STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PROGRAM AUDIT

OFFICE OF THE INSPECTOR GENERAL DEPARTMENT OF HUMAN SERVICES

JANUARY 2021

FRANK J. MAUTINO

AUDITOR GENERAL

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OFFICE OF THE AUDITOR GENERAL
FRANK J. MAUTINO

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

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

The audit was conducted pursuant to Section 1-17(w) of the Department of Human Services Act (20 ILCS 1305). This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

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

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

Springfield, Illinois
January 2021

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

REPORT DIGEST

PERFORMANCE AUDIT

Release Date: January 2021

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

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EXECUTIVE SUMMARY

Illinois Department of Human Services Office of the Inspector General

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

For FY20, there were a total 518 community agencies with 4,401 program sites that were under the investigative jurisdiction of the OIG. In addition, there were also 14 State-operated facilities under the investigative jurisdiction of the OIG. OIG investigators in many cases are responsible for hundreds of program sites covering large areas of the State, as well as 14 State-operated facilities.

In this audit we reported that:

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

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

AUDIT SUMMARY AND RESULTS

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

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

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

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

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

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

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

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

Source: OAG analysis and OIG data.

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

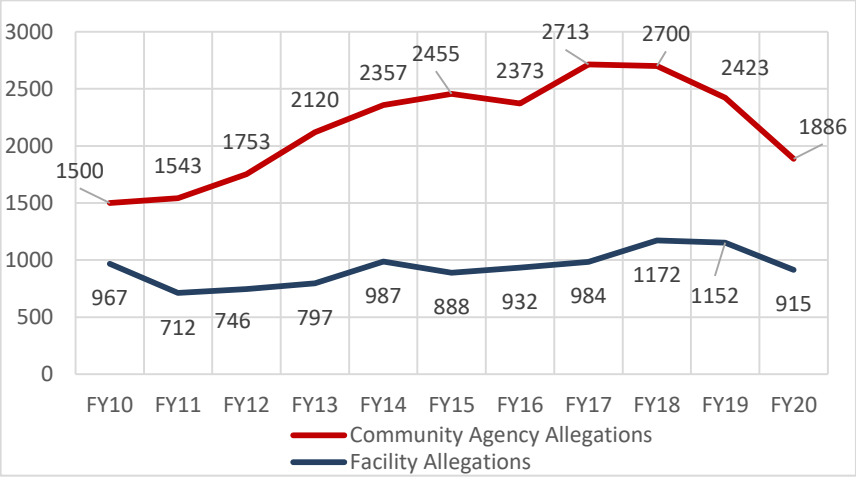
The total number of allegations increased from 2,467 in FY10 to 3,872 in FY18 before decreasing to 3,575 in FY19. For FY20 the total number of allegations declined to 2,801. This overall increase is due primarily to the increase in allegations reported at community agencies. **From FY10 to FY18 the total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

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

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

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

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



Source: OIG data summarized by OAG.

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

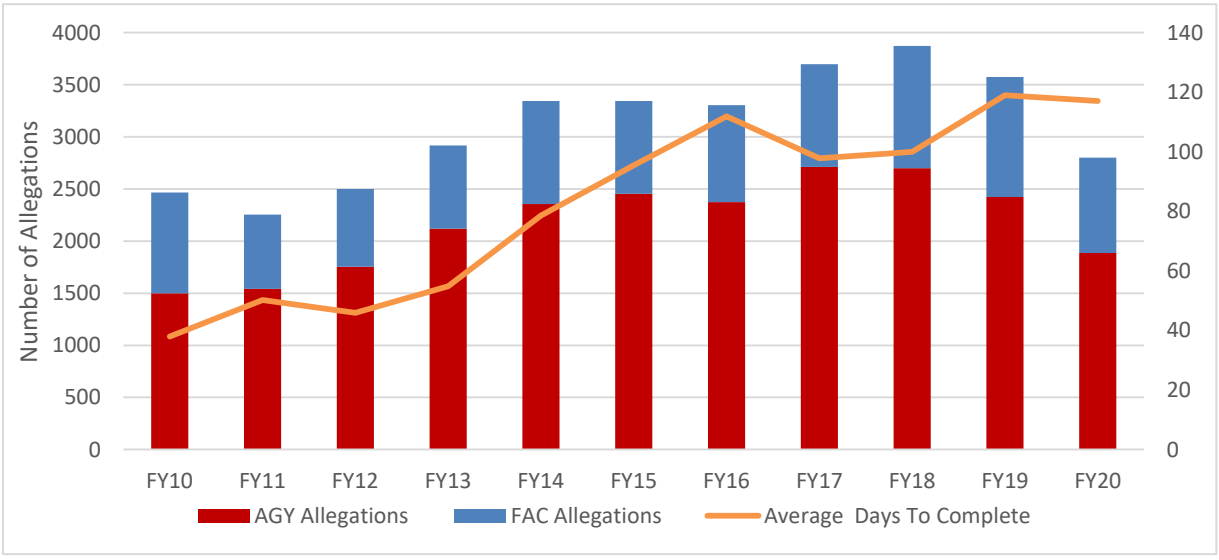
Increase in Allegations and Time to Complete Investigative Cases

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

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

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

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



Source: OAG analysis of OIG data.

Timeliness of Investigations

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

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

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

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

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

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

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

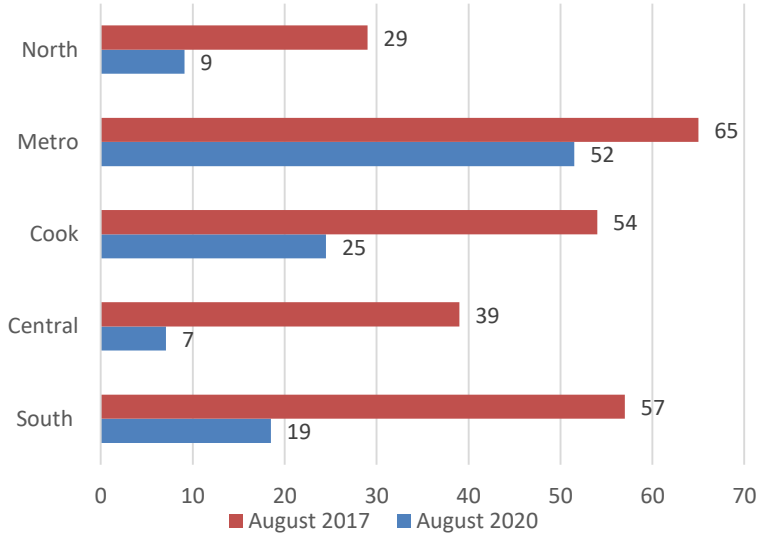
- **Obtaining Interviews or Statements from Victims** – The OIG's timeliness to obtain interviews or statements from victims has worsened by 77 percent since the last audit. For the FY20 cases sampled where a victim was interviewed and/or a statement was taken, it took an average of 46 days from the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

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

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

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

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



Source: OIG data summarized by OAG (unaudited).

Thoroughness of Investigations

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

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

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

Case Completion Timeliness Standards

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

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

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

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

Actions, Sanctions, and Recommendations

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

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

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

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

Other Issues

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

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

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

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

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

RECOMMENDATIONS

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

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

SIGNED ORIGINAL ON FILE

JOE BUTCHER
Division Director

This report is transmitted in accordance with Sections 3-14 and 3-15 of the Illinois State Auditing Act.

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

FJM:PMR

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Chapter One

INTRODUCTION AND BACKGROUND

REPORT CONCLUSIONS

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

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

For FY20, there were a total of 14 State-operated facilities, and 518 community agencies with 4,401 program sites that were under the investigative jurisdiction of the OIG. In our FY17 audit we reported that there were 421 agencies operating 4,552 programs. OIG investigators in many cases are responsible for hundreds of program sites covering large areas of the State. For instance, the Cook County Bureau has 8 investigators that are responsible for allegations reported for 2 State-operated facilities and 1,573 community agencies program locations (**197 locations per investigator**). In the Central Bureau, 9 investigators are responsible for 3 State-operated facilities and 995 community agency program locations across 47 counties covering **28,588 square miles, or 3,176 square miles per investigator**.

