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OFFICE OF THE AUDITOR GENERAL
WILLIAM G. HOLLAND

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

This is our report of the Program Audit of the Department of Mental Health and Developmental Disabilities – Reporting of Resident Abuse and Neglect. The audit was conducted pursuant to Public Act 86-1013 (30 ILCS 5/3-2), effective January 3, 1990.

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

WILLIAM G. HOLLAND
Auditor General

Springfield, Illinois
April 1996

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REPORT DIGEST

Program Audit of the *DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES*

REPORTING OF RESIDENT ABUSE AND NEGLECT

SYNOPSIS

As directed by Public Act 86-1013, this audit examined the Department of Mental Health and Developmental Disabilities (DMHDD) facilities' reporting of allegations of resident abuse and neglect. This audit found:

- DMHDD facilities were not reporting all incidents (such as abuse allegations and resident injuries) as required by State law and Department policy. Our sample of 630 resident files found 28 unreported incidents, including 6 allegations of abuse or neglect.

- DMHDD facilities need to improve the timeliness of reporting abuse and neglect allegations:

  - 20% were not reported to the Department of Public Health (IDPH) within 24 hours;

  - 33% were not reported to the Department of Children and Family Services (DCFS) within 24 hours; and

  - 6% were not reported within one working day to OIG (Inspector General).

- DMHDD needs to update its incident reporting policy to clarify reporting requirements.

- Allegations of resident abuse reported by DMHDD facilities increased 9 percent, from 903 in Fiscal Year 1993 to 984 in Fiscal Year 1995. The total population at DMHDD's residential facilities declined 12 percent over the same period. OIG officials said they are currently investigating reasons for the increase in abuse allegations.

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INTRODUCTION

Since January 3, 1990, the Illinois State Auditing Act (30 ILCS 5/3-2) has required the Auditor General to conduct a program audit, simultaneously with the biennial financial audit of the Department of Mental Health and Developmental Disabilities (DMHDD), to report trends or patterns of suspected abuse and neglect (collectively referred to as "abuse" in this report) of DMHDD residents. This audit deals only with "alleged" resident abuse, not with "substantiated" abuse cases.

DMHDD operates 21 residential facilities for the mentally ill and developmentally disabled. Facilities are required to report a variety of incidents, including abuse allegations, to DMHDD's Inspector General. Abuse allegations are also reportable to the Illinois Department of Public Health (IDPH) and – in cases involving residents under the age of 18 – to the Department of Children and Family Services (DCFS). (Pages 1-6)

REPORT CONCLUSIONS

The number of abuse allegations at DMHDD's 21 residential facilities *increased* 9 percent from Fiscal Year 1993 to Fiscal Year 1995 (903 in Fiscal Year 1993, 938 in Fiscal Year 1994, and 984 in Fiscal Year 1995). The resident population at these facilities *decreased* 12 percent during the same period (6,832 to 6,039). OIG officials said they are currently investigating reasons for the increase in abuse allegations.

DMHDD facilities are not reporting all incidents (such as abuse allegations and resident injuries) as required. Our sample of 630 resident files disclosed 28 unreported incidents, including 6 abuse allegations. In our 1994 audit, we found 23 unreported incidents, including 2 abuse allegations.

Facilities need to improve the timeliness of reporting abuse allegations. We found that 20 percent of abuse allegations were not reported to IDPH within 24 hours, and 33 percent were not reported within 24 hours to DCFS. Six percent of abuse allegations were not reported to OIG within one working day as required by DMHDD policy.

DMHDD's reporting policy needs to be updated to clarify incident reporting requirements. Changes in the policy should address areas such as clarifying the definition of certain reportable incidents and the documentation of incident information.

The number and rate of abuse allegations reported by facilities varied widely. Abuse allegation rates at mental health (MHC) centers remained at least twice that of developmental centers (DC). Dual facilities (MHDC) had the highest abuse allegation rates two of the past three years.

ABUSE ALLEGATIONS REPORTED

Digest Exhibit 1 shows that from Fiscal Year 1993 to Fiscal Year 1995 abuse allegations increased while the DMHDD facility population decreased.

Digest Exhibit 1
DMHDD FACILITY CENSUS & ABUSE ALLEGATIONS

Fiscal Year	Census	Abuse Allegations
1993	6,832	903
1994	6,428	938
1995	6,039	984

Source: DMHDD/OIG Reports
Note: Census figures at end of Fiscal Year

OIG officials said they are currently investigating reasons for the increase in abuse allegations. (Page 3)

UNDERREPORTING OF INCIDENTS

This audit and our prior audits found that DMHDD facilities did not report all incidents as required by State law and DMHDD policy. Failure to report all incidents required by Department policy could compromise resident safety and the credibility of the incident reporting system.

This audit found 28 unreported incidents in 630 resident files sampled; 6 of the unreported incidents were abuse allegations. In our 1994 audit, we sampled 630 resident files and found 23 unreported incidents, 2 of which involved alleged abuse. This audit recommends that DMHDD adopt stronger measures to ensure that facility personnel report incidents as required by State law and DMHDD policy. (Pages 9-19)

TIMELINESS OF INCIDENT REPORTING

DMHDD facilities need to improve the timeliness of reporting abuse allegations. In 9 percent (161 of 1,797) of the allegations reviewed, more than 8 hours passed from the time an incident was discovered to the time it was reported to the facility director. DMHDD policy requires reporting no later than by the end of an employee's shift.

Twenty percent of abuse allegations reviewed were not reported to IDPH within 24 hours. Thirty-three percent (19 of 57) of abuse allegations reviewed involving residents less than 18 years old were reported to DCFS more than 24 hours after discovery; State law requires "immediate" reporting to DCFS. Six percent (109 of 1,791) of abuse allegations were not reported to the OIG within one working day, as required by DMHDD policy. (Pages 14-17)

DOCUMENTATION OF ABUSE ALLEGATIONS

DMHDD facilities need to improve the documentation of abuse allegations by properly completing incident report forms and witness statements as required by DMHDD policy. OIG telephone notification was not documented in 105 (6%) of 1,899 abuse allegations reviewed; OIG mail notification was not documented in 129 (7%) of 1,899 allegations.

Twenty-five percent of the files reviewed did not contain all required initial written statements from employees who were present when the alleged abuse occurred. DMHDD policy requires that employees furnish a signed and dated report of what they heard or observed relative to the incident. (Pages 13, 14, 17, 18)

DMHDD REPORTING POLICIES

DMHDD's policy on abuse and neglect reporting should be revised to:

- Define injuries requiring "emergency medical treatment";
- Require reporting of abuse allegations to IDPH within 24 hours (as defined by IDPH administrative rules); and
- Require documentation of reporting times to DCFS. (Pages 19-23)

OTHER ISSUES

Public Act 89-0427, signed into law December 7, 1995, amended Section 3-2 of the Illinois State Auditing Act to obviate additional audits of abuse reporting "for any year for which the Inspector General submits a report to the Governor and General Assembly as required under Section 6.7 of the Abused and Neglected Long Term Care Facility Residents Reporting Act." The OIG's Fiscal Year 1995 annual report was due on January 1, 1996, but it was not issued until March, 1996. We recommended that the Office of the Inspector General comply with State law and issue its annual report on a timely basis. (Pages 1, 29)

RECOMMENDATIONS

This audit contains three recommendations related to the reporting of incidents by DMHDD facilities. The Department concurred with these recommendations. See Appendix D for the Department's complete response.

WILLIAM G. HOLLAND
Auditor General

WGH\JK
April 1996

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CHAPTER ONE
INTRODUCTION

The Illinois State Auditing Act requires the Auditor General to conduct a program audit simultaneously with the biennial financial audit of the Department of Mental Health and Developmental Disabilities (DMHDD). This audit requirement was added by Public Act 86-1013 (30 ILCS 5/3-2), effective January 3, 1990 (Appendix A). The program audit is to report trends or patterns of suspected resident abuse and neglect (referred to collectively as "abuse" in this report) of DMHDD facility residents. This audit deals primarily with reports of "alleged" resident abuse and not with "substantiated" cases of abuse. There are many allegations of abuse that are not substantiated by subsequent investigation.

The Office of the Auditor General has previously completed three program audits on the reporting of resident abuse. In May 1990, the Auditor General released a program audit which included an examination of the reporting of resident abuse. Program audits reporting on trends and patterns of alleged abuse were released in November 1992 and June 1994.

Public Act 89-0427, effective December 7, 1995, amended Section 3-2 of the Illinois State Auditing Act to obviate additional audits of abuse reporting "for any year for which the Inspector General submits a report to the Governor and General Assembly as required under Section 6.7 of the Abused and Neglected Long Term Care Facility Residents Reporting Act." Public Act 89-0427 also extended the requirement that the Auditor General conduct biennial program audits of the Inspector General's effectiveness in investigating abuse allegations.

REPORT CONCLUSIONS

Abuse allegations increased from 903 in Fiscal Year 1993, to 938 in Fiscal Year 1994, and to 984 in Fiscal Year 1995. During the same period the population at DMHDD's 21 residential facilities decreased 12 percent from 6,832 to 6,039. Office of Inspector General (OIG) officials stated that they are currently investigating the reasons for the increase in abuse allegations.

We identified several areas in the facilities' reporting of abuse allegations where improvements are needed:

- **Facilities did not report all incidents, such as abuse allegations and resident injuries, as required by State law and DMHDD policy. In our 1994 audit, we found 23 reportable incidents in 630 resident files reviewed which were not reported to the OIG. In this audit, the number of**

unreported incidents increased to 28 in 630 resident files; 6 of the 28 unreported incidents were abuse allegations. There were an additional 5 unreported injuries in 630 injury reports reviewed.

- Facility staff need to improve the documentation of allegations; basic information was not provided on reporting forms. Telephone notification of the OIG was not documented on the OIG Incident Report Form in 105 (6 percent) of the 1,899 abuse allegations reviewed and the OIG mail notification date was not documented on 129 (7 percent) of the 1,899 allegations. DMHDD officials stated they encourage facility staff to forward these initial reporting forms promptly and not to hold them to ensure proper paper documentation.

