REPORT DIGEST

PROGRAM AUDIT OF

THE DEPARTMENT OF HUMAN SERVICES

OFFICE OF THE INSPECTOR GENERAL

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SYNOPSIS

This is our tenth audit of the Department of Human Services' Office of the Inspector General's (OIG's) effectiveness in investigating allegations of abuse or neglect. The OIG has taken significant actions toward implementing the recommendations from our previous audit. These included: capturing data for non-reportable allegations; more evenly distributing investigative caseloads; and reviewing samples of unsubstantiated and unfounded cases for consistency.

In this audit we also reported that:

- The OIG made improvements in the timeliness of investigations since our last audit. However, 40 percent of investigations were not completed within 60 calendar days in FY08. Using the more lenient working days standard established in 2002, the OIG's timeliness of case completion for FY07 and FY08 was similar to the previous audit.
- Although recommended in prior audits, the OIG has not added serious injuries to its investigative database.
- In response to a prior audit finding, the OIG revised its Checklist for Notification to Illinois State Police/Local Law Enforcement to include the date and time of the determination that credible evidence existed that would require reporting. However, in a few cases we reviewed which were reported to the State Police, this new Checklist was not used.
- In 17 of the 117 (15%) cases sampled where an assignment date could be determined, the case was not assigned to an investigator within the required one working day.
- In FY08, 7 percent of alleged incidents of abuse or neglect at facilities and 25 percent at community agencies were not being reported within the four hours required by statute and OIG's administrative rules.
- For some community agency conducted investigations in our sample, it was difficult to determine which bureau and investigator was responsible for reviewing the case.
- The Inspector General or his designee is not required to review substantiated cases of mental injury or neglect unless it is deemed "egregious" neglect.
- In 15 percent (6 of 41) of the cases sampled, more than six months passed from the date the case was completed to the date when a written response delineating the corrective actions taken was submitted by the State facility or community agency and approved by DHS.
- DHS could not document that all staff at State-operated facilities received the required training in reporting abuse and neglect.

REPORT CONCLUSIONS

The Department of Human Services Act (Act) requires the Office of the Inspector General (OIG) to investigate allegations of abuse and neglect that occur in mental health and developmental disability facilities operated by the Department of Human Services (DHS). The Act also authorizes the OIG to conduct investigations in community agencies licensed, certified, or funded by DHS to provide mental health and developmental disability services. In FY08, DHS operated 18 State facilities. There were also 346 community agencies operating 3,672 programs providing services to individuals with developmental disabilities or mental illness in community settings within Illinois that were under OIG's jurisdiction. The Act requires the Office of the Auditor General to conduct a biennial program audit of the Inspector General's effectiveness of investigations of abuse and neglect and compliance with the Act. This is the tenth audit we have conducted of the OIG since 1990.

The OIG has taken significant actions toward implementing the recommendations from our previous audit. These actions include among others:

- Capturing data for non-reportable allegations;
- Improving the timeliness of investigations;
- More evenly distributing investigator caseloads;
- Reviewing samples of unsubstantiated and unfounded cases for consistency; and
- Meeting timelines for submitting site visit reports to facility directors or hospital administrators.

Total allegations of abuse and neglect reported to the OIG have continued to increase since our 2006 audit. In FY06, 1,814 allegations were reported (1,485 abuse and 329 neglect). This compares to 2,026 in FY08 (1,631 abuse and 395 neglect) or a 12 percent increase. Although total allegations of abuse and neglect have increased, the number of allegations reported at State facilities has been decreasing. Of the 1,814 allegations reported in FY06, 921 allegations were reported at State facilities and 893 allegations were reported at community agencies. For FY08, of the total of 2,026 allegations of abuse or neglect, 798 were from State facilities and 1,228 from community agencies. FY07 and FY08 represent the first time that the number of allegations of abuse and neglect reported at community agencies was greater than the number reported at State facilities.

During our previous audit, the OIG was not capturing data related to non-reportable allegations that would enable investigators to look for patterns. Beginning in December 2006, OIG started entering non-reportable allegations into its incident database and also included a list of non-reportable complaints on subsequent calls so that a more complete past history is displayed. However, the OIG still does not collect information related to serious injuries without any allegation of abuse or neglect. In our 2004 audit, we recommended that the OIG capture data for all allegations of serious injuries in its database. In the 2006 audit, we again recommended that the OIG included serious injuries in its investigative database. As of FY08, the OIG still does not capture this data. According to OIG officials, the DHS Office of Legal Services determined that mandating agencies to report all serious injuries to OIG would first require a change in statute.

The timeliness of OIG investigations continued to improve in FY07 and FY08. In FY06, 52 percent of OIG investigations were completed in 60 calendar days. Timeliness improved in FY07 with 56 percent and in FY08 with 60 percent completed within 60 calendar days. In January 2002, the OIG amended its administrative rules to require investigations be completed within 60 ***working*** days. Using the more lenient working days standard established in 2002, the OIG's timeliness of case completion for FY07 and FY08 was similar to the previous audit.