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

FY20 Decrease in Allegations

For FY20 the total number of allegations declined to 2,801. Beginning in March of 2020 a stay-at-home order due to COVID-19 was issued by Governor Pritzker, which mandated employees deemed non-essential to remain at home. OIG officials stated that when compared to the same time period from the previous year, March 1, 2020 through June 30, 2020, allegations were down by 45.7 percent. Based on these numbers COVID-19 played a large factor in these

reductions. The closing of the day programs and restricting individuals to their residences during COVID-19 is likely responsible for some of the drop in complaints. However, at the community agencies, the reduced presence of supervisory/administrative staff at the CILAs/homes may have resulted in a reduction of complaints. While the number of allegations has decreased at facilities, it appears that the drop in allegations is more significant at the community agencies.

Timeliness of Investigations

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

- **Case Completion** – The timeliness of completion for OIG investigations has worsened since our FY17 audit. For FY17, 50 percent of closed cases were completed within 60 working days. For FY18, FY19, and FY20, the percentage of cases completed within 60 working days was **44 percent, 38 percent, and 45 percent, respectively.** Timeliness of investigations has been an issue in all of the 12 previous OIG audits. In May 2017, the OIG's administrative rules were amended to remove the requirement that investigations be completed within 60 working days. However, this requirement is still included in the OIG's directives.

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

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

- **Investigator Assignments** – OIG directives require that investigations be assigned to an investigator within one working day of the Bureau Chief or Investigative Team Leader receiving the allegation. For investigations closed during FY20, 97 percent (3,482 of 3,582) were initially assigned within one working day of the Bureau Chief or Investigative Team Leader receiving the allegation. However, when compared to the date reported, 45 percent (1,621 of 3,582) of allegations took two or more working days to be assigned to an investigator meaning there was a delay in notifying the Bureau Chief or Investigative Team Leader.

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

- **Obtaining Interviews or Statements from Victims** – The OIG's timeliness to obtain interviews or statements from victims has worsened by 77 percent since the

last audit. For the FY20 cases sampled where a victim was interviewed and/or a statement was taken, it took an average of 46 days from the assignment date for the victim to have a statement taken or interviews to be performed, compared to an average of 26 days during our FY17 audit. Within the FY20 sample there were 12 cases which took between 119 and 574 days to interview the victim, which impacted the average time significantly.

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

- **Open Cases and Average Caseloads** – Open cases and average caseloads have decreased significantly since our FY17 audit. Overall, open cases decreased from 1,797 total cases as of August 2017 to 1,093 as of August 2020. For August 2017, caseload averages ranged from a high of 65 cases per investigator in the Metro Bureau to a low of 29 in the North Bureau. For August 2020, caseload averages ranged from a high of 52 cases per investigator in the Metro Bureau to a low of 7 in the Central Bureau. The average investigator caseload for each bureau has improved since our last audit.

Thoroughness of Investigations

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

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

Actions, Sanctions, and Recommendations

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

DHS, in some cases, still takes an extended amount of time to receive and approve the actions taken by the community agencies or State-operated facilities. State-operated facilities and community agencies are required to submit a written response to DHS for all substantiated

cases of abuse and neglect, or cases with other administrative issues within 30 calendar days from receipt of the investigative report. In our sample of 100 investigations, there were 31 cases where a written response was required; OIG could not provide the written response for two of these cases. For the remaining 29 cases, the average time for DHS to receive the response after sending out the case report to the facility or agency was 42 days. About half of the responses (15) were received within the 30 days required by statute. Six cases (19%) took 90 days or longer for DHS to receive and approve the response. All six cases that took 90 days or longer were community agency cases.

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

Other Issues

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

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

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

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

INTRODUCTION

The Department of Human Services Act directs the Auditor General to conduct a program audit of the Department of Human Services, Office of the Inspector General on an as needed basis. Section 1-17(w) of the Act that establishes the authority for this audit can be seen in Appendix A. The Act specifically requires the audit to include the Inspector General's compliance with the Act and effectiveness in investigating reports of allegations occurring in any facility or agency. The audit is required to be released no later than January 1 following the audit period (20 ILCS 1305/1-17(w)).

BACKGROUND

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

The 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 OIG 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 OIG was expanded to include the authority to investigate reports of abuse and neglect at facilities or programs not only operated by DHS (facilities), but also those licensed, certified, or funded by DHS (community agencies). This includes State-operated mental health centers and developmental centers, Community Integrated Living Arrangements (CILAs), developmental training programs, and outpatient mental health services.

State-Operated Facilities

A State-operated facility is a mental health facility or a developmental disabilities center operated by DHS. As of July 2020, there were 13 State-operated facilities, with one dual facility. Six of these facilities are mental health facilities, and six are developmental disabilities centers. Choate, located in southern Illinois, is a mental health facility and a developmental disabilities center.

Community Agencies

A community agency is an agency that is licensed, funded or certified by DHS to provide mental health services or developmental disabilities services, such as a CILA. Also falling under this category are programs licensed, funded or certified by DHS to provide mental health services or developmental disabilities services, such as a day training program. As of July 2020, there were 518 different community agencies in Illinois, which operated approximately 4,400 program sites.