- The timeliness of facilities' abuse reporting needs improvement. We found that 20 percent of abuse allegations were not reported to the Illinois Department of Public Health (IDPH) hotline within 24 hours. Also, 33 percent of abuse allegations involving residents less than 18 years old were reported to the Department of Children and Family Services (DCFS) more than 24 hours after discovery. State law requires "immediate" reporting to DCFS.

- We found that 25 percent of the allegations reviewed did not contain all the required initial written statements concerning what employees might have observed regarding an abuse allegation. DMHDD officials stated they are considering a variety of approaches to ensure that written statements are gathered from all appropriate staff.

DMHDD's incident reporting policy has not been updated since 1990. We identified several areas where the policy needs to be revised; facility directors and staff also commented that revisions to the policy were needed. The Department was in the process of revising its reporting policy at the end of our audit fieldwork, in December 1995.

The nature of the non-compliance with reporting policies found in this audit indicates that additional training of facility staff in incident reporting is needed. According to OIG officials, the Department is reviewing its current training program related to incident reporting.

As in prior audits, there was a wide variation in the number of abuse allegations reported by DMHDD facilities. Abuse allegation rates at mental health facilities continued to run at least twice as high as the rates at developmental facilities. Facilities serving both the mentally ill and developmentally disabled have had the highest abuse allegation rates two of the past three years. We found that residents were often

involved in multiple abuse allegations; 138 residents were mentioned in three or more abuse allegations.

Finally, the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6.7) requires that the Inspector General submit to the General Assembly and Governor an annual report analyzing trends on the number of allegations and their disposition no later than January 1 following the end of a fiscal year. The OIG did not issue the Fiscal Year 1995 annual report until March 1996.

BACKGROUND

The Department of Mental Health and Developmental Disabilities (DMHDD) provides care and treatment to mentally ill and developmentally disabled citizens of Illinois. Exhibit 1-1 shows that the resident population at DMHDD's 21 residential facilities decreased from 7,961 residents in Fiscal Year 1990 to 6,039 residents at the end of Fiscal Year 1995.

Exhibit 1-1
DMHDD FACILITY CENSUS & ABUSE ALLEGATIONS

Fiscal Year	Census	Abuse Allegations
1990	7,961	857
1991	7,722	954
1992	7,642	1,079
1993	6,832	903
1994	6,428	938
1995	6,039	984

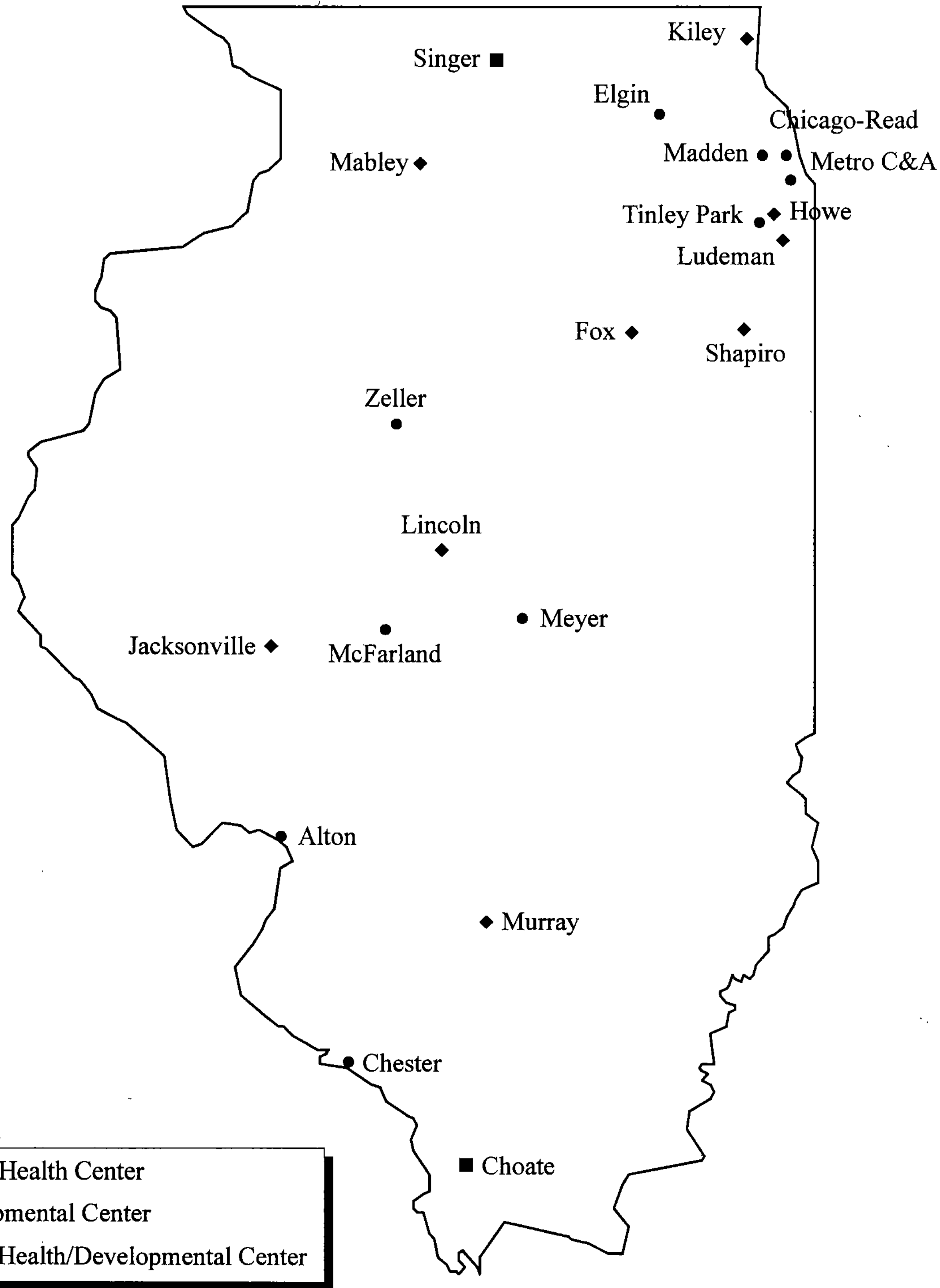
Source: DMHDD/OIG Reports
Note: Census figures at end of Fiscal Year

Although the number of facility residents has been decreasing for several years, abuse allegations increased from 903 in Fiscal Year 1993, to 938 in Fiscal Year 1994, and to 984 in Fiscal Year 1995. DMHDD's Inspector General stated that the OIG did not know whether the increase in reporting was due to better training and a heightened staff awareness or to characteristics of the individuals served in Department facilities. OIG officials said they are currently studying this issue.

In Fiscal Years 1994 and 1995, nine State-operated residential facilities served the developmentally disabled, ten facilities served the mentally ill, and two facilities served both groups. During Fiscal Year 1994, DMHDD reorganized the functional and operational responsibilities of several facilities. The adult units at the Illinois State Psychiatric Institute (ISPI) were closed and transferred to Madden Mental Health Center (MHC) and the University of Illinois at Chicago. The adolescent units at Chicago-Read MHC and ISPI were transferred to Chicago Metropolitan Child and Adolescent Services (Metro C&A), a restructured and renamed child and adolescent mental health center. Also, although the Meyer MHC closed December 31, 1995, it was in operation during the entire audit period. Exhibit 1-2 shows the location of DMHDD's 21 residential facilities.

Exhibit 1-2

DMHDD RESIDENTIAL FACILITIES



Source: OAG Analysis of DMHDD data

REPORTING REQUIREMENTS

State law establishes requirements for reporting suspected abuse of mental health or developmental center (DC) facility residents to the Illinois Department of Public Health (IDPH), the Department of Children and Family Services (DCFS), and the OIG. DMHDD's Policy and Procedures Directive 01.05.06.03 (PPD) contains requirements for DMHDD facilities to report incidents, of which resident abuse is one category.

The Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/1-16) (Act) requires all persons who provide services or have direct contact with residents to report all incidents of suspected abuse immediately to the Illinois Department of Public Health. Under terms of the Interagency Agreement between IDPH and OIG, employees of DMHDD State-operated facilities are to complete an OIG Incident Report Form for all allegations of abuse and other specified incidents and transmit a copy by facsimile to a 24-hour toll-free number established by IDPH. DMHDD's PPD requires that reports be made immediately upon becoming aware of the incident, but no later than the end of the next calendar day after the incident was discovered. The Act allows IDPH to delegate public agencies to perform the actual investigation. The agreement makes the OIG responsible for conducting or monitoring investigations of alleged abuse at DMHDD facilities.

DMHDD's PPD requires that after reporting to the IDPH Hotline, facility directors or their designee must also report all allegations of abuse and certain other incidents to the OIG promptly by telephone. This telephone report must be made no later than the end of the next working day after the incident was discovered; all reportable incidents, as defined in the PPD, must also be reported by mail to the OIG within seven calendar days. Additionally, the PPD requires that for every allegation of resident abuse, each employee on duty and in the area furnish, before the end of that employee's shift, a signed and dated report of what he or she observed or heard relative to the incident.

The Abused and Neglected Child Reporting Act (325 ILCS 5/1-11) mandates that all field personnel of DMHDD, among others, immediately report incidents of suspected abuse of recipients under the age of 18 to the Department of Children and Family Services' (DCFS) State Central Register (SCR). DCFS maintains a single State-wide toll-free telephone number which persons, whether mandated or not, may use to report the suspected abuse of a child. Reports by persons mandated to report under the Act are to be confirmed in writing within 48 hours of the initial report. SCR staff receive the reports and determine whether or not the information given meets the DCFS criteria for a report to be "taken." If the report is taken, the critical information is entered into SCR's Child Abuse/Neglect Tracking System, which automatically assigns a SCR case number. Information is forwarded to a DCFS Child Protective Services Unit which initiates an investigation. DCFS conducts its own investigations at the facilities but may coordinate its investigations with the OIG. DMHDD's PPD specifies that the facility director or designee notify the DCFS Child Abuse

Hotline "immediately" by telephone and confirm the notification in writing by submitting a written report to the SCR within 24 hours of the Hotline report.

Exhibit 1-3 shows the types of incidents reportable to the OIG as defined in the PPD. The categories of abuse include occurrences or allegations of employee mistreatment of residents, including physical abuse requiring emergency medical treatment, other physical abuse, sexual abuse, and verbal/psychological abuse. Neglect includes but is not limited to an act or omission by an employee that places the resident's physical or psychological health or safety at risk.