Although there has been some improvement, timeliness of cases taking longer than 60 working days to complete continues to be a problem for some investigative bureaus for cases closed during FY08. The Central and South bureaus had the smallest percentages of cases taking longer than 60 working days with 5 percent and 6 percent respectively. The percentages for the North and Metro bureaus were much greater. The percentage of cases taking longer than 60 working days was 25 percent for the North Bureau and 64 percent for the Metro Bureau. Although the timeliness for the North Bureau is an improvement over the previous audit, the Metro Bureau's timeliness has gotten worse. The South Bureau dropped from 20 percent over 60 working days in FY06 to 6 percent in FY08.

The OIG has taken steps to address these timeliness problems by utilizing other bureaus to help complete cases for the Metro and North bureaus. This includes assigning cases to be completed by the Bureau of Domestic Abuse and the Bureau of Hotline and Intake. The OIG has also taken additional steps to increase timeliness by filling existing investigator vacancies and obtaining more computers. For the 1,929 cases closed in FY08, 219 cases were completed by other bureaus. This represents a large increase over the 19 cases that were conducted by other bureaus during the previous audit in FY06. The 219 cases included 91 assigned to clinical

coordinators which include death cases and cases that involve a medical issue. Of the remaining cases, 65 were assigned to intake investigators, and 63 were assigned to investigators from the Bureau of Domestic Abuse.

In response to our 2006 audit recommendation regarding reporting to the State Police, the OIG revised its Checklist for Notification to Illinois State Police/Local Law Enforcement to include the date and time of the determination that credible evidence existed that would require reporting. In our testing of FY08 cases, 4 cases were referred to State Police. We obtained copies of all four checklists from the investigative files. For all four cases, we determined that the incident was reported to the State Police within the required 24 hours. However, even though the OIG updated its checklist in December 2006, all four files contained the old checklist which does not include the date that it was determined that credible evidence existed. Three of the four cases occurred after the form had been revised. For one of the cases which occurred in December 2007, we could not readily determine whether it was reported in a timely manner because the old checklist was used. Therefore, OIG management cannot ensure that the allegation was reported within the 24-hour reporting requirement found in the Act.

We reviewed investigator caseloads for the different investigative bureaus at the OIG. The OIG has made significant improvement in reducing investigator caseloads since the previous audit. Investigator caseloads have decreased substantially for the North and Metro bureaus and are also more evenly distributed among bureaus. Caseloads as of August 2008 ranged from 11 in the Metro and South bureaus to 7 in the North Bureau. In August 2006, caseloads ranged from a high of 30 in the Metro Bureau to a low of 4 in the Central Bureau.

The number of interviews conducted appears to be more consistent between investigative bureaus than in our previous audit. In the previous audit we found that the number of interviews conducted by the investigative bureaus differed significantly, ranging from 3 interviews per investigation in the South Bureau to 11 per investigation in the North Bureau. The average number of interviews for FY08 cases sampled was much closer and ranged from 6 interviews in the Metro Bureau to 8 interviews in the South Bureau.

OIG directives no longer require “critical” interviews to be completed by the assigned investigator within five working days of approval of the investigative plan. However, during our case file review, we found on average it took investigators 8 days to complete interviews with the alleged victim and 20 days to complete interviews with the alleged perpetrator in each case. These are both an improvement over the

previous audit in which it took an average of 12 days to interview the alleged victim and 25 days to interview the alleged perpetrator.

The OIG needs to improve the timeliness of investigator assignment and completion of investigative plans. OIG directives require that investigations be assigned to an investigator within one working day of the OIG assuming responsibility for the investigation. For 17 of the 117 (15%) cases we sampled and could determine an assignment date, the assignment was not made within one working day. OIG directives also require assigned investigators to complete an investigative plan within three working days of assignment, except if the case is closed at intake. For 16 of the 127 (13%) of cases we sampled, we could not determine whether the plan was completed in a timely manner because there was either no date on the investigative plan or we could not determine the date assigned. For the remaining 111 cases sampled, 5 (5%) were not completed and approved within the required three working days.

Alleged incidents of abuse and neglect are not being reported to the OIG by facilities and community agencies in the time frames required by the statutes and OIG's administrative rules. In FY08, 7 percent of facility incidents and 25 percent of community agency incidents were not reported within the four-hour time requirement. Effective June 13, 2006, Public Act 94-853 added a provision that states that a required reporter who willfully fails to comply with the reporting requirements is guilty of a Class A misdemeanor.

OIG case reports generally were thorough, comprehensive, and addressed the allegation. However, we found that photographs were missing in 5 of 29 (17%) cases where there was an allegation of an injury sustained from our FY08 sample. Injury Reports were missing in 3 of 29 (10%) cases where there was an allegation of an injury sustained. Two of the 127 sample cases tested did not contain a Case Routing/Approval Form. Although all case files in our sample contained a Case Tracking Form, two of the forms were not completed. During the review of our 127 sample cases, two files did not contain pertinent medical records, treatment plans, or progress notes. One case sampled where restraints were used did not contain the appropriate documentation.