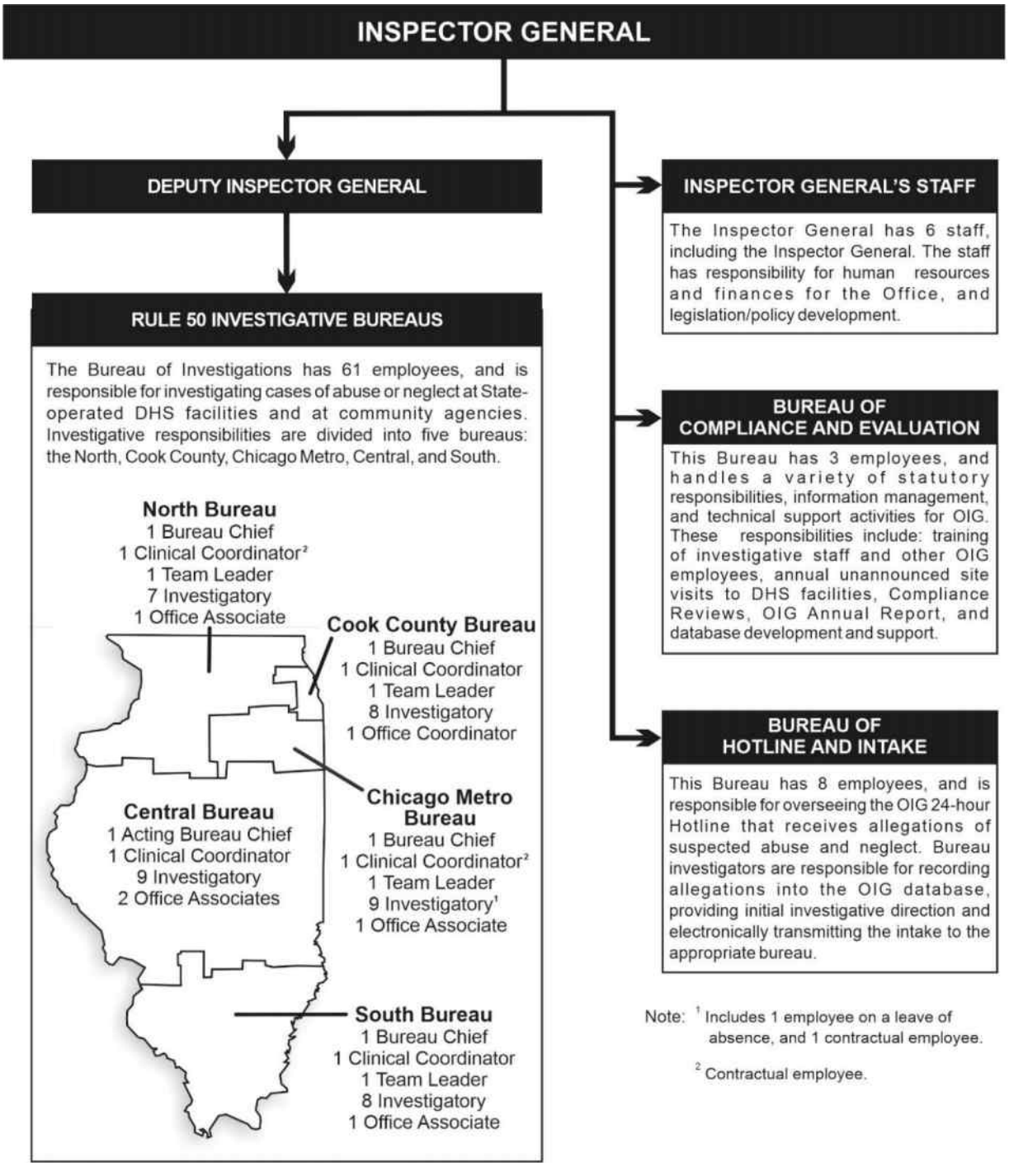
OIG ORGANIZATION

The Inspector General reports to the Secretary of DHS and to the Governor. The Inspector General as of June 30, 2020, Peter Neumer, was appointed to be the Acting Inspector General by Governor Pritzker in November of 2019. Prior to being appointed as Inspector General, Mr. Neumer worked as an Assistant Inspector General for the city of Chicago.

The mission statement of the Office of the Inspector General states: "The Office of the Inspector General assists agencies and facilities in prevention efforts by investigating all reports of abuse, neglect and mistreatment in a timely manner, to foster humane, competent, respectful and caring treatment of persons with mental and developmental disabilities."

As shown in Exhibit 1-1, as of June 30, 2020, the OIG has five investigative bureaus, which all report to the Deputy Inspector General. The OIG also has a Bureau of Hotline and Intake and a Bureau of Compliance and Evaluation that includes Clinical Coordinators that conduct death reviews.

Exhibit 1-1
OIG ORGANIZATIONAL CHART
As of June 30, 2020



Source: OAG analysis of DHS OIG organizational charts and staffing information.

During FY20, the OIG had a total of 78 employees, including the Inspector General. Two of these staff were contractual employees. There were a total of 50 investigative employees located within the investigative bureaus. As of July 2017, the OIG had a total of 60 employees, including 2 contractual employees.

The five OIG bureaus that conduct investigations of allegations at State facilities and community agencies are broken down by region. According to information provided by the OIG, as of February 2020:

- The **Cook County** Bureau is responsible for two facilities (Chicago-Read Mental Health Center and Madden Mental Health Center) and 1,573 program sites operated by 197 community agencies in Cook County;

- The **North** Bureau is responsible for three facilities (Elgin Mental Health Center, Kiley Developmental Center, and Mabley Developmental Center) and 875 program sites operated by 97 community agencies in 20 counties in northern and northwestern Illinois;

- The **Chicago Metro** Bureau is responsible for two facilities (Shapiro Developmental Center and Ludeman Developmental Center) and 402 program sites operated by 44 community agencies in five counties in the northeastern part of the State;

- The **Central** Bureau is responsible for three facilities (Fox Developmental Center, McFarland Mental Health Center, and Alton Developmental Center) and 995 program sites operated by 98 community agencies in 47 counties in the central part of the State; and

- The **South** Bureau is responsible for three facilities (Chester Mental Health Center, Choate Mental Health Center and Developmental Center, and Murray Developmental Center) and 548 program sites operated by 82 community agencies in 29 counties in the southern section of the State.

Exhibit 1-2 summarizes the five OIG bureaus and the number of counties, facilities, community agencies, program sites and square mileage each is responsible for investigating.

For FY20, there were a total 518 community agencies with 4,401 program sites that were under the investigative jurisdiction of the OIG. In our previous audit we reported that there were 421 community agencies operating 4,552 programs. As is shown in Exhibit 1-2, OIG investigators, in many cases, are responsible for hundreds of program sites covering large areas of the State. For instance, the Cook Bureau has 8 investigators that are responsible for allegations reported for 2 State-operated facilities and 1,573 community agencies program locations (**197 locations per investigator**). In the Central Bureau, 9 investigators are responsible for 3 State-operated Facilities and 995 community agency program locations across 47 counties covering **28,588 square miles, or 3,176 square miles per investigator**.

Exhibit 1-2
SUMMARY OF OIG BUREAUS AND RESPONSIBILITIES
As of June 30, 2020

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

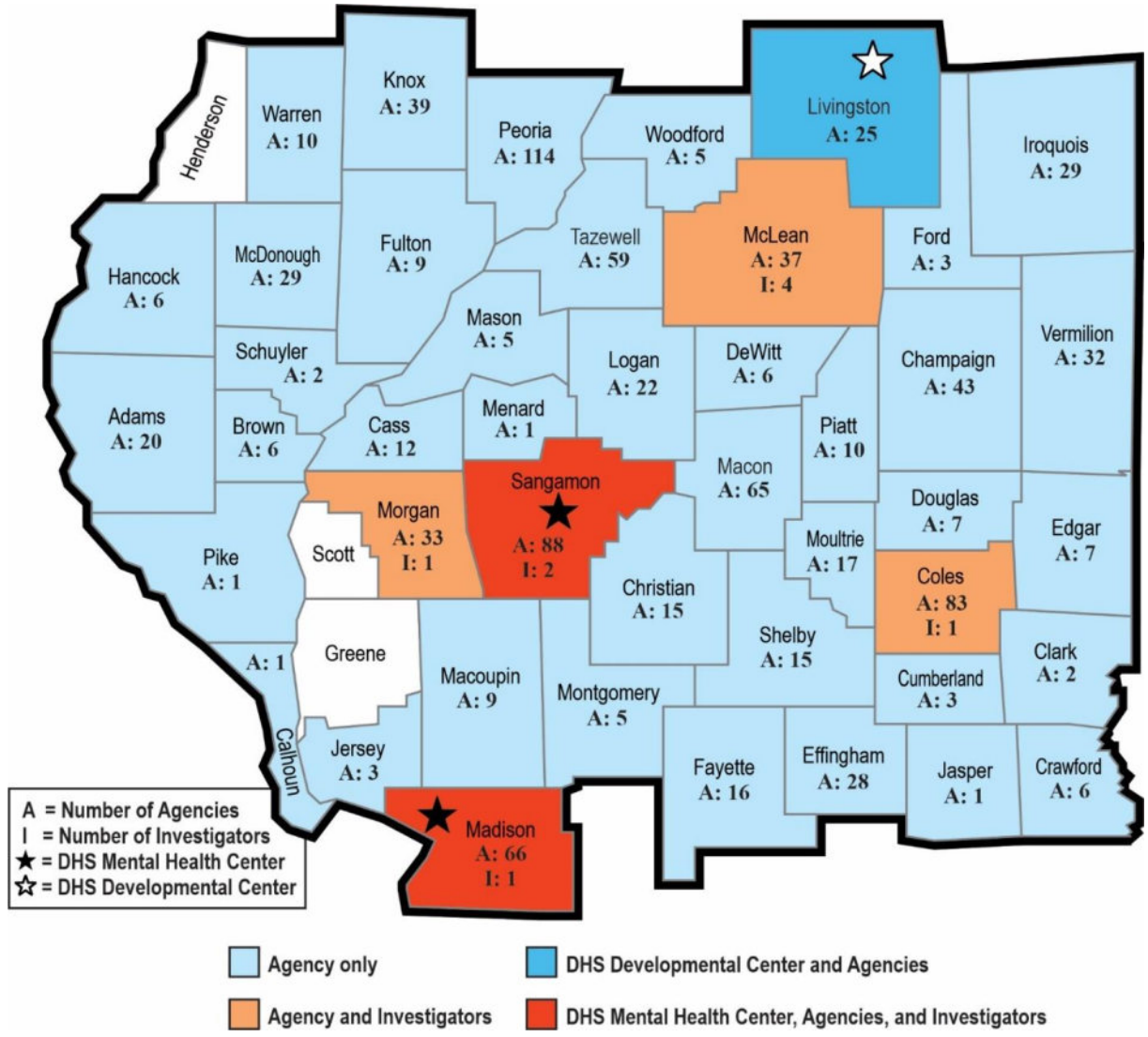
Notes:
[1] Choate is a dual facility located in the South Bureau.
[2] Some community agencies operate program sites in multiple OIG bureaus. Therefore, the count of agency and program sites by bureau includes some duplication. Column totals may not add.
[3] There were 8 program sites in our data that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

Source: OAG analysis and OIG data.