Exhibit 1-3
TYPES OF INCIDENTS REPORTABLE TO THE INSPECTOR GENERAL

ABUSE AND NEGLECT	OTHER REPORTABLE INCIDENTS
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	1f. 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. All other allegations of misconduct, malfeasance, misfeasance or other conduct serious enough to warrant reporting

Source: DMHDD Policy and Procedures Directive 01.05.06.03

This report addresses trends in the reporting of abuse allegations at DMHDD facilities. A program audit of the OIG, scheduled for release in late 1996, will address abuse allegation substantiation rates, as well as the effectiveness of OIG investigations.

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.

Incident reporting information was collected during our financial and compliance audits of each DMHDD facility for the two years ended June 30, 1995. We collected and analyzed resident abuse data from the Office of the Inspector General and DMHDD facilities to determine trends and patterns of abuse allegations. We compiled data from the files of abuse allegations reported at each facility. We tested for compliance with applicable laws, rules, and policies. We conducted a survey of facility directors, their designees, and direct care staff.

In Fiscal Year 1994, 938 abuse allegations were reported to the OIG and in Fiscal Year 1995, 984 abuse allegations were reported for a two-year total of 1,922. Based on abuse allegation information provided by DMHDD for Fiscal Years 1994 and 1995, we constructed our own database of abuse allegations. We found some instances where we concluded multiple allegations had been reported on a single DMHDD-107 incident report. In these cases, we entered each allegation separately into our database. Other allegations which we concluded had been misclassified as abuse or neglect or contained incomplete information were not entered into our database. As a result, our database for the same two year period contained 1,899 abuse allegations.

There were three audit objectives to assess the effectiveness of facilities' reporting of resident abuse. The first objective was to determine whether all reportable incidents were reported to the OIG. We addressed this objective by reviewing 30 resident files at each facility to identify unreported incidents, including abuse allegations, and 30 injury reports at each facility. We also examined the OIG's initiatives to identify instances of non-reporting of reportable incidents.

The second audit objective was to determine whether abuse allegations were reported promptly and correctly. To fulfill this objective we determined the intervals between the date and time of discovery of the abuse allegation and the reporting to the facility director, DCFS, IDPH, and the OIG. We also determined whether the incident reports included complete information required by the PPD and whether employees filled out written statements as appropriate.

The third audit objective was to determine patterns and trends related to abuse allegation reporting. We collected and analyzed information on the number and type of allegations reported by all facilities and individual facilities, resident demographics, and the time and location of the alleged incident. We used data presented in our prior program

audits (May 1990, November 1992, June 1994) as a base for measuring agency performance.

We reviewed DMHDD and individual facility policies and procedures related to reporting resident abuse allegations. We also examined other management controls, such as the OIG's review of facility incident reporting. We relied on the audit work of the Auditor General's contract auditors in connection with the financial and compliance audits to identify other areas where individual facility management controls needed to be improved.

The scope of this audit focused on DMHDD facilities' reporting of abuse allegations; we did not examine the effectiveness of the incident report processing systems at the Department of Public Health or the Department of Children and Family Services. See Appendix B for additional information on our audit methodology.

REPORT ORGANIZATION

Chapter Two reviews underreporting of incidents by facilities, examines DMHDD facility practices regarding incident reporting, and analyzes incident reporting policies and procedures.

Chapter Three examines incident reporting patterns and trends at DMHDD facilities.

Chapter Four discusses other issues related to incident reporting.

CHAPTER TWO
REPORTING PRACTICES AND POLICIES

As found in previous audits, facilities did not report incidents as required. In this audit we identified a total of 28 unreported incidents, including 6 unreported abuse allegations from our review of 630 resident files; in our 1994 audit, we identified 23 unreported incidents from this review, which included 2 unreported abuse allegations. In this audit we also reviewed 630 injury reports and found 5 additional unreported injuries.

DMHDD facilities need to improve their reporting of abuse allegations to IDPH, DCFS, and the OIG. We found that 20 percent of abuse allegations were not reported to the IDPH hotline within 24 hours. Also, 33 percent of abuse allegations involving residents less than 18 years old were reported to DCFS more than 24 hours after discovery. State law requires "immediate" reporting to DCFS. We also found that documentation on incident report forms needs to be improved and that required employee written statements were not being routinely completed.

The Department's incident reporting policy has not been updated since 1990. Based on the findings in this audit and comments from facility directors and staff, the policy needs to be updated. Also, additional training in incident reporting may be needed by facility staff. The Department was in the process of updating the incident reporting policy at the close of audit fieldwork (December 1995) and was examining the incident reporting training program for staff.

FACILITY REPORTING PRACTICES

For an abuse reporting system to be effective, allegations must be adequately documented and reported in a timely manner to the appropriate parties for investigation. Based on our review of the abuse reporting practices at DMHDD's 21 facilities, improvements need to be made. We identified incidents, including abuse allegations, which were not reported as required by State law and DMHDD policy. In addition, reporting time guidelines were not always met, basic information was missing from many reporting forms, and some required employee statements were missing.

Unreported Allegations

Facilities continued to not report all incidents required by State law and Department policy. Failure to report all incidents required by Department policy could compromise resident safety and the credibility of the incident reporting system.

In this and prior audits, we reviewed a random sample of 30 resident files at each of the 21 residential facilities to determine if any incidents should have been reported but were not. DMHDD employees are required to report all abuse allegations and certain other incidents; therefore, our file reviews included testing for all incidents reportable under DMHDD policy.

Exhibit 2-1
UNREPORTED INCIDENTS AND ABUSE ALLEGATIONS IN OAG PROGRAM AUDITS
(Review of Resident Files)

Year Audit Issued	Total Unreported Incidents	Unreported Abuse Allegations
1992	18	0
1994	23	2
1996	28*	6

*Does not include 5 unreported injuries identified in our review of injury reports.

Source: OAG review of 630 resident files.

Our review of the 630 resident files found an increasing number of unreported incidents and abuse allegations over past audits, as shown in Exhibit 2-1. The number of unreported incidents identified in our review of 630 resident files increased from 18 in the 1992 audit, to 23 in our June 1994 audit, and to 28 in this audit. Our sample of 630 resident files in this audit identified 935 reportable incidents, of which, 28 were unreported. Included in the 28 unreported incidents identified in this audit were 6 allegations of abuse and 1 instance of improper employee conduct. This is an increase over prior audits in the number of abuse allegations that were unreported. Exhibit 2-2 provides examples of unreported incidents.

Exhibit 2-2
EXAMPLES OF UNREPORTED INCIDENTS

- Resident received large (8" x 4") bruise between shoulder blades apparently after having been struck by a resident.
- Resident ingested rat poison and was taken to emergency room.
- Resident had sexual relations with another resident.
- Resident received abrasions and swelling to head while being transported in a wheelchair with head supports installed backwards, with the rough edges to the inside.
- Resident was found crying and holding arm upon her return from workshop. X-rays showed fractured humerus; cause unknown.

Source: OAG review of resident files

Because of our prior audits' findings on underreporting, in this audit we expanded our testing to include 30 DMHDD-108's (Injury Reports) at each facility. In the sample of 630 injury reports, we found 125 reportable injuries, 5 of which were not reported to the OIG.

Department of Mental Health and Developmental Disabilities' Comment:

Although there is still room for improvement, we are pleased that your audit found that more than 95% of the incidents were reported to OIG.

Several of the facilities with underreporting findings in prior audits continued to have findings in this audit. In addition to the findings in this audit, we reported on findings of unreported incidents at Chester MHC, Howe DC, Madden MHC and Singer Mental Health and Developmental Center (MHDC) in our November 1992 audit, at Jacksonville DC in our June 1994 audit, and at Kiley DC in both our November 1992 and June 1994 audits. Exhibit 2-3 shows the number and type of unreported incidents by facility for both the sample of 630 resident files and the sample of 630 injury reports.

Exhibit 2-3
UNREPORTED INCIDENTS

FACILITY	UNREPORTED INCIDENTS	NUMBER AND TYPE OF UNREPORTED INCIDENTS
Alton MHC	4	1 Allegation of sexual abuse 1 Allegation of physical abuse 2 Resident on resident injuries
Chester MHC	2	2 Allegations of verbal abuse
Howe DC	1	1 Injury requiring emergency treatment
Jacksonville DC	4	1 Injury requiring emergency treatment 3 Resident on resident injuries
Kiley DC	5	3 Injuries requiring emergency treatment 2 Resident on resident injuries
Ludeman DC	6	1 Allegation of improper employee conduct 1 Injury requiring emergency treatment 4 Resident on resident injuries
Madden MHC	3	1 Injury requiring emergency treatment 2 Resident inappropriate sexual conduct
Murray DC	6	2 Allegations of neglect 3 Injuries requiring emergency treatment 1 Resident on resident injury
Singer MHDC	2	1 Resident on resident injury 1 Resident inappropriate sexual conduct
Total	33	

Source: OAG sample of 630 resident files and 630 injury reports.

Our June 1994 audit contained the recommendation that DMHDD adopt stronger measures to ensure that facility personnel report incidents as required and that DMHDD implement procedures to monitor facilities for underreporting. DMHDD accepted the recommendation and stated that the OIG would test for underreporting during its annual surveys of each facility.

The OIG has reviewed underreporting at all facilities (except Meyer, which was scheduled for closure). The OIG examined 594 resident files for four selected months of Fiscal Year 1994 and found 12 unreported incidents (Chester - 1, Choate - 1, Howe - 2, Metro C&A - 1, Tinley Park - 7).

For this audit, as well as for our previous audits, our method of testing for underreporting was to examine facility records to identify documented reportable incidents, including abuse allegations, and then determine whether they were appropriately reported. Reasons cited in facility compliance audits for underreporting included employee oversight and employee misinterpretation of reporting guidelines.

We also asked direct care and support staff at each facility to estimate the percentage of unreported abuse allegations at their facility. For facilities that quantified their responses, the median estimates of unreported abuse allegations were less than or equal to 5 percent at 18 facilities and greater than or equal to 10 percent at one facility (Kiley). In response to our survey of facility directors, Kiley's director stated that he is unaware of any unreported abuse allegations, but he stated that a poll was taken and found the following situations that could contribute to underreporting of abuse and neglect: peer pressure, lack of understanding of milder forms of abuse, staff being unaware of the details of policy, lack of staff stability, fear of discipline, and reprisal from co-workers.