During the previous audit, we concluded that there were inconsistencies between investigative bureaus related to how the bureaus classify findings. In addition, we found inconsistencies between what is and is not accepted by the Bureau of Hotline and Intake as an allegation of abuse or neglect. Beginning in January 2007, the Deputy Inspector General and one investigative bureau chief (on a rotating basis) began quarterly reviews of unfounded and unsubstantiated cases to ensure consistency across bureaus. During our fieldwork, we reviewed the

second quarter FY08 review conducted by the Deputy Inspector General. Although the review identified problems such as cases missing an investigative plan or clinical coordinators' summary and cases in which interview statements were not numbered, the review did not find any cases involving improper findings or different interpretations of finding criteria, nor did it find any cases that might have been substantiated.

For community agency conducted investigations in our sample, it was sometimes difficult to determine which bureau and investigator was responsible for reviewing the case. For some community agency conducted investigations the OIG Bureau of Hotline and Intake was reportedly responsible for reviewing the case. For these cases that were reportedly assigned to the Bureau of Hotline and Intake, review forms were either missing or not completed.

In the previous audit we recommended that the Inspector General should clearly define what constitutes physical injury and physical harm. This has not been accomplished. According to the OIG response in the previous audit, officials agreed and stated they believed that the issue of definitions would be resolved by revisions to the statute. Until the statute is revised such a change to the OIG's administrative rules (Rule 50) would be premature. However, in the meantime, OIG would reinforce that physical "harm" is a physical "wrong or injustice."

According to 59 Ill. Adm. Code 50.90, an employee may request a hearing with the Department of Human Services and present evidence supporting why his or her finding does not warrant reporting to the Health Care Worker Registry. The percentage of cases appealed in which the Administrative Law Judge's (ALJ) decision upheld the referral of the employee to the Health Care Worker Registry has increased when compared to our previous audit. The ALJ decision was to refer the employee in 56 percent of the appeal hearings in FY08 (15 of 27) and 56 percent of those in FY07 (18 of 32), compared to 41 percent in FY06 (13 of 32) and 21 percent in FY05 (6 of 28).

We reviewed 10 substantiated cases in which the ALJ rejected the referral to the Health Care Worker Registry in FY08. In the 10 cases in which the referral was rejected, the ALJ found that the Department had not demonstrated by a preponderance of the evidence that the finding of abuse against the petitioner warranted reporting to the Registry. Several overturned cases cite the credibility of witnesses as a problem. In one case, the ALJ found the OIG investigation was unreliable. The OIG investigator in the case had been placed on leave and is no longer with the OIG. In another case, the ALJ found that the petitioner's actions were inappropriate but did not rise to the level of reporting to the Registry.

In our previous audit we recommended that the OIG revise its policies and procedures to ensure that all cases with findings that warrant reporting to the Registry are reported. The Department of Human Services Act requires physical abuse, sexual abuse, and egregious neglect to be referred to the Registry. Although the OIG has not updated the definition of egregious as it relates to neglect, the OIG directives have been updated and a process added for a stipulated motion to dismiss. This process is triggered by a 50.90 petition on certain physical abuse cases that, although the finding meets the definition of physical abuse, may not be severe enough to deserve placement on the Registry. In September 2006 the OIG implemented a new stipulation process authorized by statute for appeals hearings. The OIG did not refer a case to the Registry based on a stipulation order on six occasions in FY07 and FY08.

State facilities or community agencies are required to submit a written response to DHS for all substantiated cases of abuse or neglect, or cases with other administrative issues. In our review of written responses we found that DHS takes an excessive amount of time to receive and approve the actions taken by the agency or facility in some cases. For one case in our sample, the agency date on the written response was September 9, 2008 and the DHS approved date was also September 9, 2008. However, the case was completed in August 2007. In addition, we requested this information on August 22, 2008. Therefore, it took more than a year to get the corrective action approved from the date of completion and it was done only after auditors requested the information. Of the 41 cases in our sample for which we could determine an investigative completion date and a response date, 6 of 41 (15%) took more than six months from the date the case was completed until the written response was approved by DHS. Two of these cases took more than a year.

Even though two State-operated facilities were terminated from participation in federal programs for non-compliance with various issues, including patient safety and client protection, the OIG did not recommend a sanction against either facility. Over the past 15 years (1994 – 2008), the Inspector General has not recommended sanctions against a State-operated facility. On June 9, 2008, the OIG did utilize its authority under 20 ILCS 1305/1-17(d) to recommend sanctions and sent letters to the DHS Division of Mental Health and to the DHS Division of Developmental Disabilities related to community agencies that had not updated their abuse/neglect reporting policies. The OIG recommended a total of nine service providers for non-renewal of their DHS service provider agreements until the policies are approved by OIG. According to OIG officials, none of the issues cited by the reviewers at Tinley Park MHC were reportable to OIG under current State law. Some issues cited by the reviewers at Howe DC did meet the State law's definitions, but OIG identified no trends or

patterns in those beyond what has been typical of other facility or agency programs.

The Quality Care Board held all required quarterly meetings during FY07-08. This is a significant improvement from the previous audit. The Board continues to have difficulty maintaining seven members as required by statute. During part of FY07 (September 2006-April 2007), the Board had seven members as required; however, in April 2007, one of the Board members resigned. This left the Board with six members near the end of FY07 and all of FY08. As of June 2008, a successor had still not been appointed to fill the vacancy.

