal Year	Total Abuse Allegations	Abuse Allegations As a Percentage of Total Incidents	Abuse Allegations As a Percentage of Population
1989	826	24.1%	10.2%
1990	860	13.7%	10.8%
1991	957	10.4%	12.4%
1992	1079	11.9%	14.1%

Source: OAG Analysis of OIG Data

When taken as a percentage of total incidents reported, abuse allegations decreased from Fiscal Year 1989 to Fiscal Year 1991, then increased slightly in Fiscal Year 1992. The expansion of a definition in reportable incidents in January 1990 caused an increase in allegations of non-abuse categories. Therefore, the percentage of abuse incidents decreased in proportion to the total. In Fiscal Year 1992, as total incident reporting started to level out, abuse allegations as a proportion of total incidents began to rise. An OIG official stated that the Department has taken several steps that have had both an immediate and long-term

effect on abuse reporting. The change to a broader definition of abuse/neglect in January 1990 caused both an immediate and gradual increase in the number of incidents reported. Further, the on-going training of newly hired Department staff focused attention on the importance of abuse and neglect issues and on the importance of reporting. The official also added that there has been an increased general awareness of abuse issues by the general public and residents.

INVESTIGATIONS OF RESIDENT ABUSE

The OIG determines who will investigate each reported incident. OIG investigates specific allegations of abuse, refers potential criminal conduct cases to the State Police, and returns non-abuse cases to the specific facility. The facilities investigate less serious allegations, such as the theft of property or employee conduct not related to residents. As of October 1992, facilities also investigate cases of resident deaths that are not the result of abuse allegations, but are the result of a known medical condition, with oversight and closure activities carried out by the OIG.

Since Fiscal Year 1991, the OIG has investigated all abuse allegations that are not referred to State Police. Prior to April 1990, the OIG referred some abuse cases to the facilities. The 1990 audit pointed out that, in the last half of Calendar Year 1988 and Calendar Year 1989, the OIG investigated only 62 percent of abuse cases. The State Police investigated 5 percent, while 33 percent were referred to the facilities. At that time, the OIG stated that the referral of abuse cases to facilities was generally due to resource limitations.

Exhibit 2-4 shows the total number of investigations by each investigating agency from Fiscal Year 1989 to Fiscal Year 1992. The OIG performed 446 investigations in Fiscal Year 1989, 835 in Fiscal Year 1990, 1,017 in Fiscal Year 1991 and 1,149 in Fiscal Year 1992.

EXHIBIT 2-4
COMPLETED INVESTIGATIONS OF ABUSE/NEGLECT*

Fiscal Year	OIG	State Police	Facilities	Total
1989	446	44	425	915
1990	835	51	89	975
1991	1017	41	0	1058
1992	1149	29	0	1178

* Includes resident death investigations
Source: OAG Analysis of OIG Data

Currently, the OIG is no longer referring abuse allegations to the facilities. However, OIG officials stated they have proposed a change in the statutes that would allow them to refer some abuse investigations to the facilities in the

future with continual oversight by the OIG. By referring the less serious cases to the facilities, they said they will be able to concentrate OIG investigative resources on the more serious abuse cases. OIG officials stated that it should be noted that this will occur only after promulgation of a rule which will establish criteria for the referral and monitoring of investigations.

Substantiated Abuse Allegations

While the number of allegations of abuse has increased, the number of substantiated cases of abuse has decreased each year since Fiscal Year 1989.

As shown in Exhibit 2-5, both the number and percentage of substantiated abuse incidents are decreasing each year. In Fiscal Year 1989, 245 abuse incidents were substantiated. In Fiscal Year 1990, 209 abuse cases were substantiated, compared to 114 cases in Fiscal Year 1991, and 83 cases in Fiscal Year 1992. The percentage of substantiated abuse cases per resident population also decreased over the four-year span from 3 percent to just over 1 percent. When viewed as a percentage of total allegations, substantiated abuse cases decreased from 30 percent to 8 percent. See Appendix D for the number of substantiated abuse cases for each fiscal year by facility.

EXHIBIT 2-5
SUBSTANTIATED ABUSE CASES

FY	Substantiated Cases	Percentage of Total Allegations	Percentage per Resident Population
1989	245	30%	3.0%
1990	209	24%	2.6%
1991	114	12%	1.5%
1992	83	8%	1.1%

Note: Substantiated cases are those closed in the stated fiscal year even though they may have been reported in prior periods.

Source: OAG Analysis of OIG Data

According to the Inspector General, the decline in substantiated cases along with the rise in the number of allegations and investigations may be due to the implementation of a Department-wide training program on the prevention and identification of abuse and neglect. In the OIG Fiscal Year 1992 State of Care Report, the Inspector General also attributes some problems with the substantiation of cases to the reluctance of facility personnel to report other employees.

The reasons for the contrasting trends, that is, an increase in abuse allegations and a decrease in substantiated cases, are not readily determinable. We contacted officials at the Center for Mental Health Services, a division within the Federal Department of Health and Human Services, the Federal Protection and Advocacy office, and a private consultant

Exhibit 2-6

FISCAL YEAR 1992 ABUSE/NEGLECT INCIDENTS AT FACILITIES

Facility by Type	Number of Residents[1]	Allegations of Abuse/Neglect[2]	Substantiated Abuse/Neglect
DD Facilities			
Shapiro DC	840	49	4
Howe DC	708	77	5
Ludeman DC	528	26	3
Lincoln DC	510	18	3
Kiley DC	484	52	5
Murray DC	383	4	2
Jacksonville DC	335	27	1
Fox DC	193	3	0
Mabley DC	126	2	1
Dual Facilities			
Choate MHDC	1051	80	5
Singer MHDC	1002	21	7
Alton MHDC	873	93	5
Meyer MHDC	396	51	3
MH Facilities			
Chicago-Read MHC	3223	136	12
Tinley Park MHC	2883	49	2
Elgin MHC	1937	185	17
Madden MHC	1425	19	1
Zeller MHC	999	22	0
I.S.P.I.	932	29	2
McFarland MHC	674	25	4
Chester MHC	370	111	1
Totals	19872	1079	83

1. Total number of individuals (not counted more than once) who were in the facility at some time during the year.
2. Substantiated cases in FY1992 include some allegations reported in prior periods. Likewise, at the end of FY1992, investigations of some allegations were still open.

DC - Developmental Center. MHC - Mental Health Center. MHDC - Mental Health and Developmental Center.

Source: OAG Analysis of DMHDD/OIG Data

specializing in the area of abuse investigations. The general consensus was that a definitive answer was not apparent. It could be that less abuse is occurring or abuse cases are not being substantiated. The following factors may be influencing the decrease in substantiated cases: the continued emphasis on abuse and neglect by the Department, including new training programs; administrative actions taken against employees who are found to have engaged in abuse toward residents; the timeliness of investigations; and increased investigator workloads. These are discussed further in Chapter Three. The consultant stated that in an investigative process, one of the most important factors is the timeliness of the investigation. This is also discussed further in Chapter Three.

The Auditor General's 1990 and 1992 audits both showed the abuse allegation rate for mental health facilities, as a group, was twice that of developmental facilities. Exhibit 2-6 compares the number of allegations and substantiated cases by type of facility. As seen in the Exhibit, the highest number of abuse allegations were from three mental health facilities, Chicago-Read, Elgin, and Chester. These three facilities comprised 40 percent of the total allegations of abuse. Of those three, Chicago-Read and Elgin also had 35 percent of all the substantiated cases. Overall, the eight mental health facilities accounted for over 50 percent of all allegations and 47 percent of all substantiated cases.

Chester is a mental health facility with a large number of abuse allegations in relation to the facility population but a much smaller substantiated case rate. Chester houses men who have either been charged with a crime but were found unfit to stand trial or not guilty by reason of insanity, or men treated in other facilities who require a maximum security environment.

ALLEGATIONS OF ABUSE BY DEMOGRAPHIC CHARACTERISTICS

We sampled 284 cases from the investigation files of the Inspector General. This sample included only reports of alleged abuse or neglect. The sample included more than 284 residents because some of the incidents involved more than one resident. We compiled information about case investigation times, case status, disposition and documentation, and demographic data such as age, race and sex of the residents and staff involved in the alleged abuse incidents. In our May 1990 audit we examined the demographic characteristics of only the residents. The current audit extends the testing to include staff demographics as well.