Exhibit 1-2 shows that investigators have jurisdiction over investigations at 995 program sites and three State-operated facilities in the Central Bureau. The Central Bureau geographically covers roughly 51 percent of the entire state of Illinois; with only nine investigators this may cause numerous challenges with completing investigations in a timely manner. The time and distance necessary to travel in order to investigate allegations could potentially impact the overall safety and well-being of alleged victims.

As shown in Exhibit 1-3 and Appendix E, the Central Bureau has nine investigators, with two investigators in Sangamon County, one in Morgan County, four in McLean County, one in Madison County, and one in Coles County. While these counties do have a large number of community agencies, other counties that have a similarly large number of agencies do not have an investigator within, or near them. For instance, there are 114 community agencies in Peoria County, with the closest investigators being located two counties to the east in McLean County. Adams County has 20 agency sites, but the closest investigator is located in Morgan County, which is two counties, and over an hour, away. Similarly, Knox County had 39 community agencies and 23 allegations during FY20, but is located three counties, and approximately 90 minutes, to the west of McLean County.

Exhibit 1-3
DHS OIG CENTRAL BUREAU
COUNT OF AGENCY SITES, FACILITIES, AND INVESTIGATORS BY COUNTY



Note: Henderson, Scott, and Greene Counties do not have any agencies, State-operated facilities, or DHS OIG investigators.

Source: OIG data compiled by the OAG.

OIG Bureaus of Investigation

As shown in Exhibit 1-4, the responsibility for OIG investigations is divided into five regional bureaus.

- The **Cook County** Bureau is located at Madden Mental Health Center with investigators located at Madden Mental Health Center and a DHS teen site.

- The **Chicago Metro** Bureau is located at Madden Mental Health Center with investigators located at Madden Mental Health Center, Ludeman Developmental Center, Elgin Mental Health Center, the Illinois Veterans' Home in Manteno, and a DHS teen site.

- The **North** Bureau is located at Madden Mental Health Center with investigators located at Kiley Mental Health Center, Elgin Mental Health Center, Mabley Developmental Center, and one located within the city of Rockford.

- The **Central** Bureau is located at McFarland Mental Health Center with investigators located at McFarland Mental Health Center, Jacksonville Family Community Resource Center, and within the cities of Mattoon, and Bloomington.

- The **South** Bureau is located at Choate Mental Health and Developmental Center with investigators located at Choate Mental Health Center, Chester Mental Health Center, and within the cities of Centralia, Mt. Vernon, and the East Saint Louis.

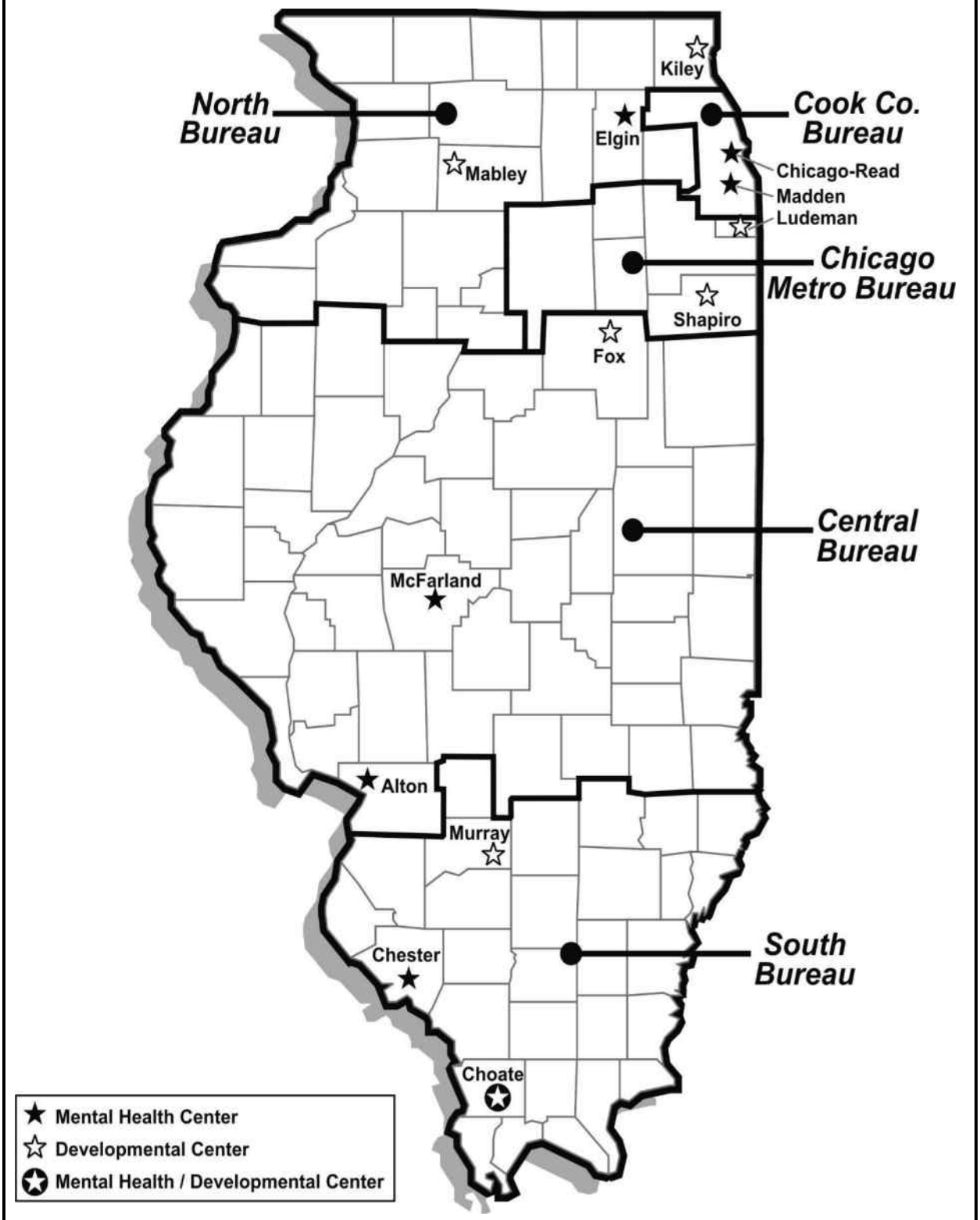
As of June 30, 2020, there were a total of 50 investigative employees in the five investigative bureaus: Cook (10), North (9), Chicago Metro (11), Central (10), and South (10). A Clinical Coordinator is also located within each bureau, and their primary job is to oversee death reviews, and assist with investigations that involve medical issues. All of the investigative bureaus report to the Deputy Inspector General. Other bureaus at the OIG include the:

- **Bureau of Hotline and Intake:** includes hotline personnel who take calls reporting allegations of abuse or neglect. As of June 30, 2020, the headcount in this bureau was eight; and

- **Bureau of Compliance and Evaluation:** includes functions such as information management, human resources, and training. The headcount in this bureau as of June 30, 2020, was three.

In addition to the bureaus discussed above, there is the Inspector General's staff. There are a total of six employees including the Inspector General. The Inspector General's staff includes the Interim Deputy Inspector General and the policy development staff.

Exhibit 1-4
DHS OPERATED FACILITIES AND OIG INVESTIGATIVE BUREAUS



Source: OAG analysis of OIG organizational charts and DHS facility locations.

FACILITY POPULATIONS AND REPORTED ALLEGATIONS

During the audit period, DHS operated a total of 13 facilities in Illinois. Six facilities served the developmentally disabled and six facilities served the mentally ill. Choate serves both mental health and developmental disabilities recipients.