During FY07 and FY08, the Office of the Inspector General conducted annual unannounced site visits at all of the mental health and developmental centers as required by statute (20 ILCS 1305/1-17(f)). Also, during FY07 and FY08, the OIG met its established timeline for submitting site visit reports to facility directors or hospital administrators. This is an improvement since the last audit.

DHS could not document that all staff at State-operated facilities received the required Rule 50 training. In addition, the OIG identified two facilities that were deficient in training staff during its FY08 site visits. The OIG site visit for Howe Developmental Center reported that only 504 of the facility's 835 (60%) employees had been trained in OIG Rule 50 during the last year, and the OIG site visit for Tinley Park Mental Health Center reported that only 172 of the facility's 207 (83%) employees had been trained in OIG Rule 50. The OIG recommended to Howe and Tinley Park that each facility should ensure that all staff, contractual workers, and volunteers received OIG Rule 50 training at least biennially. For Tinley Park, it was the third year that the recommendation for training staff had been repeated.

BACKGROUND

The Office of the Inspector General (OIG) was initially established by Public Act 85-223 in 1987 which amended the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/1 *et seq.*). Under this Act, the Inspector General was required to conduct investigations of abuse and neglect within State-operated facilities serving the mentally ill and developmentally disabled. In 1995, the role of the Office of the Inspector General was expanded to include the authority to investigate reports of abuse or neglect at facilities or programs not only operated by the Department of Human Services (facilities), but also those licensed, certified, or funded by DHS (community agencies).

Effective August 28, 2007, Public Act 95-545 amended the Department of Human Services Act (20 ILCS 1305) and the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30) transferring all provisions concerning the Office of the Inspector General within the Department of Human Services from the Abused and Neglected Long Term Care Facility Residents Reporting Act to the Department of Human Services Act.

During FY08, the Department of Human Services operated 18 facilities Statewide that served 12,506 individuals. In addition, DHS licenses, certifies, or provides funding for approximately 346 community agencies operating 3,672 programs providing services to individuals with developmental disabilities or mental illness in community settings within Illinois. In FY08, approximately 29,500 individuals with developmental disabilities and approximately 167,456 individuals with mental illness were served in community agencies required to report to the OIG.

As of July 1, 2008, the OIG had 61 employees, including three on leave. In addition, the OIG hired two contractual employees to bring the total employees to 63. The number of investigative staff for abuse and neglect investigations is similar to the number of staff during the previous audit (21 in FY06; 20 in FY08).

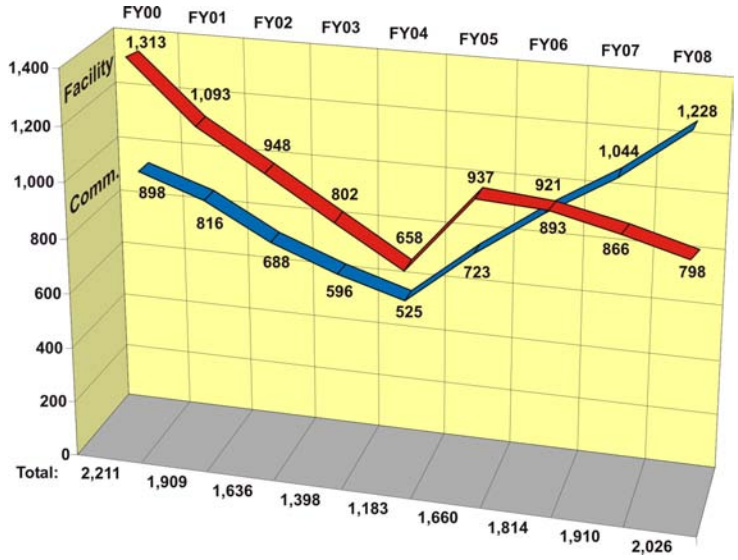
The Office of the Auditor General has conducted nine prior OIG audits to assess the effectiveness of its investigations into allegations of abuse and neglect, as required by statute. These audits were released in 1990, 1993, 1994, 1996, 1998, 2000, 2002, 2004, and 2006. (pages 6-9, 21)

FY07 represents the first time that the number of allegations of abuse and neglect reported at community agencies was greater than the number reported at State facilities.

REPORTING OF ALLEGATIONS

Total allegations of abuse and neglect reported to the OIG have continued to increase since our 2006 audit. In FY06, 1,814 allegations were reported (1,485 abuse and 329 neglect). In FY08, a total of 2,026 allegations of abuse or neglect were reported to the OIG (798 from State facilities and 1,228 from community agencies). However, the number of allegations reported at State facilities has been decreasing since FY05. FY07 represents the first time that the number of allegations of abuse and neglect reported at community agencies was greater than the number reported at State facilities (See Digest Exhibit 1).

Digest Exhibit 1
TOTAL ABUSE OR NEGLECT ALLEGATIONS REPORTED TO OIG
Fiscal Years 2000 to 2008



Note: State facilities served 2,626 individuals with developmental disabilities and 9,880 individuals with mental illness in FY08. Community agencies served approximately 29,500 individuals with developmental disabilities and approximately 167,456 individuals with mental illness in FY08.