The results reported cannot be generalized to the entire resident population of DMHDD facilities. Inferences based on the sample results refer to a population which consists of alleged abuse reports submitted to and subsequently investigated by the Office of the Inspector General. This population may or may not reflect the attributes of the general resident population.

Part of our sample analysis involved testing to determine if there were any significant associations between the demographic characteristics of the persons involved in reported abuse allegations and substantiated abuse cases. We did this by performing the chi-square test of independence between variables. See Appendix B for sampling methodology. The results of the sample analysis are shown in Exhibit 2-7 and described below:

1. A summary analysis of the sample found a higher than expected incidence of abuse allegations by residents against staff of the same race: 45 of 83 black residents were allegedly abused by black staff members, while 78 of 158 white residents were allegedly abused by white staff employees.

2. The sample data shows a higher than expected incidence of abuse allegations by female residents against staff of another race: 14 of 26 black female residents were allegedly abused by white staff, and 37 of 70 white female residents were allegedly abused by black staff.

3. Analysis of the sample by both the race and gender of both the residents and staff however, found that there was a higher than expected incidence of abuse allegations by white females against white male staff.

4. The sample was also analyzed for those cases where the abuse allegations were substantiated. Analysis by race only and both race and gender of the residents found no significant relationships between the demographic characteristics of the residents and whether or not the allegation was substantiated.

Exhibit 2-7
Race Characteristics of DMHDD Staff and Residents Alleging Abuse - Fiscal Year 1992

	Race of DMHDD Staff			
Race of Residents in Overall Sample	Black	White	Other	Total
Black	45	37	1	83
White	71	78	9	158
Other	4	3	2	9
Total	120	118	12	250
Male Subgroup				
Black	33	23	1	57
White	34	47	7	88
Other	0	3	0	3
Total	67	73	8	148
Female Subgroup				
Black	12	14	0	26
White	37	31	2	70
Other	4	0	2	6
Total	53	45	4	102

Note: Table reflects incidents where more than one resident or staff member may have been involved and where resident or staff are involved in multiple incidents.

Source: OAG Analysis of OAG Sample - Fiscal Year 1992 OIG Investigations

Of the 284 investigation cases sampled, 19 cases were substantiated and involved 24 residents. Cases in our sample that were substantiated involved six black male residents, ten white male residents, seven white female residents, and one hispanic female resident. There

were no cases that involved black female residents in our sample that were substantiated. Figures published in the Inspector General's Fiscal Year 1992 annual report show that 70.3 percent of the victims in substantiated abuse cases were white and 26.5 percent were black. A break down of these figures showed that 43.7 percent were white males, 26.6 percent were white females, 14 percent were black males and 12.5 percent were black females. In our sample of substantiated cases, 70.8 percent of the residents were white and 25 percent were black. Our sample distribution showed that 41.7 percent were white males, 29.2 percent were white females and 25 percent were black males. The sample distribution generally reflects the demographic distribution of residents in substantiated abuse cases in the general facility population.

Overall, the sample data presented above shows male residents were more likely to allege abuse against staff of the same race. Our analysis of substantiated cases did not identify any relationship between the race of the resident and substantiation of abuse. Thus, the evidence as a whole does not clearly identify any definitive relationships between the racial characteristics of residents and staff for alleged or substantiated cases of abuse.

CHAPTER THREE
OIG INVESTIGATIONS

The thoroughness in documenting case investigations and tracking of recommended administrative actions has improved markedly since our 1990 audit. The OIG has implemented case documentation requirements and follows up on recommended administrative actions to facilities. Our testing showed that 95 percent of completed OIG investigation case files contained the required documentation and administrative actions were tracked to final disposition.

The OIG's timeliness in completing investigations has improved since our 1990 audit but further improvements are still needed. About 30 percent of the cases sampled in Fiscal Year 1992 took more than 60 days to complete. Also, 24 cases we sampled were still open, with ongoing investigations ranging from 161 days old to 491 days old. In addition, OIG supervisors did not consistently monitor the status of cases over 60 days old.

IMPROVEMENTS IN CASE DOCUMENTATION

In June 1990, the OIG established documentation requirements for investigation case files and for verification that facilities have taken corrective actions. These actions were in response to recommendations in the 1990 performance audit.

Corrective Action Documentation

The OIG implemented requirements for documentation of corrective actions taken by facilities after the 1990 audit. When an investigation is completed and sent to the facility, the facility then reviews the investigation report and the action recommended by the OIG. The facility makes a determination as to the action to be taken against an employee and, after the action is completed, returns the case to the OIG with a request for closure.

The OIG requires the facility to include documentation of the corrective action taken against the staff person. If an employee was suspended or terminated, the OIG requires a copy of the personnel transaction form. If an employee received a written reprimand, the OIG requires a copy of the reprimand. If an employee received an oral reprimand, the OIG

requires a copy of the memo to the employee's personnel file noting the date, time and reason for the reprimand. Finally, if an employee received counseling, the OIG requires a memo documenting the date and reason for the counseling session before the case can be closed. In addition, the OIG requires the facilities to send monthly listings of all disciplinary actions taken that month as a result of OIG reportable incidents.

In addition to the above requirements, DMHDD's Office of Internal Audits incorporated audit procedures to test personnel files for documentation of corrective actions in their audit program of facilities' personnel operations. A review of the most recent facility audit cycle showed DMHDD's internal audits reported that two facilities did not comply with the directive to submit monthly reports of corrective actions to the OIG. While one of the facilities did not comply with the monthly submission requirement, the audit noted that the personnel files contained the required documentation of disciplinary actions.

For additional confirmation, we performed a limited test by reviewing three cases from three facilities drawn from our sample that contained documentation of action taken. The three facilities were Madden, Chicago-Read and McFarland. We confirmed that the documentation in the investigative case file was also found in the employees' personnel files.

Case File Documentation Requirements

The OIG formalized case file documentation requirements for their investigations of abuse and neglect. Documentation requirements include: the DMHDD 107 form - the form used to report the incident; investigative evidence, such as signed statements and progress notes; summaries of interviews, if any were done; an OIG case report; a recommendation memo from the OIG transmitting the case to the facility director; a response to the report from the facility; and specific documentation of any administrative action taken against staff.

Illinois' case file documentation requirements compared favorably with that of other states. We conducted a telephone survey of 12 other states that investigate abuse allegations at mental health/developmental disabilities facilities. Of the 12 states, two had written case file documentation requirements similar to Illinois, two had written requirements that were not as comprehensive as Illinois, three had only informal requirements, three had no documentation requirements, one required each facility to use their own procedures, and the other state said they had written requirements but did not provide specific information.

We sampled 284 case files from the abuse allegations made in Fiscal Year 1992. Two hundred and fifty-seven investigations were completed and of these cases, 243 were closed cases. The majority of the closed cases, 232 (95 percent), contained the required documentation.

Eleven (5 percent) of the 243 completed cases in our sample did not contain all the required documentation. Three cases contained no documentation of the corrective actions

taken by the facilities; three contained no witness statements or interviews; one contained no facility response; and four were missing case reports as well as other required documents.

RECOMMENDATION NUMBER 1

The Inspector General should ensure that all case files contain the required documentation before a case is closed.

OIG Comment:

OIG accepts the recommendation. We have now developed a checklist to ensure complete and thorough documentation before closure. In addition, we have developed a formal process to internally audit investigative files on a regular basis after closure.

INVESTIGATION TIMELINESS AND GUIDELINES

Investigation timeliness has improved since the OIG implemented timeliness guidelines following our 1990 audit. However, some problems with the length of investigations still exist.

The length of an investigation is measured from the time an incident is reported to OIG until the OIG sends a recommendation letter to the facility informing it of the investigation results. After the facility receives the recommendation letter from the OIG, the facility reviews the case, takes any disciplinary action necessary, and sends a response letter back to the OIG requesting case closure. If the OIG has no questions or concerns about the facility comments or actions, the OIG closes the case. If the OIG has questions or concerns, for example if a corrective action was taken and the OIG does not agree with the action, the OIG will return the case to the facility for further action. Therefore, we are making a distinction between the length of an investigation and the time it takes to close the case. In this section, we discuss the length of the investigation time only.

OIG Timeliness Requirements

Prior to January 1990, OIG had a 30-day guideline for completing investigations. That policy was changed because of concern that investigators might hurry investigations to

close cases within the 30 days. In early 1990, the OIG changed the policy to state that investigations should be completed as expeditiously as possible. The 1990 audit recommended that the OIG should consider establishing time guidelines for completing investigations which could vary for the different degrees of seriousness of the abuse report.