Exhibit 1-5
UNDUPLICATED INDIVIDUALS SERVED IN STATE FACILITIES
FY10 through FY20

Fiscal Year	Developmental Centers	Mental Health Centers	Total
FY10	2,485	10,237	12,722
FY11	2,279	9,469	11,748
FY12	2,037	8,960	10,997
FY13	1,918	6,829	8,747
FY14	1,854	6,762	8,616
FY15	1,798	5,709	7,507
FY16	1,897	5,459	7,356
FY17	1,878	5,109	6,987
FY18	1,853	4,587	6,440
FY19	1,881	4,319	6,200
FY20	1,891	3,863	5,754

Source: OIG data FY10 through FY20.

State-Operated Facility Populations

The number of individuals being served in State run facilities has decreased since our last audit. Exhibit 1-5 shows the number of unduplicated residents served at State facilities for the period FY10 through FY20. **Overall, since FY10, the total number of unduplicated residents at all facilities has declined by 55 percent. The number served at State mental health centers has decreased by 62 percent.**

Trends in Reporting Allegations of Abuse and Neglect

When incidents of abuse or neglect are reported, the complaints are phoned into the OIG Hotline and may come from recipients, parents/guardians, individual employees, neighbors, and friends. OIG's administrative rules require that incidents of abuse and neglect be reported within four hours of the discovery of the incident.

Exhibit 1-6
ALLEGATIONS OF ABUSE & NEGLECT REPORTED
FY10 through FY20

Fiscal Year	Facility Allegations	Community Agency Allegations	Total
FY10	967	1,500	2,467
FY11	712	1,543	2,255
FY12	746	1,753	2,499
FY13	797	2,120	2,917
FY14	987	2,357	3,344
FY15	888	2,455	3,343
FY16	932	2,373	3,305
FY17	984	2,713	3,697
FY18	1,172	2,700	3,872
FY19	1,152	2,423	3,575
FY20	915	1,886	2,801

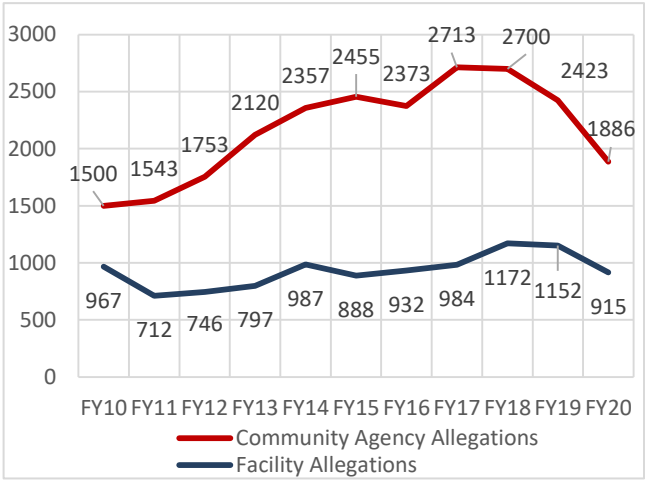
Source: OIG annual reports and OIG data.

Exhibit 1-6 shows the total number of allegations increased from 2,467 in FY10 to 3,872 in FY18 before decreasing to 3,575 in FY19 and 2,801 in FY20. This overall increase is due primarily to the increase in allegations reported at community agencies. **From FY10 to FY18 the total number of allegations reported at community agencies increased by 1,200 or 80 percent**. For FY18, FY19, and FY20, community agency allegations accounted for 70 percent, 68 percent, and 67 percent of all reported allegations of abuse or neglect, respectively.

As is shown in Exhibit 1-7, allegations reported by community agencies increased from 1,500 in FY10 to 2,700 in FY18 or 80 percent. Allegations of abuse and neglect reported at State facilities also increased from 967 in FY10 to 1,172 in FY18.

Exhibit 1-8 shows the allegations reported for the period FY10 through FY20 by the type of allegation. Although allegations of both abuse and neglect have increased, allegations of neglect more than doubled from FY10 to FY18. For FY10 there were 1,877 allegations of abuse and 590 allegations of neglect. For FY18, there were 2,502 allegations of abuse and 1,370 allegations of neglect.

Exhibit 1-7
ABUSE AND NEGLECT ALLEGATIONS REPORTED TO OIG BY TYPE OF FACILITY
FY10 through FY20

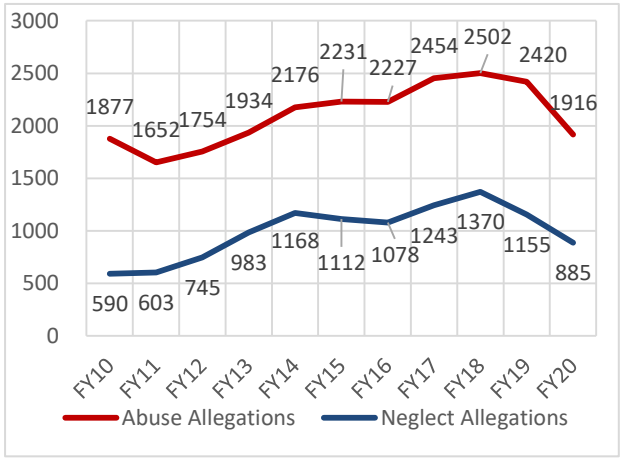


Source: OIG data summarized by OAG.

FY20 Decrease in Allegations

As can be seen in Exhibits 1-5, 1-6, and 1-7, as well as in Chapter 2 exhibits, the allegations for FY20 decreased substantially compared to previous years. During March of 2020 a stay-at-home order was issued by Governor Pritzker, which mandated employees deemed non-essential to remain at home. We asked OIG officials for a reason that allegations decreased dramatically compared to recent years. OIG officials stated that when compared to the same time period from the previous year, March 1, 2020, through June 30, 2020, allegations were down by 45.7 percent. Based on these numbers COVID-19 played a large factor in these reductions. The closing of the day programs and restricting individuals to their residences during COVID-19 is likely responsible for some of the drop in complaints. However, at the community agencies, the reduced presence of supervisory/administrative staff at the CILAs/homes may have resulted in a reduction of complaints. Based on the numbers, while the number of allegations decreased at facilities, it appears that the drop in allegations is more significant at the agencies.

Exhibit 1-8
TRENDS IN REPORTING ABUSE AND NEGLECT
FY10 through FY20



Source: OIG data summarized by OAG.

OIG INVESTIGATION PROCESS

The investigation process begins when an allegation is reported to the OIG Hotline. The Act requires that suspected abuse and neglect be reported by phone to the OIG Hotline no later than four hours after the initial discovery of the incident. The OIG Hotline investigator determines whether the allegation meets the definition of abuse and neglect. If abuse and neglect is suspected, the case is assigned to the investigative bureau responsible for that facility or region (for community agencies). Depending on the allegation and the direction given by the OIG investigator, trained facility or community agency personnel may collect physical evidence and take initial statements from those involved in the incident.

Allegations are assigned, based on location, to one of five OIG investigative bureaus. OIG directives require the Bureau Chief to assign the case to an investigator within one working day. The OIG no longer requires investigators to complete an investigative plan within three working days of the assignment unless it is during the investigator's probationary period. When the investigator completes an investigation, an investigative report is developed in accordance with OIG directives and is forwarded to the Investigative Team Leader or the Bureau Chief for initial review and approval. According to OIG directives, the case is required to be reviewed, absent extenuating circumstances, within 15 working days of receipt.

For substantiated cases, the Investigative Team Leader or Bureau Chief is required to complete a Supervisory Review Checklist and complete the Elemental Review Sheet started by the assigned investigator. Once the Bureau Chief reviews and approves a substantiated case of physical abuse, sexual abuse, financial exploitation, or egregious neglect, the report will then be sent to the Inspector General or his/her designee for review. After this review, the investigative report shall be submitted to the Inspector General within 60 working days of the assignment unless there are extenuating circumstances. **In May 2017, the 60 working day requirement and all case file requirements for investigations were removed from the OIG's administrative rules.** The requirement to complete cases within 60 working days is, however, still included in the OIG's directives.

For cases that involve medical issues, the OIG directives require that the investigators contact a Clinical Coordinator for a consultation. The OIG investigator must also consult with a Clinical Coordinator prior to rendering a conclusion in a case involving a medical issue.