In addition to finding allegations unreported by DMHDD facilities, we also found instances where the number of allegations was understated. During our incident file reviews we found 35 OIG Incident Reports that contained multiple separate and distinct allegations of abuse. The PPD does not specify whether or not multiple allegations can be reported on a single OIG Incident Report Form.

An example of this type of reporting involved a case where a staff member was accused on a single form of the following separate incidents: (1) pushing/dragging and verbally abusing a resident, (2) making derogatory statements to and about another resident, and (3) physically harming another resident. Another example involved a resident who accused one facility employee of hitting him three times with a clipboard, and who accused the same employee of slapping and pulling the hair of another resident; although these incidents allegedly occurred about two weeks apart, they were reported as one incident. While technically these additional allegations were reported to the OIG, reporting of multiple allegations on a single reporting form understates the actual number of abuse allegations.

Incomplete Documentation of Abuse Allegations

Facility reports on abuse allegations were often incomplete. Our reviews found deficiencies in both quality and content of the information contained on the submitted incident report forms, the source document for pertinent information regarding an incident. Information surrounding an incident must be complete and accurate to ensure effective investigations. Incident reports must adequately describe what occurred, to whom it occurred, when it occurred, and other relevant information. Some of the documentation problems we identified were:

- The narrative descriptions of incidents on many incident report forms did not clearly describe who was involved.
- Telephone notification of the OIG was not documented on the incident reporting form in 105 (6 percent) of the 1,899 abuse allegations reviewed and the OIG mail notification date was not documented in 129 (7 percent) of the 1,899 allegations.
- Misclassifications of the type of incident, such as a narrative describing one resident hitting another resident, but the incident classified on the incident report form as "physical abuse by staff."

Reasons for incomplete documentation of abuse allegations included employee oversight and inattentiveness to detail. We discussed the incomplete and inaccurate forms with personnel from the OIG. An OIG official indicated that the Inspector General's office was aware of the inaccuracies and incompleteness of submitted incident report forms, but the OIG was more concerned with allegations being reported as soon as they occurred so investigations could be initiated in a timely manner. While timeliness of reporting is important, accurate and complete documentation about the incident is also crucial to the subsequent investigation.

Department of Mental Health and Developmental Disabilities' Comment:

We have encouraged facility administrative staff to forward these initial reporting forms to OIG promptly, and not to hold them to ensure proper paper documentation.

We also were unable to determine if the facilities complied with the DCFS reporting requirements for 92 allegations because the incident report forms for these allegations had neither a DCFS notification date nor any notation in the narrative indicating the Hotline was notified. The OIG case number for these incidents could not be reconciled with DCFS's State Central Register (SCR) case numbers because the respective indexing methods are

incompatible. DCFS's information for allegations reported by DMHDD facilities in Fiscal Year 1994 and Fiscal Year 1995, for which reports were either not taken by DCFS or were taken and disposed of as "unfounded," was unavailable for comparison. If a SCR call floor worker determined that the information provided by a facility mandated caller did not meet the DCFS criteria for an abuse allegation report to be taken, the information would not have been entered into the SCR's Child Abuse/Neglect Tracking System. Additionally, if a report from a mandated caller was taken, but the subsequent DCFS investigation determined the allegation was "unfounded," the information for that incident would have been removed from the system after 39 days.

Timeliness of Abuse Allegation Reporting

DMHDD facilities need to improve the timeliness of their reporting of abuse allegations to facility directors, the Illinois Department of Public Health (IDPH), the Department of Children and Family Services (DCFS), and the DMHDD Office of Inspector General (OIG). Prompt reporting can help preserve the quality of evidence and witness testimonies for use in substantiating abuse allegations.

Timeliness of Reporting to Facility Directors

DMHDD's incident reporting policy states that the reporting person must immediately, and in no event later than the end of that person's shift, complete an incident report form and submit it directly to the facility director or designee. In 91 percent (1,636 of 1,797) of the allegations reviewed which had both the discovery time and the facility director reporting time, the facility director was notified no more than eight hours after discovery; in 9 percent (161 of 1,797) of the allegations reviewed, more than eight hours passed from the time an incident was discovered until it was reported to the facility director. Exhibit 2-4 shows facilities with the highest percentages of abuse allegations reported to facility directors more than 8 hours after discovery.

Exhibit 2-4
ALLEGATIONS REPORTED TO FACILITY DIRECTORS MORE THAN 8 HOURS AFTER DISCOVERY
(Five Highest Percentages)

(FY94-FY95)

FACILITY	% OVER 8 HOURS
METRO C&A	24%
SINGER	21%
MURRAY	20%
ZELLER	18%
KILEY	16%

SOURCE: OAG analysis of DMHDD facility files.

Timeliness of Reporting to Department of Public Health

We compared information from DMHDD's reporting forms with IDPH records and found that DMHDD facilities reported 1,888 of 1,899 abuse allegations to IDPH. Two facilities accounted for 7 of the 11 unreported allegations to IDPH: Metro C&A (4) and Choate MHDC (3). The Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/1-16) requires immediate reporting of suspected abuse of facility residents to the IDPH hotline. IDPH's administrative rules (77 Ill. Adm. Code 400.100) define "immediate" as within 24 hours. DMHDD's PPD requires reporting by the end of the next calendar day, which conflicts with IDPH administrative rules. These conflicting reporting requirements are discussed more fully later in this chapter.

Exhibit 2-5
ALLEGATIONS REPORTED TO IDPH MORE THAN 24 HOURS AFTER DISCOVERY
(Five Highest Percentages)

(FY94-FY95)

FACILITY	% OVER 24 HOURS	% OVER 1 CALENDAR DAY
ZELLER	68%	52%
MEYER	39%	22%
METRO C&A	35%	31%
HOWE	32%	17%
LUDEMAN	23%	11%

SOURCE: OAG analysis of DMHDD facility files.

Of the 1,742 allegations which had both an incident discovery time and an IDPH reporting time, almost 20 percent (340) were reported to IDPH 24 hours or more after the time of discovery. Forty percent (705) were reported to the hotline no more than 8 hours after discovery; 697 (40 percent) were reported from between 8 to 24 hours after discovery.

Exhibit 2-5 shows the five facilities with the highest percentages of abuse allegations reported to IDPH more than 24 hours after discovery. It also provides the percentage reported late using DMHDD's time requirement for reporting by the end of the next calendar day. For all facilities, 243 of 1,888 allegations (13 percent) were reported to IDPH two or more calendar days after discovery.

Timeliness of Reporting to Department of Children and Family Services

DMHDD facilities need to improve compliance with DCFS notification requirements. The Abused and Neglected Child Reporting Act (325 ILCS 5/1-11) mandates that all field personnel of DMHDD, among others, immediately report incidents of suspected abuse of persons under the age of 18 to DCFS.

Of the 166 abuse allegations reviewed that required DCFS notification, only 57 cases contained both discovery and documented DCFS notification dates and times, 17 contained incomplete DCFS and discovery notification information, and 92 did not contain any DCFS notification information. The PPD requires only that DCFS be notified as appropriate, it does not require facilities to document the DCFS notification time. Of the 57 cases with a DCFS notification date and time, 26 (46 percent) were reported to the Hotline within less than 8 hours after discovery, 12 (21 percent) were reported from between 8 to 24 hours after discovery, and 19 (33 percent) were reported more than 24 hours after discovery. Examples of allegations that were reported to the Hotline more than one day after discovery include:

- Seventeen year-old resident alleged that a facility employee grabbed her around the neck. This allegation was reported by DMHDD staff to DCFS three days after the resident made the allegation. (Reported to OIG on discovery date.)

- Thirteen year-old resident alleged that two facility employees twisted his legs. This allegation was reported by DMHDD staff to DCFS eight days after the resident made the allegation. (Reported to OIG one day after discovery.)

Timeliness of Reporting to the Inspector General

The timeliness of facilities reporting of abuse allegations to the OIG decreased slightly since our 1994 audit, in which we found that 95 percent of abuse allegations sampled were reported within the one working day period specified in the PPD. In this audit, of the 1,791 abuse allegations with both a phone notification and discovery date listed on the incident report form, 1,682 (94 percent) were reported within one working day. Exhibit 2-6 shows the facilities with the higher non-compliance rates.

Exhibit 2-6
ALLEGATIONS REPORTED TO OIG LATER THAN END OF NEXT WORKING DAY
(Five Highest Percentages)

(FY94-FY95)

FACILITY	% LATE
METRO C&A	27%
CHICAGO-READ	16%
CHESTER	13%
ZELLER	13%
MURRAY	11%

SOURCE: OAG analysis of DMHDD facility files.

There were 109 allegations (6 percent) where OIG phone notification listed on the incident report form was from 2 to 79 days after discovery, with 34 of these 109 allegations reported 6 or more days after discovery. Exhibit 2-7 contains examples of allegations with delayed reporting to OIG.

A high percentage of allegations was reported by mail within the 7-day period specified in the PPD. Of the 1,767 abuse allegations with a mail notification and discovery date listed on the incident report form, 1,741 (98.5 percent) were reported within the required 7-day period. We calculated reporting intervals between the day the incident was discovered and the day on which the OIG was notified of the allegation by mail, telephone, or facsimile.

Reasons for untimely reporting to the OIG included employee oversight, employee misinterpretations of reporting requirements, and delays between the time incidents are discovered and the time that the facility designee receives the reports.

Exhibit 2-7
EXAMPLES OF ALLEGATIONS WITH DELAYED REPORTING TO OIG

- Resident allegedly was struck in eye by facility employee. Reported to facility director on discovery date, but not reported to OIG until 8 days later. File did not indicate a reason for this delay.
- Resident and her mother alleged the resident was neglected while in full leather restraints during the entire night shift. Reported to facility director on the day of discovery, but not reported to OIG until 54 days later. File did not indicate a reason for this delay.
- Resident's mother alleged her daughter was sexually abused by a male facility employee. Incident form completed on the day of discovery, but the facility director did not receive the report until 25 days later. Director reported to OIG two days later. The OIG concluded that the incident was not reported in a timely manner because "the program of the person receiving services was written with instructions contrary to Departmental Policy and Procedure."
- Resident alleged physical abuse by staff. Both the facility director and the OIG were notified 79 days after discovery. File did not indicate a reason for this delay.