In response to the 1990 audit, the OIG changed its policies and procedures concerning investigation timeliness requirements. OIG's current guidelines on investigation timeliness still state that investigations should be completed as expeditiously as possible but add that OIG investigations will not exceed 60 days absent exceptional circumstances. Investigators are also required to submit a case status report on each investigation that is not completed in 60 days and every 30 days thereafter until the investigation is complete and sent to the facility. Exceptional circumstances include difficulty receiving a death certificate or autopsy report, vacation or extended sick leave of a suspect or witness, review by an external entity, or low priority due to high caseloads.

Seven of the 12 states we contacted in our telephone survey had more stringent investigation timeliness requirements than Illinois. These varied from five to 30 days. One state required that a draft report is to be completed within five working days after the last interview. The four other states in the survey had no requirements but two stated they should be completed within a reasonable time.

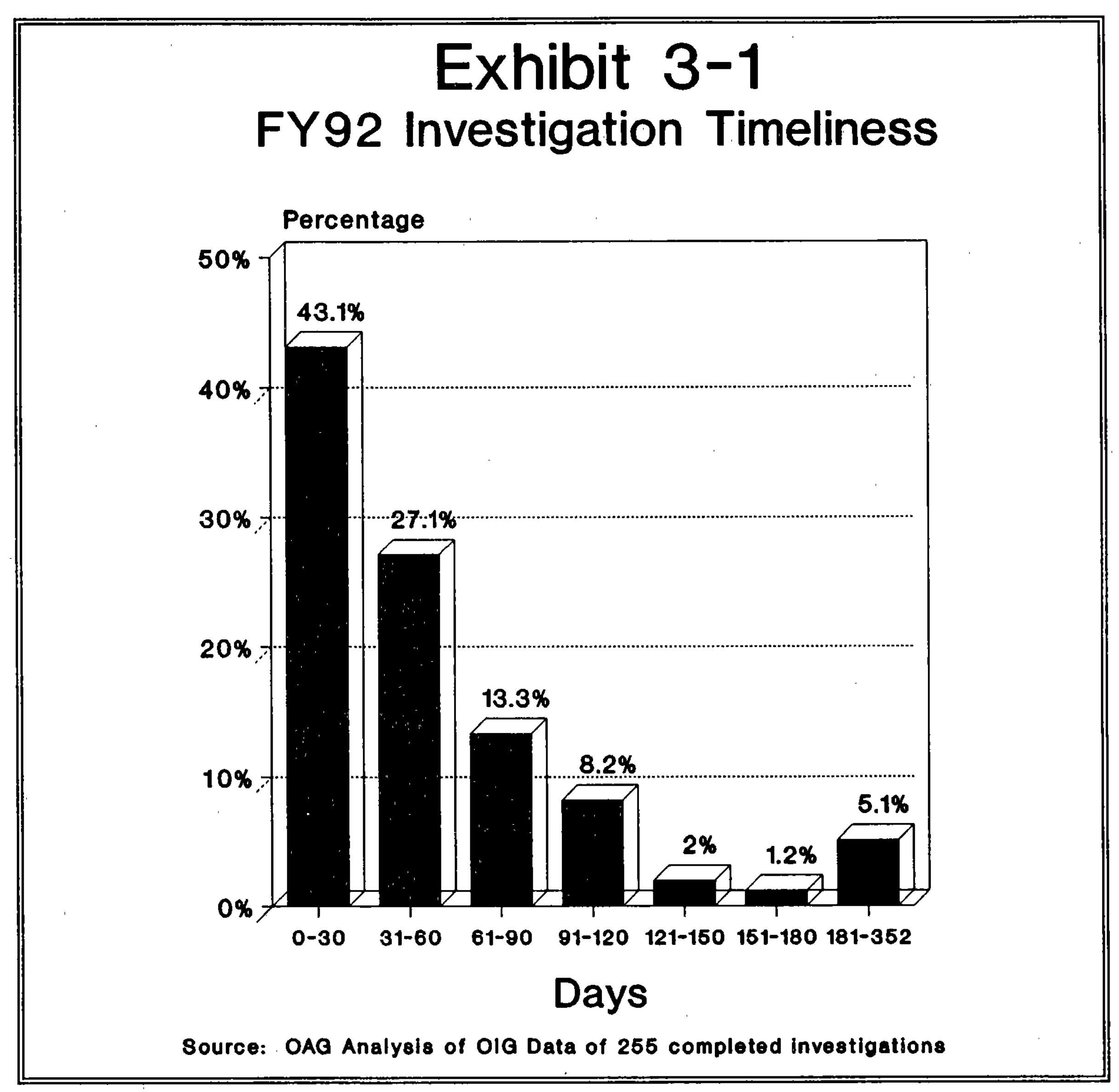
OIG Comment:

Notably, in Illinois, OIG has conducted abuse/neglect investigations solely through the use of off-site investigators. Further, OIG has more extensive documentation and report format requirements, each of which may extend the time for completion.

Investigation Timeliness

The number of investigations completed within 30 days increased from 29 percent of the sample cases in the 1990 audit to 43 percent in our current sample. The number of investigations completed within 60 days also increased, from 63 percent to 70 percent. In our sample of 284 cases reported to the OIG in Fiscal Year 1992, 257 cases were completed investigations. Two of these cases did not contain sufficient documentation to enable us to determine the length of the investigation. Therefore, the timeliness data presented is based on 255 completed investigations. Investigation times ranged from 3 to 352 days. Over 80 percent of investigations were completed within 90 days. However, 16 investigations (6 percent) took over 150 days to complete. Exhibit 3-1 illustrates the timeliness of the 255 completed investigations.

In our sample of 284 cases, two were facility investigations that were mistakenly coded as OIG investigations and one was a State Police investigation. In 24 cases, investigations were still open. However, only 22 had sufficient documentation to allow us to



determine how long they have been open. These open cases ranged from 161 days old to 491 days old. Five of these cases were over 270 days old. Two cases were over six months old and had little documentation in the case file. These were both cases that were transferred from one investigator to another due to a leave of absence. One case that was over five months old contained three status reports, each stating that the case was in typing. One case did not have a status report in the file until it was seven months old. This status report stated the investigation was completed but the investigator's current duties prevented the case report from being written. The case was still open when we pulled our sample a month and a half later. Another open case was received by the OIG in March 1992 and assigned to one investigator who later went on leave. In September 1992, the case was reassigned to another investigator who stated the prior investigator never initiated an investigation. One case over six months old had no documentation in the file to show why it was delayed.

RECOMMENDATION NUMBER 2

The Inspector General should ensure that investigations are completed as soon as possible, but, absent exceptional circumstances, within 60 days.

OIG Comment:

OIG accepts the recommendation. Through training programs, specific time guidelines, and a lowering of caseloads, OIG investigators have been required to complete investigations in a more timely manner. Any case older than 60 days must receive supervisory authorization.

CASE REVIEW PROCESS

Improvements are needed in the case review process. For example, we noted that no action was taken on one case for several months because it was misfiled, 78 cases lacked status reports, and no documentation was available to show any work was done on four cases for six months because they were transferred from one investigator to another. Also, when we pulled our case sample, OIG personnel could not find one of the case files in our sample. OIG officials later found the missing case file.

After an abuse allegation is made, the investigation is assigned to the investigator responsible for that particular facility. Once a case is completed, the investigator sends the case file to the OIG office in Springfield for final review. If the case reviewer has any questions or wants additional information included in the investigative file, the case is returned to the investigator for additional information or follow-up. However, there is no documentation of that review or any resulting follow-up information provided in the case file. Therefore, it is not possible to determine if a significant delay in completing a case is the result of a request for more information by a case reviewer or if the delay is a result of no action on the case.

The OIG implemented the use of a status report to provide for an interim review of overdue cases. When an investigation takes longer than 60 days, the investigator is required to fill out a status report at 60 days and every 30 days thereafter. However, status reports were often not filled out or not reviewed. According to an OIG official, there are occasional spot checks done to determine if status reports were being filled out, but this is not done

systematically. The status reports are not a part of formal case documentation requirements but are useful in monitoring and tracking case timeliness and status.

OIG officials are in the process of implementing a systematic case review process. At the time of our fieldwork, this process was not in place and could not be tested.

Status Reports

The status report form was implemented in January 1990 as a means to determine reasons for late cases and to identify actions that could be taken to expedite an investigation. The form lists the case number, investigator, date submitted, reviewer, date reviewed, the reason for the delay in completing the case, and actions that could be taken to speed completion of the case.