Case closure is a two-step process: first, the investigation is completed and the investigative report is mailed; second, after the reconsideration period has ended and any additional action has been taken, the case is administratively closed.

To begin the reconsideration process, the OIG sends notice of the outcome of the investigation to the complainant, the individual who was allegedly abused or neglected or his or her legal guardian, and the person alleged to have committed the offense. Any of these parties may submit, in writing, a request for reconsideration or clarification of the finding (59 Ill. Adm. Code 50.60). Requests for reconsideration or clarification must be submitted within 15 working days after the receipt of the report or notification of the finding(s).

For unsubstantiated cases without recommendations, a letter of finding is sent to the facility or community agency. If the case is substantiated or contains recommendations, the OIG sends the facility or community agency a copy of the investigative report that includes the OIG's finding in the case. The OIG is also required by rule to send a copy of the finding in all cases to the complainant, the individual that was allegedly abused or neglected, and the person alleged to have committed the offense. The investigative report and the investigation are considered closed 30 calendar days after being provided to the facility or agency.

The Inspector General is required by the Act to provide a complete investigative report within 10 business days to the Secretary of DHS when abuse or neglect is substantiated or administrative action is recommended (20 ILCS 1305/1-17(m)). For any case in which the OIG substantiates abuse or neglect or makes one or more recommendations, the community agency or facility is required to submit a written response within 30 calendar days to the respective DHS program division office. If reconsideration is requested and denied, or after clarification has been provided, the community agency or facility shall submit a written response within 15 calendar days after the receipt of the clarification or denial of reconsideration. The Director of the applicable DHS division (Mental Health or Developmental Disabilities) is required to approve the written response (59 Ill. Adm. Code 50.80).

Death Reviews

The Act requires that absent an allegation of abuse and neglect, deaths are to be reported by phone to the OIG Hotline within 24 hours after initial discovery. This includes any death at a facility or agency or any death occurring within 14 calendar days after discharge or transfer of an individual from a residential program or facility.

The responsibility for death reviews is shared between the OIG Clinical Coordinators and the investigative bureaus. If the Clinical Coordinator determines that there may be an allegation of abuse and neglect associated with a death review, the appropriate Bureau Chief is notified, and the case is referred to an OIG investigator. The Clinical Coordinator assists with the investigation, but the standard OIG investigation process is followed.

If the Clinical Coordinator determines that a death is not due to abuse and neglect, the Clinical Coordinator will notify the Bureau Chief and assume primary responsibility for the review. This includes conducting necessary interviews, collecting relevant documentation, and completing the death report. For these cases the Bureau Chief is also the final reviewer.

Health Care Worker Registry

If an investigation substantiates an allegation of physical abuse, sexual abuse, egregious neglect, or financial exploitation, the Inspector General is required by the Act to report the identity of the accused employee and finding to the Health Care Worker Registry. The Health Care Worker Registry is discussed further in Chapter Four of this report.

REPORTING ALLEGATIONS

When looking at FY18 and FY19, total allegations of abuse and neglect reported to the OIG have remained relatively unchanged since our previous audit for FY17. In FY17 there were a total of 3,697 allegations reported (2,454 abuse and 1,243 neglect). In FY18, 3,872 allegations were reported (2,502 abuse and 1,370 neglect), and in FY19 there were 3,575 allegations reported (2,420 abuse and 1,155 neglect). However, FY20 declined sharply with only 2,801 allegations reported (1,916 abuse and 885 neglect). Potential reasons for the decline are discussed previously in this chapter.

Reporting to the OIG Hotline

DHS facilities and community agencies are required by the DHS Act to report allegations of abuse and neglect within four hours of discovery of an incident by calling the OIG Hotline. An OIG Hotline investigator makes an assessment as to whether the allegation is reportable and whether it is abuse or neglect, the intent being to reduce the number of inappropriate cases from being investigated. Hotline investigators directly enter the information into a database, and the case is then forwarded to the appropriate investigative bureau to begin the investigation.

Facility and community agency employees are required to report to the OIG if they witness, are told of, or have reason to believe an incident of abuse, neglect, or death has occurred. The OIG's administrative rules (59 Ill. Adm. Code 50.20) require that the following allegations be reported:

- Any allegation of abuse by an employee, including financial exploitation;
- Any allegation of neglect by an employee, community agency, or facility;
- Any injury or death of an individual that occurs within a facility or community agency program when abuse or neglect is suspected.

Reporting Criminal Acts

State law requires the OIG to report any suspected abuse and neglect that indicates a possible criminal act may have been committed to the Illinois State Police (ISP) or other appropriate law enforcement authority within 24 hours after determining that there is credible evidence indicating that a criminal act may have been committed. The ISP is required to investigate any report from a State-operated facility indicating a possible murder, sexual assault, or other felony by an employee (20 ILCS 1305/1-17(l)).

OTHER STATE AGENCIES

While the Act requires the OIG to investigate abuse and neglect, other State agencies, including the Illinois State Police, the Department of Children and Family Services, and the Department of Public Health, also have statutory responsibility to investigate potential instances of abuse and neglect. The Act requires the OIG to promulgate rules that set forth instances

where two or more State agencies could investigate an allegation so that OIG investigations do not duplicate other investigations (20 ILCS 1305/1-17(g)).

The OIG's administrative rules stipulate that *"when two or more State agencies could investigate an allegation of abuse and neglect at a community agency or facility, OIG shall not conduct an investigation that is redundant to an investigation conducted by another State agency (Section 1-17(a) of the Act) unless another State agency has requested that OIG participate in the investigation (such as the Departments of State Police, Children and Family Services, or Public Health)"* (59 Ill. Adm. Code 50.30). The Inspector General has clarified the investigatory roles with the Illinois State Police and Department of Public Health through interagency agreements.

Illinois State Police

The Act requires the OIG to report to the Illinois State Police *within 24 hours after determining that a reported allegation of suspected abuse and neglect indicates that any possible criminal act has been committed or that special expertise is required in the investigation*. The OIG is required to notify the Illinois of State Police or the appropriate law enforcement entity, or ensure that such notification is made. The Illinois of State Police are required to investigate any report from a State-operated facility indicating a possible murder, sexual assault, or other felony by an employee (20 ILCS 1305/1-17(l)).

The OIG has an agreement with the Illinois State Police which clarifies the reporting and investigative responsibilities of each agency. The agreement not only requires reporting by the OIG to the Illinois State Police within 24 hours of determining that a possible criminal act has been committed, but also requires that when the Illinois State Police receive an allegation of abuse or neglect and decline to investigate, they must notify the OIG within 24 hours. This agreement was updated on July 8, 2020, and is set to expire on June 30, 2024.

When allegations are investigated by the Illinois State Police, the OIG may conduct a separate investigation after the investigation is completed. The Illinois State Police only look at the criminal aspects of the incident; it is up to the OIG to examine any administrative issues relating to the incident.

Department of Public Health

The Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30) requires the Illinois Department of Public Health (DPH) to conduct investigations of suspected abuse and neglect at DPH-licensed long-term care facilities. This includes any long-term care institution participating in the Medicare or Medicaid programs, including State facilities operated by DHS and community mental health centers.

The Abused and Neglected Long Term Care Facility Residents Reporting Act requires all persons who provide direct care services or have direct contact with residents to report all incidents of suspected abuse and neglect to DPH immediately. DPH investigations focus on quality of care issues, such as allegations of actual or potential harm to patients, patient rights, infection control, and medication errors. DPH also investigates allegations of harm or potential harm due to an unsafe physical (building) environment.

The current interagency agreement between the OIG and DPH was executed in March 2012. The agreement clarifies the responsibilities for each agency and generally delineates that:

- The OIG will refer allegations and reports of incidents received regarding DPH-licensed long-term care facilities to the DPH Long-Term Care Residents Reporting Hotline; and

- DPH will refer all allegations and reports of incidents occurring at programs within DHS-OIG's jurisdiction to the OIG.