Source: OIG data summarized by the OAG.

According to OIG officials, the most significant factor in the drop in allegations at State facilities is the comparable drop in the number of individuals served in the State facilities. OIG officials attribute the increase in community agency allegations reported to continued training efforts and increased citing of community agency failure to report or late reporting (264 cases in FY07 and 273 cases in FY08). (pages 11-12)

Beginning in December 2006, OIG started entering non-reportable allegations into its incident database.

Reporting Serious Injuries

During the previous audit, the OIG was not capturing data related to non-reportable allegations that would enable investigators to look for patterns. Beginning in December 2006, OIG started entering non-reportable allegations into its incident database and also included a list of non-reportable complaints on subsequent calls so that a more complete past history is displayed.

However, the OIG continues to consider serious injuries without an allegation of abuse or neglect to be not reportable. Until FY03, these cases were reported and were investigated by the OIG even though there was no

allegation of abuse or neglect. Serious injuries caused by neglect may not have a direct allegation associated with them, such as incidents involving resident on resident injuries. Resident on resident incidents may be a result of neglect by staff and the OIG should consider requiring that these types of cases be reported for review and/or investigation.

In our 2004 audit, we recommended that the OIG capture data for all allegations of serious injuries in its database. In the 2006 audit we again recommended that the OIG include serious injuries in its investigative database (Recommendation 3). As of our fieldwork in 2008, we determined that the OIG does not capture this data. According to OIG officials, the DHS Office of Legal Services determined that mandating agencies to report all serious injuries to OIG would first require a change in statute. (pages 15-16)

INVESTIGATION TIMELINESS

During this audit period, the OIG made improvements in its timeliness for completing investigations.

Timeliness of investigations has been an issue in all of the nine previous OIG audits. During this audit period, the OIG made improvements in its timeliness for completing investigations. In FY06, 52 percent of OIG investigations were completed in 60 calendar days. Timeliness improved in FY07 with 56 percent and in FY08 with 60 percent completed in 60 calendar days. Using the more lenient working days standard established in 2002, the OIG's timeliness of case completion for FY07 and FY08 was similar to the previous audit. Digest Exhibit 2 shows timeliness data for OIG investigations for the last six fiscal years.

Although there has been some improvement, timeliness of cases taking longer than 60 working days to complete continues to be a problem for some investigative bureaus for cases closed during FY08. The Central and South bureaus had the smallest percentages of cases taking longer than 60 working days with 5 percent and 6 percent respectively. The percentages for the North and Metro bureaus were much greater. The percentage of cases taking longer than 60 working days was 25 percent for the North Bureau and 64 percent for the Metro Bureau. Although the timeliness for the North Bureau is an improvement over the previous audit, the Metro Bureau's timeliness has gotten worse. The South Bureau dropped from 20 percent over 60 working days in FY06 to 6 percent in FY08.

The OIG has taken steps to address these timeliness problems by utilizing other bureaus to help complete cases for the Metro and North bureaus. This includes assigning cases to be completed by the Bureau of Domestic Abuse and the Bureau of Hotline and Intake. The OIG has also taken additional steps to increase timeliness by filling existing investigator

vacancies and obtaining more computers. For the 1,929 cases closed in FY08, 219 cases were completed by other bureaus. This represents a large increase over the 19 cases that were conducted by other bureaus during the previous audit in FY06. The 219 cases included 91 assigned to clinical coordinators which include death cases and cases that involve a medical issue. Of the remaining cases, 65 were assigned to intake investigators, and 63 were assigned to investigators from the Bureau of Domestic Abuse. (pages 25-27)

Digest Exhibit 2
CALENDAR DAYS TO COMPLETE ABUSE OR NEGLECT INVESTIGATIONS
Fiscal Years 2003 to 2008

Days to Complete Cases	FY03 % of Cases	FY04 % of Cases	FY05 % of Cases	FY06 % of Cases	FY07 % of Cases	FY08 % of Cases
0-60	**30%**	**39%**	**55%**	**52%**	**56%**	**60%**
61-90	16%	11%	22%	19%	15%	13%
91-120	17%	10%	11%	14%	13%	13%
121-180	23%	20%	6%	11%	11%	11%
181-200	5%	5%	1%	2%	1%	0%
>200	9%	14%	5%	2%	3%	2%
Total > 60 days	**70%**	**61%**	**45%**	**48%**	**44%**	**40%**
Total Cases by FY	1,248	1,472	1,659	1,597	1,936	1,929

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

Source: OAG analysis of OIG data.

Reporting to the State Police

In response to our 2006 audit recommendation regarding reporting to the State Police, the OIG revised its Checklist for Notification to the Illinois State Police/Local Law Enforcement to include the date and time of the determination that credible evidence existed that would require reporting. In our testing of FY08 cases, four cases were referred to the State Police. We obtained copies of all four checklists from the investigative files. For all four cases, we determined that the incident was reported to the State Police within the required 24 hours. However, even though the OIG updated its checklist in December 2006, all four files contained the old checklist which does not include the date that it was determined that credible evidence existed. Therefore, OIG management

cannot ensure that the allegation was reported within the 24-hour reporting requirement found in the Act. (pages 29-30)

Clinical Services Cases

OIG's Clinical Coordinators handle cases that involve medical issues as well as death cases. The Coordinators work and consult with Clinical Services at DHS. During the majority of FY08, OIG had only one Clinical Coordinator to cover the entire State.