When a case is 60 days old, and every 30 days thereafter, the investigative file, along with the status report, is supposed to be sent to the Springfield OIG for review. The status report is then to be signed and the file returned to the investigator.

While the use of the case status reports is an improvement in monitoring overdue cases, we did note some problems in their administration. In our sample of cases, 102 investigations required status reports. Of these 102 cases, 78 (76 percent) were missing some or all of the required status reports. Eleven of these cases were over six months old. For example, we found cases that had status reports for five months but lacked any evidence of review. In one case, all five status reports indicated the report was in typing. One case that was 60 days old contained a status report that stated there was no reason why the report was not drafted. We also noted reports that were reviewed and signed by the investigator assigned to the case. One case contained a 180 day status report that stated the case was misfiled.

These examples point out the need for more systematic monitoring and review of overdue investigations to ensure cases are being completed in as timely a manner as possible. OIG officials stated they plan to implement a system to send all cases over 45 days old to a case reviewer.

RECOMMENDATION NUMBER 3

The Inspector General should ensure that all investigations are reviewed at regular intervals and documentation of any comments or problems is maintained.

OIG Comment:

OIG accepts the recommendation. We have developed a monthly review process of all open investigations over 60 days old. This process, although not documented in the case file, will require documented supervisory review on a regular basis.

INVESTIGATOR CASELOADS AND TRAINING

During the whole of Fiscal Year 1992, eleven investigators worked for the OIG. While the background experiences of the investigators varied from person to person, most of the investigators had experience either in law enforcement, investigative work, or the mental health field.

Investigator Caseload

During Fiscal Year 1992, seven investigators were assigned to Chicago area facilities and four to downstate facilities. Investigators are assigned to specific facilities and investigate all abuse cases at those facilities. Exhibit 3-2 shows the total number of cases assigned by investigator in Fiscal Years 1990 and 1992 and the average time to complete investigations in Fiscal Year 1992. As seen in the exhibit, the number of cases and average investigative times vary widely. Fiscal Year 1992 caseloads varied from 45 to 156. One of the reasons for the uneven caseloads are

EXHIBIT 3-2
INVESTIGATOR CASELOADS

	Total Cases FY 1990	Total Cases FY 1992	Average Days to Complete FY92 Cases
Chicago Investigators			
#1	6	83	59
#2	61	126	63
#3	104	138	29
#4	58	56	60
#5	9	156	30
#6	59	45	34
#7	113	97	93
Downstate Investigators			
#8	55	72	69
#9	74	151	32
#10	40	46	96
#11	61	98	71

Source: OAG Analysis of OIG Data

that investigators are assigned by facilities and some facilities have more complaints than others. The average investigation times also varied widely, from 29 days to 96 days. Timeliness may vary due to the complexity of the cases and the workloads of the investigators.

Caseloads varied from Fiscal Year 1990 to Fiscal Year 1992. Exhibit 3-2 also shows the caseloads and how they differed between those years. As seen in the Exhibit, downstate caseloads increased between 1990 and 1992. Upstate caseloads also varied, increasing for four investigators from Fiscal Year 1990 to 1992 and decreasing for three investigators.

Training

The OIG did not maintain documentation of training received by all investigators. Documentation was available for most training received by the downstate investigators. An OIG official stated that the prior Inspector General did not keep training records for the Chicago area investigators.

Public Act 87-1158 (210 ILCS 30/6.2) requires the OIG to establish and conduct periodic training programs for Department employees concerning the prevention and reporting of neglect and abuse. In addition, the Act requires the OIG to establish training for all abuse investigators.

The Inspector General has established the training programs and is in the process of conducting training programs for OIG investigators as well as facility investigators.

In February 1993, the OIG conducted a training session on "Prevention and Identification of Abuse and Neglect." This session was given to the OIG and facility investigators, but in addition, the class was regarded as a "Train the Trainer" session. Facility investigators received the training with the intent that they will train the other facility personnel on abuse prevention and reporting. In addition, facilities are instructed to include abuse information in the orientation for new employees. A handbook that outlines abuse and neglect issues was developed by the Department for facility personnel in May 1987 and updated in January 1991.

The OIG provided us with the training schedule for November 1992 through May 1993. All OIG investigators as well as facility investigative personnel are mandated to attend the training. Training sessions are scheduled monthly for OIG investigators and bi-monthly for facility investigators. The sessions are scheduled through May 1993 and include such topics as "Investigatory Training," "Interviewing Techniques," "Abuse and Neglect," "Overview of Disciplinary Process," "Recipient Credibility," and "Writing a Case Report."

RECOMMENDATION NUMBER 4

The Inspector General should ensure that documentation exists for training received by OIG investigators and for facility employees.

OIG Comment:

OIG accepts the recommendation. We have maintained formal training records of training received by OIG and facility investigators since the enactment of Public Act 87-1158. These records are in the form of a certificate of training provided to the employee which may be placed in the employee's personnel file.

SANCTIONS AND ADMINISTRATIVE ACTIONS

The OIG is empowered to make recommendations for administrative actions against employees and sanctions to DMHDD and to the Department of Public Health based on investigations or for other reasons. Sanctions include appointment of on-site monitors or receivers, transfer or relocation of residents, and closure of units. An OIG official stated that there have never been instances where they have closed a facility, a unit, or transferred all residents from a unit. In the spring of 1992, the OIG appointed on-site monitors at two facilities as a result of visits to the facilities, but not as a result of an abuse allegation investigation.

An OIG official also noted that it is not uncommon to transfer residents because of problems with other residents. However, there have never been more than one or two residents moved at a time. These were transfers that were not related to abuse by staff or conditions at facilities, but because of interaction with other residents. The OIG official added that if there is a situation with problems between a staff person and a resident and they can substantiate a case of abuse or neglect against a staff person, then they move the staff person, not the resident. However, in the spring of 1992, a resident was moved to another unit because of alleged problems with a staff person. The OIG official stated that the recipient alleged three incidents against the staff person. The first two investigations found no misconduct or abuse. The third investigation did not find abuse or neglect, but found an administrative infraction against the employee. In that case, the recipient was moved to another unit and no further problems were reported.

OAG Sample Cases Substantiated

Of the 243 closed cases in our sample, 19 (eight percent) were substantiated cases of abuse and administrative actions were recommended by the OIG. This is the same percentage of abuse cases (eight percent) substantiated in the total Fiscal Year 1992 universe of abuse allegations as discussed in Chapter Two. The cases substantiated varied and included cases of verbal abuse such as an employee calling a recipient ugly, a neglect case where a recipient fell to the floor and dislocated a shoulder but was not examined by a doctor until 17.5 hours had elapsed, and a physical abuse case where a recipient was grabbed by an employee and dragged to a chair. The 19 substantiated cases were classified as follows:

- Ten (52.6 percent) physical abuse;
- Seven (36.8 percent) verbal/psychological abuse; and,
- Two (10.5 percent) neglect.

Two of the substantiated cases (one of physical abuse and one of neglect) were subsequently overturned in the grievance process. In one particular case, the OIG concluded there was physical abuse by two employees. The OIG recommended administrative action be taken and the facility suspended the employees and planned to fire them. However, at the grievance hearing the residents' testimony was found to be unreliable and the discharges were not approved. The employees were returned to work at a different unit in the same facility.

OIG Comment:

This particular case was unfortunate in that the victim was initially consistent and credible, but, by the time of the grievance hearing, had deteriorated to the point that his testimony was found to be unreliable. We have proposed a variety of initiatives to address these types of problems.

Corrective Actions by Facilities

As discussed previously, when allegations of abuse are substantiated, various corrective actions are taken against the facility employees. These corrective actions range from informal counseling or retraining to suspension and/or discharge.

After an investigation is completed, the OIG will usually make a general recommendation to the facility. If abuse is substantiated, normally the OIG will recommend that there is a need for administrative action. If a lesser charge is substantiated, such as procedures were not followed, or an incident was not reported timely, the OIG's recommendations often use the same general wording. While the OIG's recommendations are worded very generally, they fall into four categories as defined by the OIG:

1) administrative action against staff - this includes termination, suspension, reprimands, formal and informal counseling, and retraining;

2) administrative and other action - this includes the actions named above as well as other actions which are taken specifically in response to the incident and includes procedural changes, retraining of an entire unit or shift, re-assignment of employees, structural changes to the facility, transfer of residents, and significant treatment changes;

3) other actions - includes non-administrative actions named in the above section; and

4) no action.