Source: OAG Review of DMHDD Data

Employee Written Reports Not Completed

We found instances where facilities did not comply with the Department's requirement that staff complete written reports documenting their knowledge of abuse allegations. DMHDD's reporting policy requires "each employee on duty and in the area to furnish, before the end of that employee's shift, a signed and dated report of what he/she observed and/or heard relative to the incident. If he/she observed and heard nothing relative to the incident, a written report stating this still must be submitted." Such statements are an important source of information for the subsequent investigation of allegations.

To determine whether such reports were being completed, we reviewed the incident reporting forms, which require the listing of all persons present when the incident occurred. The incident files were then reviewed to determine whether the identified staff completed written reports. One or more employee written reports were not provided in 414 of 1,662 (25%) incident report forms examined.

Department of Mental Health and Developmental Disabilities' Comment:

We are reviewing the process of gathering these initial written statements, and are considering a variety of approaches to ensuring that they are gathered from all appropriate staff.

We also found instances where employee written reports were not completed before the end of the employee's shift. Reasons for findings regarding employees not completing required statements included inattentiveness to detail by employees and misinterpretation of reporting requirements.

RECOMMENDATION NUMBER 1

The Department of Mental Health and Developmental Disabilities should adopt stronger measures to ensure that facility personnel report incidents as required by the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/1-16) and DMHDD Policy and Procedures Directive 01.05.06.03. Specifically, the Department should:

- ***a. Strengthen controls to ensure that facility personnel report all incidents as required;***
- ***b. Improve the timeliness of facilities' reporting of incidents to the Department of Public Health, the Department of Children and Family Services, and the Office of the Inspector General;***
- ***c. Implement review procedures to ensure that incident report forms are properly and fully completed; and***
- ***d. Ensure that staff complete the required written reports before the end of their shift.***

Department of Mental Health and Developmental Disabilities' Response:

We accept this recommendation. We are increasing our efforts at reviewing the timeliness and completeness of reporting of incidents from the facilities. We are also reviewing each facility to determine the best possible approach to ensuring that all initial written statements are submitted.

DMHDD REPORTING POLICIES

DMHDD's incident reporting policy needs to be updated. In addition, some facilities' reporting policies and procedures are not consistent with the Department's PPD. The non-compliance with reporting requirements, coupled with survey responses from facility directors and staff, indicates that additional training of staff on incident reporting is needed.

DMHDD Reporting Policy

The Department's policy regarding facility incident reporting needs to be revised. The policy was last revised in 1990; the Department was in the process of revising it at the end of fieldwork (December 1995).

We interviewed and surveyed the facility directors, their designees and direct care staff of DMHDD's 21 residential facilities to assess their support for the incident reporting system and to determine if policies provided sufficient guidance regarding reporting responsibilities. Nineteen of 21 facility directors and 21 facility director's designees responded to our survey questionnaires, and we interviewed 210 facility direct care and support staff. Facility directors and their designees were asked if the PPD provided sufficient guidance on the reporting of incidents and if there were areas that could be improved. Some suggested improvements were:

- Simplify and rewrite the PPD;
- Address the notification requirements to guardians in instances of alleged abuse; and
- Reduce reporting requirements where reporting is not productive.

Facility directors also cited a need to develop a specific definition in the PPD for injuries which are serious enough to require emergency medical treatment by a physician.

The PPD requires such injuries to be reported to the OIG. Questions have arisen over what constitutes "emergency medical treatment." For example, a resident at Howe DC was running and ran into another recipient, causing him to break his upper arm bone. Although the attending physician classified this injury as moderately severe, the incident was not reported to the OIG.

The PPD is also inconsistent with reporting requirements found in the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/1-16) and the related administrative rules. The Act requires "immediate" reporting of abuse allegations to the Department of Public Health; IDPH's administrative rules (77 Ill. Adm. Code 400.100) define immediate reporting as that which occurs within 24 hours. The PPD requires immediate reporting to IDPH no later than the end of the next calendar day after the incident's discovery. If an incident were to be discovered, for example, at 1 a.m. on a Tuesday, and reported to IDPH at 11 p.m. on Wednesday, the reporting of that incident would comply with DMHDD policy but far exceed the 24-hour reporting requirement specified in IDPH's administrative rules.

Department of Mental Health and Developmental Disabilities' Comment:

By request of IDPH, our policy requires reporting only by the end of the next calendar day. However, we are considering requiring that these reports be made within 24 hours.

The PPD also requires reporting of incidents to the OIG "no later than the end of the next working day after the incident was discovered"; it is not specified whether this statement refers to the facilities' working day or the OIG's working day. The PPD does state that the OIG is available to receive reports from facilities during the OIG's normal working hours, which are from 8:00 a.m to 5:00 p.m. Monday through Friday. If an abuse allegation is discovered on a Friday afternoon, and the following Monday is a holiday, then a report could be filed to the OIG the following Tuesday and still comply with PPD requirements. OIG officials stated that if a serious incident occurs during non-business hours, the facility will attempt to notify the OIG investigator assigned to the facility, even on weekends and holidays.

The time periods in which DMHDD staff are required to report abuse allegations to IDPH and to the OIG vary. As stated earlier, IDPH's administrative rules define the required reporting time as within 24 hours, State law requires immediate reporting to IDPH, and DMHDD's PPD requires reporting to the OIG no later than the end of the next *working* day and to IDPH by the end of the next *calendar* day. A uniform reporting time, such as 24 hours, for reporting abuse allegations to both IDPH and to the OIG may help resolve any confusion over reporting times for facility staff.

Some facility staff also stated that their reporting of an incident to the OIG investigator assigned to the facility satisfies the PPD's abuse allegation notification requirements to the OIG. However, this notification is not always documented on the incident reporting form. The practice of reporting abuse allegations to facility investigators and related procedures are not contained in the Department's PPD on incident reporting.

As discussed earlier in this chapter, we could not ascertain the date and time DCFS was notified in 92 (55 percent) of the allegations we reviewed involving alleged abuse of residents less than 18 years old. The PPD does not require that the DCFS reporting time be recorded on the incident reporting form.

As noted earlier in the chapter, the PPD does not specify whether or not more than one incident may be reported on an OIG Incident Report Form (DMHDD-107). The PPD details procedures for facility staff to follow upon becoming aware of a reportable incident, as defined in the policy. The PPD delineates the procedures as they relate to an individual reportable incident. The PPD, however, does not specify whether it is appropriate to report more than one allegation on the DMHDD-107.

DMHDD's reporting policy currently does not address whether or not staff accused of an abusive act should be completing the incident report form. We noted several allegations where the incident report form was filled out and submitted by the alleged staff perpetrator of an abuse incident; this practice may impair the objectivity of the reports filed. One example involved a DMHDD employee of Jacksonville DC who filled out an incident report form stating that a resident stated that: "I [the employee] was making fun of her, that I was wanting to hurt her, calling her names. . . .for the whole time she was on the third floor she was making false accusations against myself and staff."

Facilities' Incident Reporting Policies And Procedures

The PPD states that facility directors cannot "modify or change the definitions or procedures" defined in the policy. Nevertheless, we found the following inconsistencies between facilities' policies and the PPD:

- Two facilities (Choate and Kiley) mention that injuries requiring emergency medical treatment by a physician include "injuries which are life threatening." The PPD makes no such distinction.

- Three of the 21 facilities (Meyer, Murray and Ludeman) included as reportable incidents four classifications of employee injuries. The PPD does not include employee injury as a reportable incident.

- Meyer MHC's policy does not require immediate reporting of all abuse allegations involving residents under 18 years old. If after hours, the Facility Nurse is to assure that program staff notify the DCFS hotline immediately only in cases of alleged abuse or neglect or other incidents which may result in criminal charges involving a minor recipient (under the age of 18). The PPD requires immediate reporting to DCFS and does not limit reporting to DCFS only in criminal cases.

We found that facilities had the following types of controls over incident reporting:

- daily reviews by administrative, supervisory, professional, and unit staff of incident report forms and unusual incident reports;
- regular meetings by facility administrative staff with residents and staff; and
- inspections to observe any non-therapeutic interactions.

Direct care and support staff were asked if reporting policies at individual facilities were clear and understandable. Ninety-three percent (195 of 210) responded favorably and 7 percent (15 of 210) said policies were unclear. Some of the reasons cited were that the forms are too confusing, procedures are too detailed, and reporting criteria keep changing so employees are unsure of requirements.

Given the reporting problems identified earlier in this chapter, the management controls at DMHDD facilities are not ensuring that the reporting of abuse allegations is complying with State law and Department policy.

As stated earlier, the OIG conducts reviews of incident reporting timeliness and potential underreporting of incidents at DMHDD facilities. Results of the OIG's review found underreporting at five facilities and 67 (11.9%) of 565 incidents reported late to the OIG by telephone. The findings are required to be reported to the facilities and summarized in a report to the Inspector General.

DMHDD Training Policies

When asked what could be done to improve the reporting of incidents of abuse, facility respondents frequently mentioned PPD clarification and continued staff training. When asked what could be done to improve the perceived deficiencies in the incident reporting policy, several staff stated that more training or retraining of staff was needed.

Currently, the only required training on abuse reporting is during new employee orientation. Some facilities provide periodic training updates when a need is perceived or

when an employee requests it. The problems noted earlier in this chapter related to underreporting and untimely reporting of incidents, incomplete documentation on incident report forms, and missing employee written reports, coupled with survey responses from facility staff and management, suggest that additional training for facility staff on the reporting of incidents is needed. The Department was in the process of updating the incident reporting policy at the close of audit fieldwork (December 1995) and was examining the incident reporting training program for staff.

RECOMMENDATION NUMBER 2

The Department of Mental Health and Developmental Disabilities should revise Policy and Procedures Directive 01.05.06.03. Consideration should be given to:

a. Including a working definition for resident injuries which require "emergency medical treatment";

b. Requiring reporting of allegations to the Department of Public Health and to the Office of the Inspector General within 24 hours or less;

c. Incorporating policies and procedures for reporting of abuse allegations to facility investigators;

d. Revising the incident reporting form to require documentation of reporting times to the Department of Children and Family Services;

e. Specifying whether the staff person accused of abuse should complete the incident report form; and

f. Clarifying whether or not events that compose separate allegations are to be reported on a separate OIG Incident Report Form.