Department of Healthcare and Family Services

The OIG has also entered into an interagency agreement with the Department of Healthcare and Family Services for the purposes of sharing investigative information. Pursuant to the Intergovernmental Cooperation Act, OIG and the Department of Healthcare and Family Services entered into an interagency agreement for the purposes of the OIG sharing information regarding investigative reports for Illinois residents enrolled in the Home and Community-Based Services Waiver for Adults with Developmental Disabilities. The purpose of the agreement is to facilitate the Department of Healthcare and Family Services' access to OIG investigative reports regarding alleged incidents of abuse, neglect, financial exploitation, and death in order to comply with federal requirements including the prevention of further incidents. The current agreement is set to expire on December 31, 2022.

STATUS OF RECOMMENDATIONS FROM PREVIOUS AUDIT

The previous audit of the OIG, released in December 2017, contained a total of thirteen recommendations: ten to the OIG, two to DHS, and one to DHS and the OIG. Follow-up for these recommendations was conducted as part of this audit, which covers FY18 through FY20. This audit follows up on any remaining recommendations that were not implemented. Any repeated recommendations are contained in this report.

Chapter Two

TIMELINESS OF ABUSE AND NEGLECT INVESTIGATIONS

CHAPTER CONCLUSIONS

The timeliness of completion for OIG investigations has worsened since our FY17 audit. For FY17, 50 percent of closed cases were completed within 60 working days. **For FY18, FY19, and FY20, the percentage of cases completed within 60 working days was 44 percent, 38 percent, and 45 percent, respectively.** Timeliness of investigations has been an issue in all of the 12 previous OIG audits. The total number of allegations reported to the OIG have continued to increase overall since 2010. Data obtained from OIG's annual reports and investigative database show that there is a correlation with the number of allegations received, and case completion timeliness.

Timeliness could not be determined for 20 percent of State-operated facility allegations and 17 percent of community allegations for FY20. This was because the incident discovered time/date was reported as unknown, was inaccurate, or the time/date recorded was not specific. For FY20, the percent of allegations not reported within the statutorily required four hours was 16 percent at community agencies and 10 percent at State-operated facilities. **Compared to the FY17 audit, late reporting at State-operated facilities has become worse, increasing from 5 percent during our last audit to 10 percent during FY20.** For community agencies, late reporting has also gotten worse, going from 11 percent during our FY17 audit to 16 percent during FY20.

The OIG needs to improve the timeliness of investigator assignment and supervisory approval. The audit found the following:

- OIG directives require that investigations be assigned to an investigator within one working day of the Bureau Chief or Investigative Team Leader receiving the intake. For investigations closed during FY20, 97 percent (3,476 of 3,582) were initially assigned within one working day of the Bureau Chief or Investigative Team Leader receiving the allegation. However, when compared to the date reported, 45 percent (1,598 of 3,582) of investigations took two or more working days to be assigned to an investigator; and

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

Even though the OIG no longer has required time frames for critical interviews, auditors continue to look at the amount of time it takes to collect statements and interview the alleged victim and the alleged perpetrator in abuse and neglect cases.

The OIG's timeliness to obtain interviews or statements has worsened by 77 percent since the last audit. For the FY20 cases sampled where a victim was interviewed and/or a statement was taken, it took an average of 46 days from the assignment date for the victim to have a statement taken or interviews to be performed, compared to an average of 26 days during our FY17 audit. Within the FY20 sample, there were 12 cases which took between 119 and 574 days to interview the victim, and impacted the average time significantly.

For FY20 cases sampled, it took an average of 45 days from the assignment date for the alleged perpetrator to be interviewed and/or a statement to be taken. Within the sample, there were 13 cases that took between 108 and 428 days to interview the alleged perpetrator, which impacted the average time significantly. For our FY17 audit cases we sampled where there was a specific alleged perpetrator identified, it took an average of 45 days.

Open cases and average caseloads have decreased significantly since the FY17 audit. Overall, open cases decreased from 1,797 total cases as of August 2017 to 1,093 as of August 2020. For August 2017, caseload averages ranged from a high of 65 cases per investigator in the Metro Bureau to a low of 29 in the North Bureau. For August 2020, caseload averages ranged from a high of 52 cases per investigator in the Metro Bureau to a low of 7 in the Central Bureau. The average investigator caseload for each bureau has improved since our last audit.

REPORTING ALLEGATIONS

The Department of Human Services Act (Act), and the OIG's administrative rules require that allegations be reported to the OIG hotline **within four hours of initial discovery** of the incident of alleged abuse and neglect (20 ILCS 1305/1-17(k)).

Exhibit 2-1 shows allegations of abuse and neglect not reported within four hours of discovery for State-operated facilities and community agencies for FY17 and for the audit period FY18 through FY20. For FY20, the percent of allegations not reported within the statutorily required four hours was 16 percent at community agencies compared to 11 percent in FY17. **For State-operated facilities, 10 percent of the allegations were not reported in the statutorily required four hour time period, compared to 5 percent in FY17.**

Exhibit 2-1
ALLEGATIONS OF ABUSE AND NEGLECT NOT REPORTED WITHIN FOUR HOURS OF DISCOVERY
FY17 through FY20

Fiscal Year	Facility	Community Agency
FY17	5%	11%
FY18	6%	12%
FY19	8%	13%
FY20	10%	16%

Source: OAG analysis of OIG data.

Additionally, there was a significant percentage of allegations for which we could not determine if the incident was reported within the required four hours for FY18 through FY20.

- **State-Operated Facility Reporting** – Timeliness could not be determined for 20 percent of FY20 State-operated facility allegations because the incident discovered time/date was reported as unknown, or the incident time recorded was not specific (i.e. "one week ago" or "ongoing"). For FY18 and FY19, timeliness could not be determined for 19 percent and 21 percent of State-operated facility allegations, respectively.

- **Community Agency Reporting** – Timeliness of reporting could not be determined for 17 percent of FY20 agency allegations because the incident discovered time/date was reported as unknown or the incident time was not specific (i.e. "ongoing," "night," "early morning," "around noon," etc.). For FY18 and FY19, timeliness could not be determined for 21 percent of community agency allegations.

While there are clearly situations in which a specific incident date and time may not be attainable, the OIG should make further efforts to ascertain a specific date and time that the reporter discovered or was informed of the allegation or incident. Without accurately gathering this information at intake, it is impossible to know whether these allegations are being reported in accordance with the four hour reporting requirement in the Act and the OIG's administrative rules.

ALLEGATION REPORTING	
RECOMMENDATION 1	***The Office of the Inspector General should:*** • ***Improve the collection of information regarding the date and time an incident is discovered; and*** • ***Continue to work with State-operated facilities and community agencies to improve the number of allegations of abuse and neglect that are reported within the four-hour time frame specified in the Department of Human Services Act and OIG's administrative rules.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	The Office of the Inspector General (OIG) accepts the recommendation. The OIG will direct its Bureau Chief to brief intake staff on the importance of obtaining specific information from callers, including the time of discovery of an alleged incident of abuse and neglect. The OIG will also review its training materials and directives and assess whether the OIG needs to further emphasize this aspect of the intake process. In addition, the OIG will continue to make recommendations to agencies and facilities in its final investigative reports regarding late reporting or failure to report and continue to require the Illinois Department of Human Services (IDHS) program divisions to approve written responses provided by agencies and facilities in response to such recommendations. *See* 20 ILCS 1305 1-17(n). On a monthly basis, the OIG will continue to provide the IDHS program divisions with a report of untimely "self-reports" the OIG received in the previous month. The report will identify each late report, the number of days each report was late, and the overall

	percentage of reports that were late. Furthermore, when there is a pattern of late reporting or failure to report by an agency or facility, the OIG will continue to notify the appropriate IDHS division. Agency and facility staff will continue to be trained biannually on the reporting requirements through Rule 50 training. The OIG will continue to work with IDHS to identify additional ways in which to improve the timeliness of IDHS' reporting.

INVESTIGATION TIMELINESS

The timeliness of OIG investigations is critical because victims who have disabilities may forget what happened or be unable to recount what happened consistently, physical evidence may become lost over time, and employees or alleged perpetrators may no longer be available for interviews because of either a change in jobs or termination. This includes timeliness of the assignment of the investigation, timeliness in conducting interviews, collection of evidence, and timeliness in supervisory review and closing cases.