The facilities determine the actual corrective action to be taken on a case-by-case basis. The facilities take the corrective actions they deem appropriate and notify the OIG of the action taken and include the documentation in the case closure request. The OIG will not close a case without documentation of corrective action taken. The OIG evaluates the action taken, and if the OIG disagrees with the action, will send the case back to the facility. If the OIG agrees that the action taken was appropriate, the OIG will close the case.

In our sample of completed cases, we noted that there were nine cases in which the facilities took some actions even though no action was recommended by OIG. Exhibit 3-3 lists the type of actions taken by facilities in our sample of cases investigated by OIG and includes all cases where corrective actions were taken, including those where abuse was not substantiated. Over half of the cases resulted in a staff person being either disciplined or counseled. Reprimanded means that the person received a written reprimand, an oral warning, or a supervisory conference. Four employees were discharged after abuse allegations were substantiated. The "other" category in Exhibit 3-3 includes situations where the staff person resigned before action was taken or in lieu of being discharged, and where clinical review issues were addressed in resident treatment as a result of the investigation.

EXHIBIT 3-3

CORRECTIVE ACTION TAKEN BY FACILITIES - FISCAL YEAR 1992

Type of Action	Per OIG Recommendation	Without OIG Recommendation	Total Cases
Reprimanded	15	0	15
Counseled	10	4	14
Trained	4	1	5
Admin. Leave	5	2	7
Terminated	3	0	3
Trained and Suspended	1	0	1
Suspended and Terminated	1	0	1
Counseled and Trained	3	2	5
Other	5	0	5
TOTAL	47	9	56

Source: OAG analysis of OIG case file sample

Timeliness of Facility Response and Case Closures

We reviewed the length of time it took the facilities to respond to the OIG's recommendation letters. After the investigation is completed, the OIG sends a recommendation letter to the facility with its findings and any recommendation for further action. If no action is required, the facility sends a closure request back to the OIG and the OIG closes the case. If an action is required, the facility will take some action and return the documentation of the action with the closure request. The OIG sends a monthly listing of open cases to each facility.

Sixty-four percent of the facility responses in our sample were returned within 15 days. Eighty percent were returned within 30 days. The longest time it took to return a response was 208 days. According to OIG officials, it may take the facility a long time to perform a corrective action, particularly in cases where the employee has gone on leave.

We also reviewed how long it took the case to be closed once the OIG received the closure request from the facility. Over half of the cases, 58 percent, were closed within 10

days. Eighty-eight percent were closed within 30 days, and 97 percent were closed within 60 days. The longest case took 127 days to close. According to OIG officials, some delays are caused by OIG disagreements with the facilities' actions. If the OIG does not agree with the facility response, they will send the case back to the facility to resolve.

CHAPTER FOUR
OTHER ISSUES

Issues related to the Inspector General that were not central to this audit are presented in this Chapter. They include the Quality Care Board, the annual report, and other issues.

QUALITY CARE BOARD

Public Act 87-1158 (210 ILCS 30/6.3, 30/6.4) establishes a Quality Care Board within DMHDD to monitor and oversee the operation, policies and procedures of the OIG to assure prompt and thorough investigations. The Board may also provide consultation to the OIG on policies, review existing facility regulations, advise the OIG on training, and recommend policies concerning intergovernmental relationships between the OIG and other State or federal agencies. The Board is to consist of seven members appointed by the Governor with the consent of the Senate, with knowledge or experience in the areas of law, investigatory techniques, or in the area of care of the mentally ill or developmentally disabled.

At the time of our fieldwork, the members had not yet been appointed to the Board. A preliminary list of potential members was circulated to the General Assembly and the OIG but a final decision had not yet been made.

ANNUAL REPORT

Public Act 87-1158 (210 ILCS 30/7) (Act) requires the OIG to provide an annual report to the General Assembly and the Governor no later that January 1 of each year. This report is to include a summary of reports and investigations for the prior fiscal year with respect to residents of DMHDD institutions. The report is also to detail the imposition of

sanctions and the final disposition of those recommendations, as well as include trend analysis of reported allegations and their dispositions.

The OIG's State of Care Report for Fiscal Year 1992 was not released until the end of February 1993. According to OIG officials, because the Act was not signed until September 1992, they did not have all the data collected necessary to fully comply with the provisions of the Act and had to generate additional data. Along with statistical data on allegations and investigations, the report contains detailed information and background on each facility.

RECOMMENDATION NUMBER 5

The Inspector General should ensure that the Annual Report is released by January 1 of each year.

OIG Comment:

OIG accepts the recommendation. Although the statute was signed in Fiscal Year 1993, we tried to include most of the required information in the Fiscal Year 1992 report, resulting in a significantly different and larger annual report. This, in turn, resulted in a longer report preparation time. However, we do not foresee this being problematic for future annual reports, and we anticipate completion by January 1 of each year.

FACILITY ACCESS

Public Act 87-1158 (210 ILCS 30/6.2) states that the Inspector General shall be granted access to any Department operated facility. It also requires the OIG to conduct unannounced site visits to the facilities at least once annually. The Inspector General had conducted unannounced site visits to each of the facilities before the Act was enacted. Since the Act was enacted, she has continued the unannounced visits and maintains documentation of the visits. The OIG investigators also conduct unannounced site visits of the facilities.

OTHER ISSUES

In addition to resident abuse allegations in State facilities, there are also two other areas where incidents may occur. These were not within the scope of this audit and are reported here for informational purposes only.

Abuse Allegations in Community-Based Programs

DMHDD currently funds approximately 2960 community-based programs. These programs provide care for an estimated 160,000 mentally ill and/or developmentally disabled persons annually and are monitored by the DMHDD's Bureau of Certification and Licensure.

While community programs were reviewed periodically by the Bureau of Certification and Licensure, the 1990 audit reported that there was no formal reporting and investigation process for resident abuse. As of January 1, 1993, the Bureau of Certification and Licensure was moved under the jurisdiction of the OIG. According to OIG officials, legislation has been introduced that will give the OIG the authority to investigate or monitor investigations at community-based centers. If the legislation is passed, all investigations, including community investigations, will be conducted or managed by the newly created OIG Investigations Bureau. The OIG officials are currently in the process of writing a new policy and procedural manual that will include the Bureau of Certification and Licensure.

OIG Comment:

We plan on including these policies and procedures in the proposed administrative rule governing all OIG activities and responsibilities referred to earlier.

Resident to Staff Incidents

From Fiscal Year 1990 to Fiscal Year 1992, there have been over 6,700 resident to staff incidents reported based on worker's compensation claim data. The numbers decreased each year from 2,495 instances in Fiscal Year 1990, to 2,288 in Fiscal Year 1991, to 1,991 in Fiscal Year 1992. These numbers represent the number of claims filed by DMHDD employees for worker's compensation and include minor incidents to severe occurrences.

OIG officials stated that the issue of resident to staff abuse is wide-spread and not easily tracked. There are several units that may perform investigations. Each facility has a workers compensation coordinator who may investigate resident to staff abuse. DMHDD's Employee Risk Management Section determines if the claim is compensable and if the

employee should be reassigned different duties. If a resident to staff abuse is of a criminal nature, DMHDD refers it to the State Police for investigation. If staff abuse or neglect causes the recipient to attack the staff person, the incident is referred to the OIG to investigate.