The time to conduct investigations assigned to a Clinical Coordinator increased significantly from FY06 to FY08.

The time to conduct investigations assigned to a Clinical Coordinator increased significantly from FY06 to FY08. In FY06, we reported the average completion time for cases referred to the Clinical Coordinator was 66 days. For FY08, the average completion time for cases referred to the Coordinators was 119 days. In our review of cases that took more than 200 days to complete, 5 of 40 were assigned to Clinical Coordinators. The OIG hired an additional Clinical Coordinator on a 60 day emergency basis in December 2007 and again in February 2008. In April 2008, a full-time Clinical Coordinator was finally hired.

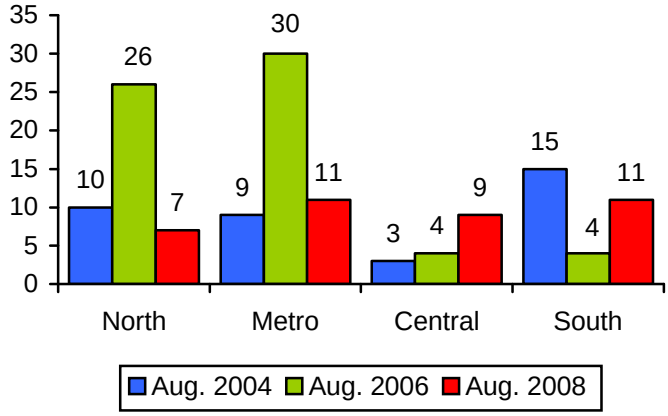
The CMS rules regarding emergency hires states that "Such appointments shall not exceed 60 days, shall not be renewed and may be made without regard to an eligible list" (80 Ill. Adm. Code 302.150 (b)). Department of Human Services' policies and procedures also do not allow for emergency appointments to exceed 60 calendar days or be renewed. In addition to the emergency hire for a Clinical Coordinator, the OIG also hired an intake investigator on an emergency basis and also renewed his appointment for an additional 60 day period. (page 30)

Investigator Caseloads

The OIG has made significant improvement in reducing investigator caseloads since the previous audit.

The OIG has made significant improvement in reducing investigator caseloads since the previous audit. Investigator caseloads have decreased substantially for the North and Metro bureaus and are also more evenly distributed among bureaus.

Digest Exhibit 3
INVESTIGATOR CASELOADS
By Bureau as of August 14, 2004, 2006, and 2008



Source: OIG data summarized by the OAG.

Digest Exhibit 3 shows the trend in caseloads by bureau from 2004 through 2008. Caseloads as of August 2008 ranged from 11 in the Metro and South bureaus to 7 in the North Bureau. In August 2006, caseloads ranged from a high of 30 in the Metro Bureau to a low of 4 in the South and Central bureaus. (page 31)

Timeliness of Assignment and Investigative Plans

The OIG needs to improve the timeliness of investigator assignment and completion of investigative plans.

The OIG needs to improve the timeliness of investigator assignment and completion of investigative plans. OIG directives require that investigations be assigned to an investigator within one working day of the OIG assuming responsibility for the investigation. More than three-quarters of the investigations we reviewed were assigned within one working day. However, for 17 of the 117 (15%) cases we sampled and could determine an assignment date, the assignment was not made within one working day. The time to assign for these cases ranged from 3 days to 10 days. For 10 cases, we could not determine the assignment date.

OIG directives also require assigned investigators to complete an investigative plan within three working days of assignment, except if the case is closed at intake. For 16 of the 127 (13%) cases we sampled, we could not determine whether the plan was completed in a timely manner because there was either no date on the investigative plan or we could not determine the date assigned. For the remaining 111 cases sampled, 5 (5%) were not completed and approved within the required three working days. (page 33)

Number of Interviews Conducted

The number of interviews conducted in FY08 is more consistent between investigative bureaus than in our previous audit. In the previous audit we found that the number of interviews conducted by the investigative bureaus differed significantly, ranging from 3 interviews per investigation in the South Bureau to 11 per investigation in the North Bureau. The average number of interviews for FY08 cases sampled was much closer and ranged from 6 interviews in the Metro Bureau to 8 interviews in the South Bureau.

The number of interviews conducted in FY08 is more consistent between investigative bureaus than in our previous audit.