The Department should also periodically review facilities' management controls, including policies and procedures and other mechanisms that govern incident reporting to ensure they are uniform with Department policies. Finally, the Department should review and revise its current training requirements related to the reporting of abuse and neglect to address identified reporting problems.

Department of Mental Health and Developmental Disabilities' Response:

We accept this recommendation and appreciate your suggestions. Under the leadership of our new Inspector General, the Department's incident reporting policy is being revised to be more specific and thorough, and each of your suggestions will be carefully considered. We will then also revise our abuse and neglect training materials.

CHAPTER THREE
PATTERNS IN INCIDENT REPORTING BY FACILITIES

There was a wide variation in the number and rate of abuse allegations reported by DMHDD facilities. Abuse allegation rates at mental health facilities continued to run at least twice as high as the rates at developmental facilities. Facilities serving both the mentally ill and developmentally disabled (i.e., dual facilities) have had the highest abuse allegation rates two of the past three years with mental health facilities having only a slightly higher rate in Fiscal Year 1994. We found that residents were often involved in multiple abuse allegations; 138 residents were mentioned in three or more abuse allegations.

The OIG's Fiscal Year 1995 statutorily required annual report was due to the General Assembly and the Governor on January 1, 1996, but it was not issued until March 1996. The statute requires that each OIG annual report include, among other items, a three-year trend analysis of the number of reported allegations and their disposition, for each facility and Department-wide. We recommended that the OIG issue its annual reports in a timely manner.

ABUSE ALLEGATIONS REPORTED BY TYPE OF FACILITY

We collected data on abuse allegations from information provided by the OIG and information collected at the DMHDD residential facilities. Exhibits 3-1 and 3-2 summarize trends in facility reporting. Appendix C also provides detailed information on the number of incidents each facility reported to the OIG.

Facilities are classified into three types: Mental Health Centers (MHC), Developmental Centers (DC), and combined Mental Health/Developmental Centers (MHDC). Abuse allegation rates were calculated for each group of facilities. Reporting rates from Fiscal Year 1993 through 1995 are presented in Exhibit 3-1.

As shown on Exhibit 3-1, over the past three years, abuse allegation rates have been at least twice as high per 1,000 resident days at mental health facilities than at developmental facilities. For two of the past three years, facilities serving both the mentally ill and developmentally disabled (i.e., dual facilities) have had the highest abuse allegation rates. These rates were .61 per 1,000 resident days in Fiscal Year 1993 and .70 in Fiscal Year 1995.

From Fiscal Year 1993 through Fiscal Year 1995, the abuse allegation rate at mental health facilities increased substantially. In Fiscal Year 1993, there were .44 abuse allegations per 1,000 resident days at mental health facilities; this rate increased to .59 in Fiscal Year 1994 and increased again to .63 in Fiscal Year 1995. From Fiscal Year 1993 through Fiscal Year 1995, the abuse allegation rate at developmental facilities also increased, but not as dramatically. Allegations per 1,000 resident days in Fiscal Year 1993 were .20 and increased to .27 in Fiscal Year 1995. Rates at dual facilities also increased over the same time period. In Fiscal Year 1993, there were .61 abuse allegations per 1,000 resident days at dual facilities; this rate decreased slightly to .58 in Fiscal Year 1994, but then increased to .70 in Fiscal Year 1995.

EXHIBIT 3-1
ALLEGATIONS BY FACILITY TYPE
(Rates Per 1,000 Resident Days)

FY93			FY94			FY95		
FACILITY	ALLEGED ABUSE		FACILITY	ALLEGED ABUSE		FACILITY	ALLEGED ABUSE	
TYPE	Number	Rate	TYPE	Number	Rate	TYPE	Number	Rate
MHC	392	.44	MHC	538	.59	MHC	523	.63
DC	272	.20	DC	287	.22	DC	333	.27
MHDC	227	.61	MHDC	113	.58	MHDC	128	.70
TOTAL	891	.34	TOTAL	938	.39	TOTAL	984	.44

NOTE: MHC=Mental Health Center, DC=Developmental Center, MHDC=Mental Health/Developmental Center. Fiscal Year 1993 data from OIG's FY93 State of Care Report. In its FY95 State of Care Report issued in March 1996, OIG revised the number of abuse allegations reported in FY93 to 903.
SOURCE: OAG analysis of OIG data. Rates are rounded.

ABUSE ALLEGATIONS REPORTED BY FACILITIES

The number and rate of abuse allegations reported by the 21 DMHDD facilities varied considerably, as shown in Exhibit 3-2. The overall rate of abuse allegations per 1,000 resident days increased from .34 in Fiscal Year 1993 to .39 in Fiscal Year 1994 to .44 in Fiscal Year 1995.

Exhibit 3-2 shows that from Fiscal Year 1993 to 1994, abuse allegation rates increased at 14 of the 21 facilities and from Fiscal Year 1994 to 1995, abuse allegation rates increased at 13 of 21 facilities. From Fiscal Year 1993 to 1995 abuse allegation rates increased each year at seven of 21 facilities. These facilities include Chester MHC, Elgin MHC, Kiley DC, Lincoln DC, Ludeman DC, Madden MHC, and Singer MHDC. The total number of abuse allegations also increased over the three-year period.

Many factors must be considered when trying to explain variations in the reporting rates at different facilities. These factors include the number of residents served by the facility, the characteristics of the resident population, the reporting practices of the facility, and the number of unsubstantiated or unfounded abuse allegations reported by facility residents. OIG officials said they are currently investigating reasons for the increase in abuse allegations.

Exhibit 3-2
ABUSE ALLEGATIONS
(Rates Per 1,000 Resident Days)

	FY93	FY94	FY95
ALTON MHC	70 (.72)	141 (1.69)	85 (1.21)
CHESTER MHC	92 (.78)	115 (.98)	123 (1.13)
CHICAGO-READ MHC	88 (.52)	35 (.27)	33 (.32)
CHOATE MHDC	83 (.55)	88 (.65)	80 (.62)
ELGIN MHC	105 (.42)	131 (.54)	145 (.59)
FOX DC	3 (.05)	0 (.00)	4 (.06)
HOWE DC	75 (.36)	43 (.26)	62 (.42)
ISPI MHC	18 (.32)	14 (.39)	*
METRO C & A MHC	*	*	45 (2.17)
JACKSONVILLE DC	50 (.43)	82 (.72)	51 (.46)
KILEY DC	43 (.26)	46 (.30)	73 (.48)
LINCOLN DC	26 (.15)	35 (.22)	41 (.25)
LUDEMAN DC	15 (.09)	23 (.14)	36 (.22)
MABLEY DC	2 (.05)	4 (.10)	2 (.05)
MADDEN MHC	12 (.18)	14 (.23)	17 (.26)
MCFARLAND MHC	29 (.57)	11 (.22)	11 (.26)
MEYER MHC	56 (1.07)	37 (.82)	39 (.89)
MURRAY DC	3 (.02)	5 (.04)	5 (.04)
SHAPIRO DC	55 (.19)	49 (.17)	59 (.21)
SINGER MHDC	18 (.25)	25 (.42)	48 (.88)
TINLEY PARK MHC	28 (.25)	20 (.21)	15 (.18)
ZELLER MHC	20 (.33)	20 (.42)	10 (.25)
TOTAL	891 (.34)	938 (.39)	984 (.44)

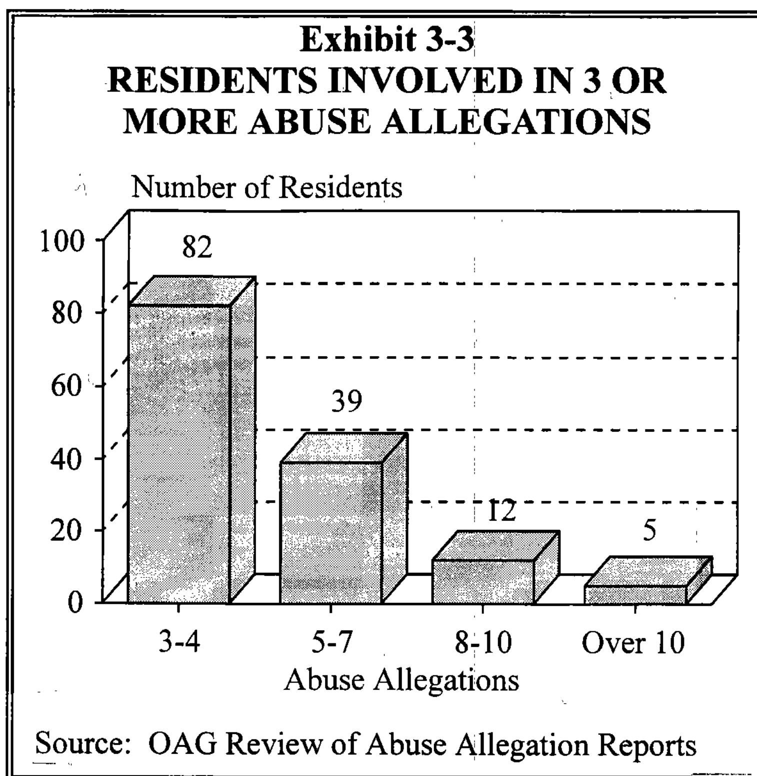
NOTE: Rounded rate per 1,000 resident days in parentheses. Fiscal Year 1993 data from OIG's FY93 State of Care report. In its FY95 State of Care Report, OIG revised the number of abuse allegations reported in FY93 to 903. MHC=Mental Health Center, DC=Developmental Center, MHDC=Mental Health/Developmental Center.
* ISPI operations reorganized and renamed in FY95.
SOURCE: OAG analysis of OIG data

PATTERNS IN ABUSE ALLEGATIONS

For all abuse allegations reviewed, we collected various information on the allegations (such as time, date, location) and on the resident and staff involved. We then analyzed this information to identify any trends, patterns, or relationships among the various variables.