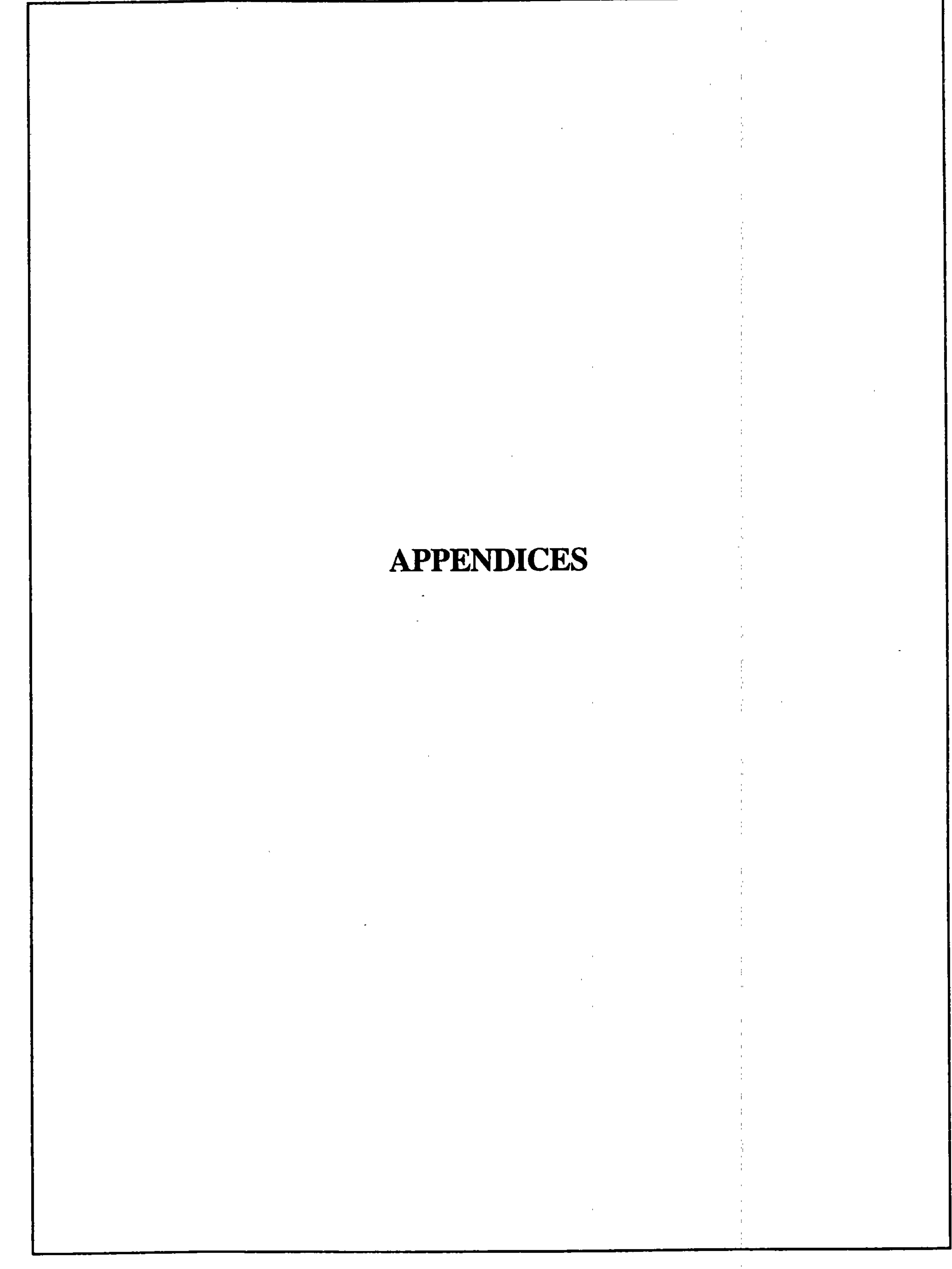
OIG Comment:

While DMHDD's Risk Management Section will continue to collect data on all staff injuries which result in a loss of work time or the need for a medical evaluation, beginning on July 1, 1993, OIG will require the reporting of all staff injuries requiring emergency medical attention that may be the result of recipient aggression.

Exhibit 4-1
Resident to Staff Incidents

Fiscal Year	Incidents
1990	2,495
1991	2,288
1992	1,991

Source: DMHDD on Worker's Compensation Claims


APPENDICES

APPENDIX A

PUBLIC ACT 87-1158

APPENDIX A

Public Act 87-1158
(Effective September 18, 1992)

Section 8

The Auditor General shall conduct a 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 Mental Health and Developmental Disabilities 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 in the initial audit to the General Assembly no later than May 1, 1993, and its findings in a subsequent audit no later than January 1, 1995.

This Section is repealed on January 1, 1996.

APPENDIX B

METHODOLOGY

SAMPLING AND ANALYTICAL METHODOLOGY

We examined a random sample of 284 investigative case files for abuse and neglect incidents reported to the Office of the Inspector General (OIG) in Fiscal Year 1992 in order to assess investigation timeliness, compliance with the OIG's documentation requirements and to discern any trends or patterns relating to the investigation of abuse allegations and to the incidence of abuse of residents.

In Fiscal Year 1992, 1079 allegations of abuse and neglect were reported to the OIG. The investigation case files are kept at the OIG's offices at the Madden Mental Health Center in Chicago and the McFarland Mental Health Center in Springfield. Random sampling was used to select a sample of 284 investigation cases from a master listing of all OIG investigative cases. The sample included more than 284 residents because some cases involved more than one resident. The cases sampled involved 305 residents. A sample of this size allows for a margin of error of 5% at a 95% confidence level.

An additional case had to be selected from the investigation case files at the Madden facility. A case file that was randomly selected for the sample was missing from the investigation files. (This case was found but not in time for use in our sample.)

To assess the timeliness of the OIG's investigation we reviewed the files and examined frequency distributions and reported on the investigation times from the date the OIG was notified of the incident by telephone or mail until an OIG investigator made a recommendation to a facility director. We determined if any cases were still under investigation and if so, how long the case had been open.

The sample files were reviewed to assess compliance with OIG requirements for documentation. Files were examined to ascertain if they contained the "documentation of action taken" reports, monthly investigative status reports, investigatory evidence and findings, if any. We reported whether or not these documents were in the file. Frequency distributions were constructed for the reporting and documentation variables. We reviewed these in aggregate and as they applied to individual investigators to assess the timeliness and efficiency of the case investigations.

To identify any trends or patterns relating to the investigation of abuse incidents and abuse incidence, tests for significant relationships between the demographic characteristics of the residents and staff involved in an incident and investigatory variables were performed using the Chi-square test for independence.

The test for a relationship between the race of the resident and the race of the staff employee involved, without regard to the gender of the resident, yielded the following statistics:

calculated Chi-square: 18.226 p-value: .0326.

This relationship was significant at the 5% level. The sample provides evidence that black residents were more likely to be allegedly abused by black staff employees and that white residents were more likely to be allegedly abused by white staff.

However, further analysis controlling for both race and gender of the resident and the race of the staff employee reported statistics:

calculated Chi-square: 18.092 p-value: .0012.

The sample provided evidence that black female residents were more likely to be allegedly abused by white staff than by staff of another race.

Analysis of the sample by both the race and gender of both the residents and staff, however, found that there was a higher than expected incidence of abuse allegations by white females against white male staff.

Further analysis by race only and race and gender of the resident found no significant relationships when examining those cases where abuse was substantiated.

APPENDIX C

Number of Incidents and Allegations Reported to OIG by Facility and Type

Fiscal Year 1992

Number Of Incidents/Allegations Reported To OIG By Facility And Type Of Incident Fiscal Year 1992

Facilities	Total Number Reported	Allegations Of Abuse/ Neglect	Improper Employee Conduct	Resident Death	Serious Resident Injury	Resident To Resident Injury	Resident Unauthorized Absence	Sexual Conduct	Theft Of Resident Property	Other
Alton MHDC	668	93	24	1	2	496	8	39	0	5
Chester MHC	243	111	18	1	1	94	0	9	0	9
Chgo-Read MHC	1,061	136	22	8	12	638	193	30	2	20
Choate MHDC	622	80	9	6	14	475	9	21	0	8
Elgin MHC	1,241	185	97	6	82	701	34	41	8	87
Fox DC	51	3	6	4	4	32	0	0	0	2
Howe DC	771	77	15	11	5	604	10	20	1	28
ISPI	150	29	15	3	15	65	5	11	0	7
Jacksonville DC	487	27	8	4	14	415	4	11	0	4
Kiley DC	511	52	10	0	7	382	9	39	1	11
Lincoln DC	327	18	6	11	1	281	2	6	0	2
Ludeman DC	534	26	4	0	5	481	12	2	0	4
Mabley DC	155	2	1	0	5	132	8	7	0	0
Madden MHC	330	19	8	1	7	154	114	13	0	14
McFarland MHC	155	25	5	3	10	63	27	12	1	9
Meyer MHDC	415	51	15	2	26	244	30	38	1	8
Murray DC	136	4	0	5	3	121	1	0	0	2
Shapiro DC	347	49	6	12	45	200	8	17	0	10
Singer MHDC	247	21	10	9	27	139	24	11	1	5
Tinley Park MHC	371	49	7	5	14	272	10	4	2	8
Zeller MHC	215	22	12	7	2	137	13	14	0	8
Totals	9,037	1,079	298	99	301	6,126	521	345	17	251

[Abbreviations: MHDC – Mental Health and Developmental Centers; MHC – Mental Health Centers; DC – Developmental Centers]