OIG directives no longer require "critical" interviews to be completed by the assigned investigator within five working days of approval of the investigative plan. However, during our case file review, we found on average it took investigators 8 days to complete interviews with the alleged victim and 20 days to complete interviews with the alleged perpetrator in each case. These are both an improvement over the previous audit in which it took an average of 12 days to interview the alleged victim and 25 days to interview the alleged perpetrator. (pages 33-34)

Timeliness of Case File Reviews

Timeliness of case file review has improved since our last audit. However, the OIG continues to fall short of the timeline requirements in its directive relating to case file review. None of the bureaus are reviewing substantiated cases within the 7-day timeline delineated in the OIG directive. The Metro Bureau takes much longer to review substantiated cases than the other three bureaus. (pages 34-35)

Timely Reporting of Allegations

Alleged incidents of abuse and neglect are not being reported by facilities and community agencies in the time frames required by statutes and the OIG's administrative rules. The Department of Human Services Act requires that allegations be reported to the OIG hotline within four hours of initial discovery of the incident of alleged abuse or neglect. Community

Digest Exhibit 4
ALLEGATIONS OF ABUSE AND NEGLECT NOT REPORTED WITHIN FOUR HOURS OF DISCOVERY

Fiscal Year	Facility	Community Agency
FY05	6%	34%
FY06	6%	29%
FY07	5%	21%
FY08	7%	25%

Source: OAG analysis of OIG data.

agencies continue to have a larger percentage of untimely reports in comparison to facilities.

Digest Exhibit 4 shows allegations of abuse and neglect not reported within four hours of discovery for State facilities and community agencies from FY05 through FY08. (page 35)

INVESTIGATION THOROUGHNESS

OIG case reports generally were thorough, comprehensive, and addressed the allegation. However, we found that photographs were missing in 5 of 29 (17%) cases where there was an allegation of an injury sustained from our FY08 sample. Injury Reports were missing in 3 of 29 (10%) cases where there was an allegation of an injury sustained. Two of the 127 sample cases tested did not contain a Case Routing/Approval Form. Although all case files in our sample contained a Case Tracking Form, two of the forms were not completed. During the review of our 127 sample cases, two files did not contain pertinent medical records, treatment plans, or progress notes. One case sampled where restraints were used did not contain the appropriate documentation.

Investigation Inconsistencies

During the previous audit, we concluded that there were inconsistencies between investigative bureaus related to how the bureaus classify findings. In addition, we found inconsistencies between what is and is not accepted by the Bureau of Hotline and Intake as an allegation of abuse or neglect. Beginning in January 2007, the Deputy Inspector General and one investigative bureau chief (on a rotating basis) began quarterly reviews of unfounded and unsubstantiated cases to ensure consistency across bureaus.

Although the OIG has taken steps to try to improve in this area, consistency in what constitutes a reportable allegation and the classification of the outcome of cases as substantiated, unsubstantiated, and unfounded continue to be areas of concern at the OIG. During our testing, we identified cases that involved clients that were left unsupervised that had different outcomes.

The Inspector General or his designee is not required to review substantiated cases of mental injury or neglect unless it is deemed "egregious" neglect.

The Inspector General or his designee is not required to review substantiated cases of mental injury or neglect unless it is deemed "egregious" neglect. Conducting case file reviews is critical to the investigations process. These reviews not only ensure an effective investigation, but also help ensure the integrity and quality of the investigatory process. (pages 39-44)

Definition of Physical Harm

In the previous audit we recommended that the Inspector General should clearly define what constitutes physical injury and physical harm. This has not been accomplished. According to the OIG response in the previous audit, officials agreed and stated they believed that the issue of definitions would be resolved by revisions to the statute. Until the statute is revised, such a change to Rule 50 would be premature. However, in the meantime, OIG would reinforce that physical "harm" is a physical "wrong or injustice."

Auditors noted that effective August 28, 2007, Public Act 95-545 amended the Department of Human Services Act (20 ILCS 1305) by transferring to it all provisions concerning the Office of the Inspector General within the Department of Human Services from the Abused and Neglected Long Term Care Facility Residents Reporting Act. According to OIG officials, since the law was not substantially altered, Rule 50 was not revised. (page 45)

OIG SUBSTANTIATED CASE WRITTEN RESPONSES

The Department of Human Services Act requires that each completed case where abuse or neglect is substantiated or administrative action is recommended, contain a written response from the agency or facility that addresses the actions that will be taken. The Secretary of DHS is required by the Act to accept or reject the written response.

In our review of written responses, we found that DHS takes an excessive amount of time to receive and approve the actions taken by the agency or facility in some cases.

In our review of written responses, we found that DHS takes an excessive amount of time to receive and approve the actions taken by the agency or facility in some cases. For one case in our sample, the written response from the agency was dated November 9, 2007 but was not approved by DHS for over nine months (August 29, 2008). In another case, the agency date on the written response was September 9, 2008 and the DHS approved date was also September 9, 2008. However, the case was completed in August 2007. We requested this information on August 22, 2008. Therefore, more than a year after the case was completed, and only after auditors requested the information, was a written response prepared and approved by DHS.

Overall there were 43 cases in our sample that required a written response. Of the 41 cases in our sample for which we could determine an investigative completion date and a response date, 6 of 41 (15%) took more than six months from the date the case was completed until the written response was approved by DHS. Two of these cases took more

than a year. For two cases, we could not determine the date the case was completed.