We found that residents were often involved in multiple abuse allegations. There were 294 residents mentioned in more than one abuse allegation, including 156 residents mentioned in two allegations and 138 residents mentioned in 3 or more allegations. Exhibit 3-3 summarizes the number of residents involved in three or more abuse allegations. At Lincoln, one resident was involved in 12 abuse allegations; at Ludeman, one resident was involved in 9 abuse allegations; and at Metro C&A/ISPI, one resident was involved in 7 abuse allegations. Two Lincoln allegations and one Ludeman allegation were substantiated; none of the Metro C&A/ISPI allegations were substantiated.

We reviewed the abuse allegations and compiled information where the location within a facility or the time the allegation occurred were known. Exhibit 3-4 shows that abuse allegedly occurred most frequently in a bedroom (20 percent), dayroom (15 percent), seclusion (14 percent), or hallway (12 percent). Our June 1994 audit also found that alleged abuse occurred most frequently in these locations.



Source: OAG Review of Abuse Allegation Reports

Most of the abuse allegations occurred during two shifts: 7am - 3pm (44%) and 3pm - 11pm (46%). This was consistent with the results of our 1994 audit where we found that 90 percent of abuse allegations occurred during the same two shifts.

We reviewed abuse allegations from each facility where the location or time the allegation occurred was known and generally found that the results of our analysis regarding the location of alleged abuse and the time of day they occurred were consistent with the system-wide results. Some noteworthy differences included the following:

- 35 percent of the allegations occurred in seclusion at one facility (Choate MHDC) and 34 percent of the allegations occurred in the dayroom at one facility (Chicago-Read MHC); and
- More than 60 percent of the allegations occurred between 3pm and 11pm at two facilities (Lincoln DC and Metro C&A) and more than 64 percent of the allegations occurred between 7am and 3pm at two facilities (Howe DC and Kiley DC).

Exhibit 3-4
ABUSE ALLEGATIONS
(By Top Four Locations)

ABUSE ALLEGATIONS	
LOCATION	FY94-FY95
BEDROOM	287 (20%)
DAYROOM	210 (15%)
SECLUSION	193 (14%)
HALLWAY	174 (12%)

SOURCE: OAG analysis of DMHDD data.

We found that no significant differences exist between the population statistics published by the OIG and the race and gender composition of residents

alleging abuse during the audit period. The population of abuse allegations was examined and compared with the resident population statistics, as published by DMHDD, to determine if any demographic category was overrepresented. In Fiscal Year 1995, the gender ratio of DMHDD's resident population was approximately 33 percent female and 67 percent male. The ethnic composition of residents in the DMHDD facilities was approximately 69 percent white, 26 percent black, 4 percent hispanic, and 1 percent other. DMHDD's demographic data for Fiscal Year 1994 contained no significant differences from its Fiscal Year 1995 demographic data. Analysis of abuse allegations produced descriptive statistics showing that approximately 1,171 (61%) of the residents involved in the allegations were males and 741 (39%) were females. This analysis included examinations of incidents where more than one resident was involved. The ethnic composition of residents alleging abuse shows that approximately 1,318 (69%) were white, 518 (27%) were black, 58 (3%) were hispanic, and 16 (1%) were classified as "other."

OIG Annual Reporting Requirements

The Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6.7) (Act) requires the Inspector General to submit an annual report summarizing the prior year's reports and investigations to the General Assembly and the Governor no later than January 1 of each year. The report is to include a trend analysis of the number of reported allegations and their disposition, for each facility and Department-wide, for the most recent three-year period; the report is also to include staffing-to-patient ratios and details on the imposition of sanctions.

According to Public Act 89-0427, which amended the Illinois State Auditing Act (30 ILCS 5/3-2), for any year the OIG does not issue an annual report, DMHDD facilities will be subject to a biennial program audit by the Auditor General. The OIG's Fiscal Year 1995 annual report was due on January 1, 1996, but it was not issued until March 1996.

RECOMMENDATION NUMBER 3

The Office of the Inspector General should comply with the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6.7) and issue its annual report on a timely basis.

Department of Mental Health and Developmental Disabilities' Response:

We accept this recommendation and apologize for the delay in publishing the FY95 OIG Annual Report. We will make publishing our report on time next year a high priority for this Office.

CHAPTER FOUR
OTHER ISSUES

There are additional issues beyond the scope of this audit related to incident reporting at DMHDD. These issues include the reporting of incidents occurring at community-based settings and the reporting of resident-to-staff incidents. Both of these issues were also discussed in our November 1992 and June 1994 program audits.

INCIDENT REPORTING IN COMMUNITY SETTINGS

DMHDD's policy to place some facility residents in a less restrictive therapeutic environment has resulted in more Illinois citizens receiving services from agency funded community-based providers. DMHDD offers a wide range of community-based residential and support services to nearly 190,000 persons, including over 9,000 residents living in community-based residential facilities. The resident population in State facilities has declined from over 25,000 in the 1960's to 6,039 in Fiscal Year 1995. Oversight of community-based programs and residential facilities has become an important issue as their use increases.

In response to this issue, Public Act 89-0427, signed into law on December 7, 1995, gave the DMHDD's Office of Inspector General the authority "to investigate and take immediate action on reports of abuse or neglect of recipients, whether patients or residents, in any facility or program that is licensed or certified by the Department of Mental Health and Developmental Disabilities or that is funded by the Department of Mental Health and Developmental Disabilities and is not licensed or certified by any agency of the State."

RESIDENT-TO-STAFF INCIDENTS

DMHDD's Risk Management Section reported 2,495 resident-to-staff injuries in Fiscal Year 1990, 2,288 in Fiscal Year 1991, 1,990 in Fiscal Year 1992, 1,704 in Fiscal Year 1993, 1,600 in Fiscal Year 1994, and 1,654 in Fiscal Year 1995. Although the number of resident-to-staff injuries has declined, the occurrence of resident-to-staff incidents remains a concern in DMHDD facilities. The deinstitutionalization of higher functioning individuals to community-based service providers suggests a significant segment of the remaining patient population are individuals who require a more intensive level of care and treatment.

Demands upon facility staff may increase because of the likelihood that these individuals may exhibit more aggressive and violent behavior.

Three DMHDD facilities (Murray DC, Howe DC, and Meyer MHDC) included in their policies a provision requiring the reporting of resident-to-staff injuries to DMHDD's Office of the Inspector General.

Department of Mental Health and Developmental Disabilities' Comment:

We appreciate the serious nature of any recipient-to-staff injuries and, in response to your last audit report, considered the benefits of requiring these to be reported to OIG. However, the statutory focus of OIG is on abuse and neglect of recipients. Other offices within the Department have responsibility for reviewing and providing training to prevent such injuries.

APPENDICES

APPENDIX A

30 ILCS 5/3-2

30 ILCS 5/3-2

Simultaneously with the biennial financial audit of the Department of Mental Health and Developmental Disabilities, the Auditor General shall conduct a program audit of each facility under the jurisdiction of that Department as described in Section 4 of the Department of Mental Health and Developmental Disabilities Act. The program audit shall include an examination of the records of each facility concerning reports of suspected abuse or neglect of any patient or resident of the facility. The Auditor General shall report the findings of the program audit to the Governor and the General Assembly, including findings concerning patterns or trends relating to abuse or neglect of facility patients and residents. However, for any year for which the Inspector General submits a report to the Governor and General Assembly as required under Section 6.7 of the Abused and Neglected Long Term Care Facility Residents Reporting Act, the Auditor General need not conduct the program audit otherwise required under this paragraph.*

**Amended by Public Act 89-0427, effective December 7, 1995.*

Note: The Auditor General has issued three reports pursuant to this Act. The first was issued in May 1990, the second was issued in November 1992, and the third was issued in June 1994.

APPENDIX B

ANALYTICAL METHODOLOGY

Methodology

We examined the Office of the Inspector General's (OIG) incident report statistics and abuse allegations occurring during Fiscal Years 1994 and 1995 in order to discern trends or patterns relating to abuse and neglect of DMHDD facility residents.

In Fiscal Year 1994, 938 abuse allegations were reported to the OIG and in Fiscal Year 1995, 984 abuse allegations were reported for a two-year total of 1,922. Files of incidents reported to the OIG are kept at each of 21 DMHDD facilities.

During fieldwork, OIG officials gave us a list of abuse allegations which we used to construct our database. This list included case numbers for 1,894 abuse allegations reported to the OIG, 926 in Fiscal Year 1994 and 968 in Fiscal Year 1995. Subsequent to the completion of fieldwork tasks at facilities, OIG provided information on additional abuse allegations reported by facilities during the audit period. The additional allegations reported resulted in the figures cited in the preceding paragraph. Upon review of the 1,894 abuse allegations, we found some instances where we concluded multiple allegations had been reported on a single DMHDD-107 incident report. In these cases, we entered each allegation separately into our database. Other allegations which we concluded had been misclassified as abuse or neglect or contained incomplete information were not entered into our database. As a result, our database for the same two year period contained 1,899 abuse allegations.

Contract auditors were instructed to complete a data collection instrument for each of the 1,894 abuse allegations. Each data collection instrument was coded according to a coding scheme developed by the audit team. Once all data collection instruments received from contract auditors had been coded, they were input into an ASCII (American National Standard Code For Information Interchange) file. This ASCII file was downloaded into a SPSS program file and saved as a system file for analysis purposes.

The following three-step verification procedure was completed on the SPSS system file and the data collection instruments. First, the information contained in the SPSS system file was checked against the coding contained on the original data collection instruments. Next, the coding on each data collection instrument was compared to the actual information provided by the contract auditors. Finally, the data collection instruments completed by the contract auditors were checked against the information contained on the associated DMHDD-107 forms (OIG Incident Report) and DMHDD-108 forms (Injury Report).

The population of abuse allegations was examined and compared with the resident population statistics, as published by the OIG, to determine if any demographic category was overrepresented. In Fiscal Year 1995, the gender ratio of DMHDD's resident population was approximately 33% female and 67% male. The ethnic composition of residents in the DMHDD facilities was approximately 69% white, 26% black, 4% hispanic, and 1% other. In Fiscal Year 1994, no significant differences existed in demographic data. Analysis of our database of abuse allegations where complete information was available produced descriptive

statistics showing that approximately 61% (1,171) of the residents were males and 39% (741) were females. The ethnic composition of residents alleging abuse shows that approximately 69% (1,318) were white, 27% (518) were black, 3% (58) were hispanic, and 1% (16) were classified as "other".