Source: OIG/DMHDD Data

APPENDIX D

Substantiated Reportable Incidents by Facility

Fiscal Year 1989 - Fiscal Year 1992

Substantiated Reportable Incidents By Facility
Comparison Of Rates Per Resident Population FY89 & FY90

Facilities	FY89 Substantiated Reportable Incidents	FY89 Facility Population	FY89 Percentage* Per Resident Population	FY90 Substantiated Reportable Incidents	FY90 Facility Population	FY90 Percentage* Per Resident Population
Alton	22	339	6.5%	9	326	2.8%
Chester	3	292	1.0%	1	322	0.3%
Chgo–Read	17	613	2.8%	19	493	3.9%
Choate	6	455	1.3%	6	420	1.4%
Elgin	44	822	5.4%	43	820	5.2%
Fox	0	194	0.0%	0	195	0.0%
Howe	26	718	3.6%	30	701	4.3%
ISPI	5	156	3.2%	6	181	3.3%
Jacksonville	6	328	1.8%	8	326	2.5%
Kiley	18	478	3.8%	18	476	3.8%
Lincoln	19	499	3.8%	13	485	2.7%
Ludeman	11	504	2.2%	11	506	2.2%
Mabley	3	115	2.6%	0	115	0.0%
Madden	15	262	5.7%	8	248	3.2%
McFarland	3	139	2.2%	2	152	1.3%
Meyer	12	169	7.1%	8	171	4.7%
Murray	1	363	0.3%	2	369	0.5%
Shapiro	9	810	1.1%	12	817	1.5%
Singer	5	266	1.9%	7	217	3.2%
Tinley Park	10	335	3.0%	3	363	0.8%
Zeller	10	240	4.2%	3	258	1.2%
Total	245	8,097	3.0%	209	7,961	2.6%

** Percentage Per Resident Population Equals The Number Of Substantiated Reportable Incidents Divided By Facility Patient Population As Of June 30 For Each Given Year.*

Prior to May 1988, Choate Mental Health and Developmental Center was named Anna Mental Health and Developmental Center. Prior to October 1988, Kiley Developmental Center was named Waukegan Developmental Center.

Source: OAG Analysis of OIG/DMHDD Data

Substantiated Reportable Incidents By Facility
Comparison of Rates Per Resident Population FY91 & FY92

Facilities	FY91 Substantiated Reportable Incidents	FY91 Facility Population	FY91 Percentage* Per Resident Population	FY92 Substantiated Reportable Incidents	FY92 Facility Population	FY92 Percentage* Per Resident Population
Alton	12	305	3.9%	5	302	1.7%
Chester	0	307	0.0%	1	315	0.3%
Chgo-Read	9	527	1.7%	12	523	2.3%
Choate	1	426	0.2%	5	439	1.1%
Elgin	21	794	2.6%	17	722	2.4%
Fox	0	187	0.0%	0	184	0.0%
Howe	14	630	2.2%	5	622	0.8%
ISPI	1	150	0.7%	2	152	1.3%
Jacksonville	3	321	0.9%	1	321	0.3%
Kiley	10	468	2.1%	5	468	1.1%
Lincoln	3	491	0.6%	3	490	0.6%
Ludeman	5	494	1.0%	3	502	0.6%
Mabley	2	118	1.7%	1	110	0.9%
Madden	6	222	2.7%	1	177	0.6%
McFarland	2	161	1.2%	4	159	2.5%
Meyer	1	162	0.6%	3	189	1.6%
Murray	3	369	0.8%	2	365	0.5%
Shapiro	9	817	1.1%	4	819	0.5%
Singer	2	237	0.8%	7	265	2.6%
Tinley Park	8	306	2.6%	2	334	0.6%
Zeller	2	230	0.9%	0	184	0.0%
Total	114	7,722	1.5%	83	7,642	1.1%

** Percentage Per Resident Population Equals The Number Of Substantiated Reportable Incidents Divided By Facility Patient Population As Of June 30 For Each Given Year.*

Prior to May 1988, Choate Mental Health and Developmental Center was named Anna Mental Health and Developmental Center.
Prior to October 1988, Kiley Developmental Center was named Waukegan Developmental Center.

Source: OAG Analysis of OIG/DMHDD Data

APPENDIX E

Staff/Resident
Direct Care
Facility Ratios

Fiscal Year 1989 - Fiscal Year 1992

FISCAL YEAR 1989 DMHDD STAFF/RESIDENT DATA

FACILITY	Population	Direct Care Staff	Direct Care Staff/Resident Ratio
ALTON	339	277.8	0.82
CHESTER	292	336.6	1.15
CHICAGO-READ	613	637.3	1.04
CHOATE	455	464.9	1.02
ELGIN	822	838.4	1.02
FOX	194	181.5	0.94
HOWE	718	922.1	1.28
ISPI	156	296.9	1.90
JACKSONVILLE	328	322.5	0.98
KILEY	478	617.3	1.29
LINCOLN	499	488.0	0.98
LUDEMAN	504	658.3	1.31
MABLEY	115	137.1	1.19
MADDEN	262	280.8	1.07
McFARLAND	139	140.9	1.01
MEYER	169	166.5	0.99
MURRAY	363	398.3	1.10
SHAPIRO	810	975.5	1.20
SINGER	266	225.4	0.85
TINLEY PARK	335	358.6	1.07
ZELLER	240	255.0	1.06
TOTAL	8,097	8,979.7	1.11

Note: Prior to May 1988, Choate Mental Health and Developmental Center was named Anna Mental Health and Developmental Center.

Prior to October 1988, Kiley Developmental Center was named Waukegan Developmental Center.

Source: OAG Analysis of DMHDD/OIG data

FISCAL YEAR 1990 DMHDD STAFF/RESIDENT DATA

FACILITY	Population	Direct Care Staff	Direct Care Staff/Resident Ratio
ALTON	326	329.5	1.01
CHESTER	322	330.1	1.03
CHICAGO-READ	493	661.4	1.34
CHOATE	420	468.0	1.11
ELGIN	820	857.3	1.05
FOX	195	177.4	0.91
HOWE	701	956.6	1.36
ISPI	181	263.8	1.46
JACKSONVILLE	326	346.2	1.06
KILEY	476	621.8	1.31
LINCOLN	485	499.0	1.03
LUDEMAN	506	638.1	1.26
MABLEY	115	138.7	1.21
MADDEN	248	292.4	1.18
McFARLAND	152	139.0	0.91
MEYER	171	165.0	0.96
MURRAY	369	397.7	1.08
SHAPIRO	817	986.0	1.21
SINGER	217	229.5	1.06
TINLEY PARK	363	370.5	1.02
ZELLER	258	255.6	0.99
TOTAL	7,961	9,123.6	1.15

Source: OAG Analysis of DMHDD/OIG data

FISCAL YEAR 1991 DMHDD STAFF/RESIDENT DATA

FACILITY	Population	Direct Care Staff	Direct Care Staff/Resident Ratio
ALTON	305	326.7	1.07
CHESTER	307	322.6	1.05
CHICAGO-READ	527	631.7	1.20
CHOATE	426	432.0	1.01
ELGIN	794	816.6	1.03
FOX	187	180.9	0.97
HOWE	630	859.1	1.36
ISPI	150	260.9	1.74
JACKSONVILLE	321	332.5	1.04
KILEY	468	577.2	1.23
LINCOLN	491	480.0	0.98
LUDEMAN	494	620.6	1.26
MABLEY	118	134.1	1.14
MADDEN	222	258.9	1.17
McFARLAND	161	137.9	0.86
MEYER	162	149.4	0.92
MURRAY	369	390.0	1.06
SHAPIRO	817	961.2	1.18
SINGER	237	210.7	0.89
TINLEY PARK	306	363.4	1.19
ZELLER	230	236.9	1.03
TOTAL	7,722	8,683.3	1.12

Source: OAG Analysis of DMHDD/OIG data

FISCAL YEAR 1992 DMHDD STAFF/RESIDENT DATA

FACILITY	Population	Direct Care Staff	Direct Care Staff/Resident Ratio
ALTON	302	315.2	1.04
CHESTER	315	324.6	1.03
CHICAGO-READ	523	653.3	1.25
CHOATE	439	404.0	0.92
ELGIN	722	840.5	1.16
FOX	184	194.5	1.06
HOWE	622	802.5	1.29
ISPI	152	240.3	1.58
JACKSONVILLE	321	326.0	1.02
KILEY	468	604.3	1.29
LINCOLN	490	489.0	1.00
LUDEMAN	502	628.6	1.25
MABLEY	110	129.6	1.18
MADDEN	177	213.7	1.21
McFARLAND	159	134.7	0.85
MEYER	189	140.6	0.74
MURRAY	365	380.8	1.04
SHAPIRO	819	983.5	1.20
SINGER	265	203.5	0.77
TINLEY PARK	334	344.4	1.03
ZELLER	184	229.4	1.25
TOTAL	7,642	8,583.0	1.12

Source: OAG Analysis of DMHDD/OIG data

APPENDIX F

ABUSE REPORTING AND OVERSIGHT

ABUSE REPORTING AND OVERSIGHT

There are several entities who report on and have responsibilities pertaining to the investigation, reporting, and/or oversight of resident abuse in DMHDD facilities. These include, but are not limited to the reports or entities listed below.