According to OIG officials, the Developmental Disabilities Division at DHS had been falling behind in approvals partly due to staffing issues. During the later part of FY08 the Division increased its efforts to approve written responses in timely manner. If DHS does not approve written responses in a timely manner, the OIG cannot effectively monitor the implementation of actions by State-operated facilities and community agencies. In addition, not ensuring that appropriate actions are taken may put client safety at risk. (pages 53-55)

HEALTH CARE WORKER REGISTRY

According to 59 Ill. Adm. Code 50.90, an employee may request a hearing with the Department of Human Services and present evidence supporting why his or her finding does not warrant reporting to the Health Care Worker Registry. The percentage of cases appealed in which the Administrative Law Judge's (ALJ) decision upheld the referral of the employee to the Health Care Worker Registry has increased when compared to our previous audit. The ALJ decision was to refer the employee in 56 percent of the appeal hearings in FY08 (15 of 27) and 56 percent of those in FY07 (18 of 32), compared to 41 percent in FY06 (13 of 32) and 21 percent in FY05 (6 of 28).

We reviewed 10 substantiated cases in which the ALJ rejected the referral to the Health Care Worker Registry in FY08. In the 10 cases in which the referral was rejected, the ALJ found that the Department had not demonstrated by a preponderance of the evidence that the finding of abuse against the petitioner warranted reporting to the Registry. Several overturned cases cite the credibility of witnesses as a problem. In one case, the ALJ found the OIG investigation was unreliable. The OIG investigator in the case had been placed on leave and is no longer with the OIG. In another case, the ALJ found that the petitioner's actions were inappropriate but did not rise to the level of reporting to the Registry.

In our previous audit we recommended that the OIG revise its policies and procedures to ensure that all cases with findings that warrant reporting to the Registry are reported. The Department of Human Services Act requires physical abuse, sexual abuse, and egregious neglect to be referred to the Registry. Although the OIG has not updated the definition of egregious as it relates to neglect, the OIG directives have been updated and a process added for a stipulated motion to dismiss. This process is triggered by a Rule 50.90 petition on certain physical abuse cases that, although the finding meets the definition of physical abuse, may not be

severe enough to deserve placement on the Registry. In September 2006 the OIG implemented a new stipulation process authorized by statute for appeals hearings. The OIG did not refer a case to the Registry based on a stipulation order on six occasions in FY07 and FY08. (pages 56-60)

SANCTIONS

During FY07, two State-operated facilities failed to comply with requirements to remain certified as eligible Medicare or Medicaid service providers. As a result, Tinley Park Mental Health Center's Medicare provider agreement was terminated effective February 23, 2007 and Howe Developmental Center was terminated from the program effective March 8, 2007.

Even though these two State-operated facilities were terminated from participation in federal programs for non-compliance with issues related to patient safety and client protection, the OIG did not recommend a sanction against either facility. Over the past 15 years (1994 – 2008), the Inspector General has not recommended sanctions against a State-operated facility.

According to OIG officials, none of the issues cited by the reviewers at Tinley Park MHC were reportable to OIG under current State law. Some issues cited by the reviewers at Howe DC did meet the State law's definitions, but OIG identified no trends or patterns in those beyond what has been typical of other facility or agency programs. According to OIG officials, the OIG cannot recommend sanctions without identifying a pattern of uncorrected problems with abuse/neglect as defined in current law.

On June 9, 2008, the OIG did utilize its authority under 20 ILCS 1305/1-17(d) to recommend sanctions and sent letters to the DHS Division of Mental Health and to the DHS Division of Developmental Disabilities related to community agencies that had not updated their abuse/neglect reporting policies. The OIG recommended a total of nine service providers for non-renewal of their DHS service provider agreements until the policies are approved by OIG. (pages 61-62)

OTHER ISSUES

Other issues identified in the audit included:

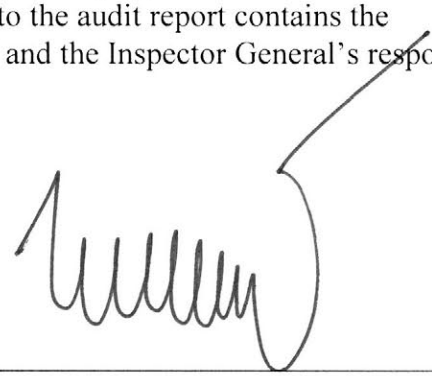
- The Quality Care Board held all required quarterly meetings during FY07-08.

- During FY07 and FY08, the Office of the Inspector General conducted annual unannounced site visits at all of the mental health and developmental centers and met established timelines for submitting site visit reports to facility directors or hospital administrators.

- DHS could not document that all staff at State-operated facilities received the required Rule 50 training in reporting abuse and neglect. In addition, the OIG identified two facilities that were deficient in training staff during its FY08 site visits. The OIG site visit for Howe Developmental Center reported that only 504 of the facility's 835 (60%) employees had been trained in OIG Rule 50 during the last year, and the OIG site visit for Tinley Park Mental Health Center reported that only 172 of the facility's 207 (83%) employees had been trained in OIG Rule 50. (pages 63-67)

RECOMMENDATIONS

The audit report contains 10 recommendations: 7 recommendations to the Office of the Inspector General and 3 recommendations to the Department of Human Services. The Inspector General and the Department of Human Services generally agreed with all 10 recommendations. Appendix E to the audit report contains the Department of Human Services' and the Inspector General's responses.



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WGH\MSP

December 2008