Frequency examinations were completed to determine when and where allegations of abuse most frequently occur. Tests for significant relationships between allegations of abuse and demographic characteristics were performed using the Chi-square test for independence at a 5 percent level of significance. Chester MHC was excluded from gender related analysis because it is an all male facility.

The Chi-square test measures the difference between the actual and expected frequencies of incidents reported with regard to incident type and demographic attributes. The more the results differ from what would be expected if there was a relationship between the variables, the larger will be the calculated Chi-square number. The Chi-square test is a test of independence between characteristics.

We performed Chi-square tests from a global perspective and frequency exams from both global and facility specific perspectives. Our analysis of the global data indicated no significant relationships between abuse allegations and the demographic characteristics of staff and recipients.

We interviewed and surveyed the facility directors, their designees and direct care staff of DMHDD's 21 residential facilities to assess their support for the incident reporting system and to determine if policies provided sufficient guidance regarding reporting responsibilities. The interviews and surveys were used to help determine if the DMHDD Policy and Procedures Directive 01.05.06.03 (PPD) provides sufficient guidance on the reporting of incidents and if there were areas that could be improved.

We examined the OIG aggregate data in order to discern any trends in the number of abuse allegations occurring by calculating rates for abuse allegations. These rates were calculated for developmental disability facilities, mental health facilities, and dual facilities. The rates we calculated were based on the number of allegations occurring per 1,000 resident days. For example, one resident spending one day at a facility is considered one resident day. Therefore 500 residents spending five days at a facility constitutes 2,500 resident days. Rates per 1,000 resident days normalize the population dynamics of the facilities and allow for facility comparison of allegation rates.

To test that facilities reported all reportable incidents in compliance with the OIG's PPD 01.05.06.03, we selected and reviewed a sample of 30 resident files from each facility. The population for the sample consisted of individual case files of all residents at each facility. Random sampling or systematic random sampling was used, thus resident files at each facility had an equal chance of being selected for Fiscal Year 1994 and Fiscal Year 1995. We also selected and reviewed a sample of 30 injury reports from each facility. The

population for the sample consisted of all injury reports completed during the audit period. Again, random sampling or systematic random sampling was used to ensure that each injury report at individual facilities had an equal chance of being selected.

APPENDIX C

ABUSE ALLEGATIONS REPORTED AND RATES PER 1,000 RESIDENT DAYS (Fiscal Years 1988 through 1995)

ABUSE ALLEGATION RATES PER 1000 RESIDENT DAYS

	FY88	FY89	FY90	FY91	FY92	FY93	FY94	FY95
ALTON MHC	0.322	0.516	0.337	0.776	0.845	0.717	1.688	1.206
CHESTER MHC	0.385	0.346	0.750	0.876	0.970	0.782	0.982	1.129
CHGO-READ MHC	0.267	0.386	0.555	0.400	0.700	0.521	0.270	0.322
CHOATE MHDC	0.211	0.296	0.413	0.662	0.518	0.551	0.647	0.624
ELGIN MHC	0.343	0.460	0.498	0.432	0.666	0.418	0.540	0.592
FOX DC	0.029	0.000	0.000	0.029	0.045	0.046	0.000	0.063
HOWE DC	0.061	0.168	0.272	0.414	0.337	0.362	0.256	0.415
ISPI	0.245	0.363	0.294	0.352	0.570	0.320	0.390	*
METRO C & A MHC	*	*	*	*	*	*	*	2.173
JACKSONVILLE DC	0.376	0.356	0.352	0.361	0.231	0.426	0.719	0.458
KILEY DC	0.134	0.186	0.198	0.246	0.310	0.260	0.298	0.478
LINCOLN DC	0.164	0.165	0.100	0.096	0.101	0.148	0.215	0.253
LUDEMAN DC	0.088	0.044	0.066	0.116	0.145	0.085	0.138	0.217
MABLEY DC	0.049	0.144	0.236	0.048	0.051	0.050	0.099	0.050
MADDEN MHC	0.340	0.382	0.347	0.342	0.259	0.180	0.225	0.260
McFARLAND MHC	0.156	0.177	0.341	0.163	0.467	0.574	0.218	0.260
MEYER MHC	0.445	1.537	0.809	0.746	0.884	1.065	0.823	0.890
MURRAY DC	0.030	0.067	0.060	0.045	0.030	0.023	0.038	0.038
SHAPIRO DC	0.253	0.240	0.133	0.191	0.167	0.188	0.173	0.213
SINGER MHDC	0.233	0.086	0.236	0.246	0.282	0.253	0.419	0.878
TINLEY PARK MHC	0.197	0.231	0.235	0.266	0.436	0.247	0.214	0.177
ZELLER MHC	0.021	0.220	0.202	0.384	0.289	0.332	0.424	0.246
TOTALS	0.209	0.282	0.297	0.341	0.392	0.339	0.393	0.435

Source: OAG Analysis of DMHDD Data

Note: Alton MHC and Meyer MHC prior to the audit period were Mental Health and Developmental Centers

ALLEGED ABUSE INCIDENTS REPORTED

	FY88	FY89	FY90	FY91	FY92	FY93	FY94	FY95
ALTON MHC	35	60	40	86	93	70	141	85
CHESTER MHC	39	37	84	101	111	92	115	123
CHGO-READ MHC	57	86	103	72	136	88	35	33
CHOATE MHDC	34	51	64	100	80	83	88	80
ELGIN MHC	103	135	150	125	185	105	131	145
FOX DC	2	0	0	2	3	3	0	4
HOWE DC	16	43	70	97	77	75	43	62
ISPI	16	23	19	22	29	18	14	*
METRO C & A MHC	*	*	*	*	*	*	*	45
JACKSONVILLE DC	44	42	42	42	27	50	82	51
KILEY DC	23	32	34	42	52	43	46	73
LINCOLN DC	29	30	18	17	18	26	35	41
LUDEMAN DC	16	8	12	21	26	15	23	36
MABLEY DC	2	6	10	2	2	2	4	2
MADDEN MHC	37	40	33	32	19	12	14	17
McFARLAND MHC	8	9	18	9	25	29	11	11
MEYER MHC	25	90	46	43	51	56	37	39
MURRAY DC	4	9	8	6	4	3	5	5
SHAPIRO DC	74	70	39	56	49	55	49	59
SINGER MHDC	18	7	18	17	21	18	25	48
TINLEY PARK MHC	26	29	32	30	49	28	20	15
ZELLER MHC	2	19	17	32	22	20	20	10
TOTALS	610	826	857	954	1,079	891	938	984

Source: OAG Analysis of DMHDD Data

Notes: Alton MHC and Meyer MHC prior to the audit period were Mental Health and Developmental Centers.
Fiscal Year 1993 data from OIG's FY93 State of Care Report. In its FY95 State of Care Report issued in March 1996, OIG revised the number of abuse allegations reported in FY93 to 903.

APPENDIX D

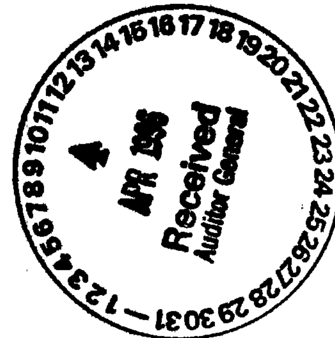
AGENCY RESPONSE

Illinois Department of Mental Health and Developmental Disabilities

401 William Stratton Building Springfield, Illinois 62765

Jim Edgar, Governor Ann Patla, Director

April 10, 1996



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

Dear Mr. Holland:

Thank you for the opportunity to read this draft of your audit of the reporting of incidents from Department-operated facilities during State Fiscal Years 1994 and 1995.

Thank you also for the opportunity to provide comments and responses to your audit for inclusion in the text of your final report. Please find these comments and responses below:

On page 2, after the first full sentence

Department comment:
Although there is still room for improvement, we are pleased that your audit found that more than 95% of the incidents were reported to OIG.

On page 2, after the first full paragraph

Department comment:
We have encouraged facility administrative staff to forward these initial reporting forms to OIG promptly, and not to hold them to ensure proper paper documentation.

On page 2, after the second full paragraph

Department comment:
By request of IDPH, our policy requires reporting only by the end of the next calendar day. However, we are considering requiring that these reports be made within 24 hours.

OFFICE OF INSPECTOR GENERAL Patricia Curtis, Inspector General

Voice: AC 217/786-6865 Fax: AC 217/786-6921 TTY: AC 217/524-2504

On page 2, after the third full paragraph

Department comment:
We are reviewing the process of gathering these initial written statements, and are considering a variety of approaches to ensuring that they are gathered from all appropriate staff.

On page 18, after Recommendation #1:

Department response:
We accept this recommendation. We are increasing our efforts at reviewing the timeliness and completeness of reporting of incidents from the facilities. We are also reviewing each facility to determine the best possible approach to ensuring that all initial written statements are submitted.

On page 22, after Recommendation #2:

Department response:
We accept this recommendation and appreciate your suggestions. Under the leadership of our new Inspector General, the Department's incident reporting policy is being revised to be more specific and thorough, and each of your suggestions will be carefully considered. We will then also revise our abuse and neglect training materials.

On page 27, after Recommendation #3:

Department response:
We accept this recommendation and apologize for the delay in publishing the FY95 OIG Annual Report. We will make publishing our report on time next year a high priority for this Office.

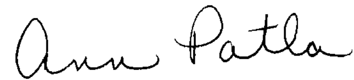
On page 29, after the last paragraph:

Department comment:
We appreciate the serious nature of any recipient-to-staff injuries and, in response to your last audit report, considered the benefits of requiring these to be reported to OIG. However, the statutory focus of OIG is on abuse and neglect of recipients. Other offices within the Department have responsibility for reviewing and providing training to prevent such injuries.

In conclusion, we thank you for the professionalism of your audit staff, especially Jim Kincaid and Mike Ingram. We appreciate their willingness to raise issues, discuss differences, and provide suggestions in a courteous and thoughtful manner.

We look forward to continuing to work with you and your staff in future audits, as we strive to improve the services we provide.

Sincerely,



Ann Patla
DMHDD Director

Pat Curtis
Inspector General

cc: Len Beck
Jo Warfield
Patrick Baikauskas
Leigh Steiner, PhD
Shawn Jeffers
Candace Keller
John Petter
File