REPORTS

OAG Performance Audits. In the last several years, the Office of the Auditor General has released audits examining reporting and investigation of abuse and neglect of DMHDD facility residents.

> An OAG program audit released in May 1990 reported on trends and patterns of abuse and neglect at facilities and the effectiveness of OIG investigations.
>
> An OAG program audit released in November 1992 reported on trends and patterns of abuse and neglect.
>
> The current program audit examines the Inspector General's effectiveness in investigating reports of alleged abuse and neglect.
>
> A forthcoming OAG program audit, scheduled for release in 1994, will report on findings concerning patterns or trends relating to abuse and neglect of facility residents.
>
> A program audit scheduled for release by January 1, 1995, will examine the Inspector General's effectiveness in investigating reports of alleged abuse and neglect.

OAG Financial and Compliance Audits. The OAG examines issues relating to abuse and neglect in its biennial financial and compliance audits of each DMHDD facility as a result of an assessment of the facility's compliance with the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/1 *et seq*; formerly Ill. Rev.Stat.1991 ch. 111½ Par. 4161 *et seq*).

OIG Annual Report. Public Act 87-1158 requires the Inspector General to include in its annual report a trend analysis of the number of reported allegations of abuse and their disposition for each facility. This is to be a department-wide analysis for the most recent three year period.

OVERSIGHT ENTITIES

In addition to the OAG, the following entities have a role in the resident abuse investigation and oversight process.

Quality Care Board. Public Act 87-1158 establishes a Quality Care Board. The Board is to be composed of seven members appointed by the Governor with the advice and consent of the Senate. Members appointed by the Governor shall be qualified by professional knowledge or experience in the area of law, investigatory techniques, or in the area of care of the mentally ill or developmentally disabled. Its functions include but are not limited to, monitoring and overseeing the operations, policies, and procedures of the Inspector General to assure prompt and thorough investigations of allegations of neglect and abuse. The Board may also provide consultation to the Inspector General on policies and protocols for investigations of alleged neglect and abuse, review existing facility regulations, advise the Inspector General on training, and recommend policies concerning intergovernmental relationships between the Inspector General and other state or federal agencies.

Protection and Advocacy, Incorporated. Protection and Advocacy, Inc. is an advocate for all dually diagnosed mentally ill and developmentally disabled persons residing in State facilities. Protection and Advocacy, Inc. conducts research and prepares public policy reports.

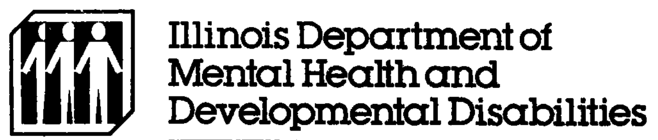
Citizens Assembly. Public Act 86-1013 authorizes the Citizens Assembly, under the direction of the Citizens Council on Mental Health and Developmental Disabilities, to review the operations, administration, execution of policy, and implementation of State law by DMHDD or any state agency providing services or administering programs in the areas of mental health or developmental disabilities.

Guardianship and Advocacy Commission. The Guardianship and Advocacy Commission provides legal representation, investigates complaints of rights violations and operates a guardianship service for disabled persons. Public Act 86-1013 amended the Guardianship and Advocacy Act (20 ILCS 3955/1 *et seq*; formerly, Ill.Rev.Stat.1991, ch. 91½, par. 701 *et seq*) to allow the Commission to monitor issues (including resident abuse) concerning the rights, care, and treatment of the disabled.

Department of Public Health. Incidents of employee mistreatment of a resident, theft, misappropriation or borrowing property from a resident, sexual abuse, resident death and resident injury are to be reported to the Illinois Department of Public Health (IDPH) Long Term Care/Nursing Home Hotline immediately upon becoming aware of an incident, but no later than the end of the next calendar day after the incident was discovered. The IDPH may investigate those incidents occurring in DMHDD facilities that participate in the federal Medicare/Medicaid program.

APPENDIX G

INSPECTOR GENERAL RESPONSES



Illinois Department of
Mental Health and
Developmental Disabilities

Central Office

April 15, 1993

John Kunzeman
Deputy Auditor General
509 S. Sixth St., Flr 1
Springfield, IL 62706

Dear Deputy Auditor General Kunzeman:

Thank you for the opportunity to provide comments and responses to the findings of the audit. I would greatly appreciate the inclusion of the comments and responses within the text of the report.

I would also like to thank your staff, especially Janet Taylor, Brenda Barker, and Tom Dart, for their professionalism, insightful questions, constructive suggestions, and objective report. This has truly been a rewarding audit experience for us.

On page 6, after the first dot-point, please insert:

In response, OIG established a formal audit process to test for under-reporting at each facility twice a year.

On page 6, after the second dot-point, please insert:

In response, OIG began tracking timeliness in January 1991 and included data on timeliness in its FY91 and FY92 annual reports.

On page 6, after the third dot-point, please insert:

In response, OIG revised its policy to include a time guideline.

On page 6, after the fourth dot-point, please insert:

In response, OIG established specific documentation requirements for corrective actions.

On page 6, after the fifth dot-point, please insert:

In response, OIG established investigative file documentation requirements for all OIG case files.

401 William Stratton Building
Springfield, Illinois 62765
217-782-7179

On page 21, after Recommendation Number 1, please insert:

OIG accepts the recommendation. We have now developed a checklist to ensure complete and thorough documentation before closure. In addition, we have developed a formal process to internally audit investigative files on a regular basis after closure.

On page 22, after the second paragraph, please insert:

Notably, in Illinois, OIG has conducted abuse/neglect investigations solely through the use of off-site investigators. Further, OIG has more extensive documentation and report format requirements, each of which may extend the time for completion.

On page 23, after Recommendation Number 2, please insert:

OIG accepts the recommendation. Through training programs, specific time guidelines, and a lowering of caseloads, OIG investigators have been required to complete investigations in a more timely manner. Any case older than 60 days must receive supervisory authorization.

On page 25, after Recommendation Number 3, please insert:

OIG accepts the recommendation. We have developed a monthly review process of all open investigations over 60 days old. This process, although not documented in the case file, will require documented supervisory review on a regular basis.

On page 27, after Recommendation Number 4, please insert:

OIG accepts the recommendation. We have maintained formal training records of training received by OIG and facility investigators since the enactment of Public Act 87-1158. These records are in the form of a certificate of training provided to the employee which may be placed in the employee's personnel file.

On page 29, after the first full paragraph, please insert:

This particular case was unfortunate in that the victim was initially consistent and credible, but, by the time of the grievance hearing, had deteriorated to the point that his testimony was found to be unreliable. We have proposed a variety of initiatives to address these types of problems.

On page 34, after Recommendation Number 5, please insert:

OIG accepts the recommendation. Although the statute was signed in Fiscal Year 1993, we tried to include most of the required information in the Fiscal Year 1992 report, resulting in a significantly different and larger annual report. This, in turn, resulted in a longer report preparation time. However, we do not foresee this being problematic for future annual reports, and we anticipate completion by January 1 of each year.

On page 34, after the last sentence on the page, please insert:

We plan on including these policies and procedures in the proposed administrative rule governing all OIG activities and responsibilities referred to earlier.

On page 35, after the last sentence on the page, please insert:

While DMHDD's Risk Management Section will continue to collect data on all staff injuries which result in a loss of work time or the need for a medical evaluation, beginning on July 1, 1993, OIG will require the reporting of all staff injuries requiring emergency medical attention that may be the result of recipient aggression.

I again thank you for your audit.

Sincerely,

CJ Dombrowski
Inspector General

CJD:JP:ms

cc: Jess McDonald
Deborah Murphy
Len Beck
Linda Ganski
Candace Keller
John Petter