Timeliness of Assignment

The OIG should improve the timeliness of data entry and notification of Bureau Chiefs and Investigative Team Leaders. For investigations closed during FY20, 97 percent (3,476 of 3,582) were initially assigned within one working day of the Bureau Chief or Investigative Team Leader receiving the allegation. Two percent (74 of 3,582) were assigned between 3 and 73 days of the Bureau Chief or Investigative Team Leader receiving the allegation, with the majority (68 cases) being assigned between 3 and 10 days. The remaining six cases were assigned between 12 and 73 days. For another six cases it could not be determined when the Bureau Chief or Investigative Team Leader received the allegation.

OIG directives require that investigations be assigned to an investigator within one working day of the Bureau Chief or Investigative Team Leader receiving the allegation from intake. However, in many cases there was a delay from the time the allegation was initially reported to the time the Bureau Chief or Investigative Team Leader was notified of the allegation. When compared to the date the allegation was reported, 45 percent (1,598 of 3,582) of investigations took two or more working days to be assigned to an investigator. Part of the reason for this delay is that approximately 35 percent (1,256 of 3,582) of the cases closed in FY20 took two working days or longer to enter into the database. For six cases the date that the Bureau Chief or Investigative Team Leader received the case from Intake could not be determined.

INVESTIGATOR ASSIGNMENT	
RECOMMENDATION 2	***The Office of the Inspector General should work to improve the timeliness of:*** • ***Initial entry of cases into the OIG database; and*** • ***Case notification to Bureau Chiefs and Investigative Team Leaders as required by OIG directives.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	The Office of the Inspector General (OIG) accepts the recommendation. The OIG is in the process of hiring an Investigative Team Leader for its Intake Bureau. In addition, the OIG has posted a position for a Chief Administrative Officer who will be tasked with reviewing the intake process from a technological perspective to identify any unnecessary delays. The OIG will also work with the Intake Bureau to identify additional efficiencies to improve the process.

Timeliness of Investigations

Prior OIG investigative guidance required that investigations be completed as expeditiously as possible and should not exceed 60 calendar days absent extenuating circumstances. The OIG changed the definition of days in its administrative rules in January 2002 to **working** rather than **calendar** days. Generally, 60 working days works out to over 80 calendar days. **Effective May 26, 2017, the OIG's administrative rules were amended to remove the requirement that investigative reports be completed within 60 working days**. This requirement is, however, still included in the OIG's directives. As in previous audits, we will continue to use both calendar and working days in our analyses so that comparisons can be made over time.

Timeliness of investigations has been an issue in all of the 12 previous OIG audits. For FY17, 37 percent of cases were completed within 60 calendar days with an average calendar days to complete an investigation of 152 days. Timeliness decreased in FY20 with only 30 percent of cases completed within 60 calendar days. **When looking at the average number of calendar days to complete an investigation, timeliness also worsened compared to FY17 with an average of 180 days to complete investigations, or an increase of 28 days (18%).**

Exhibit 2-2
CALENDAR DAYS TO COMPLETE ABUSE AND NEGLECT INVESTIGATIONS
FY18 through FY20

Days to Complete Cases	Percentage of Cases Completed		
	FY18	FY19	FY20
0-60 days	**32%**	**24%**	**30%**
61-90 days	13%	14%	16%
91-120 days	10%	10%	9%
121-180 days	17%	15%	11%
181-200 days	4%	3%	3%
>200 days	25%	33%	30%
Percent > 60 days	**68%**	**76%**	**70%**
Total Cases Completed	**3,402**	**3,728**	**3,379**

Note: Totals may not add due to rounding.
Source: OAG analysis of OIG data.

Exhibit 2-2 shows the percentage of cases completed in terms of ranges of the number of **calendar days** to completion for FY20 compared to FY18 and FY19. Case completion is measured from the date the allegation of abuse or neglect is reported to the OIG to the date the investigative report is sent to the State-operated facility or community agency notifying them of the investigation outcome. Data analysis was conducted on the entire population of cases closed in each of the fiscal years.

We also looked at the percent of cases completed within **60 working days**. With the more lenient working day standard, the OIG completed 45 percent of its FY20 cases, 38 percent of its FY19 cases, and 44 percent of FY18 cases within 60 working days. For FY17, 50 percent of closed cases were completed within 60 working days.

Exhibit 2-3
PERCENTAGE OF CASES COMPLETED WITHIN 60 WORKING DAYS BY BUREAU
FY18 through FY20

Bureau	FY18	FY19	FY20
Central	42%	38%	57%
Cook	24%	21%	27%
Metro	31%	34%	18%
North	88%	71%	68%
South	17%	23%	47%
Totals	**44%**	**38%**	**45%**

Source: OAG analysis of OIG data.

According to the OIG, the timeliness issues are directly related to issues within specific bureaus. As seen in Exhibit 2-3, while the OIG has fallen well short of meeting the 60 working day standard for case completion overall, certain bureaus are more untimely than others. During FY18 the South Bureau only completed 17 percent of its investigative cases within 60 working days. In FY19 the Cook County Bureau was only able to complete 21 percent of its cases within 60 working days. For FY20, the Chicago Metro Bureau was only able to complete 18 percent of its investigative cases within 60 working days. Overall, the North Bureau is consistently the timeliest bureau during this time period, with a 60 working day completion rate of 88 percent, 71 percent, and 68 percent for FY18 through FY20, respectively. Exhibit 2-3 shows that the remaining bureaus fall well short of the 60 working day requirement for the same time period. Outside of the North Bureau, only the Central Bureau was able to complete more than 50 percent of its cases within the 60 working day requirement for FY20 (57%).

Increase in Number of Allegations and Case Completion Times

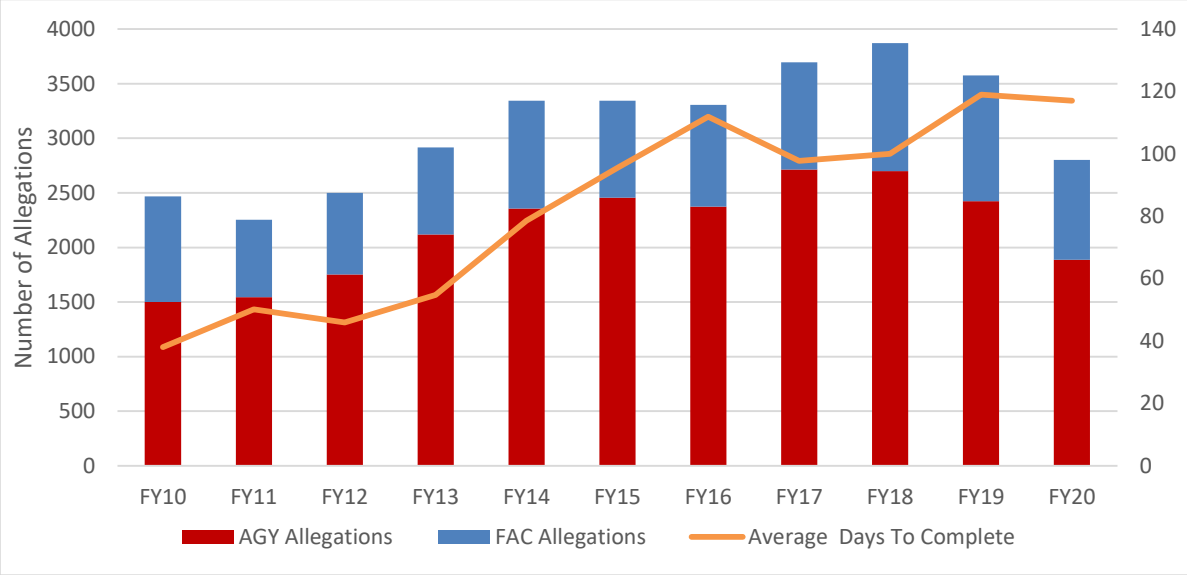
The total number of allegations reported to the OIG has continued to increase overall since FY10. During FY10 the OIG reported 2,467 allegations of abuse and neglect. During FY18 the OIG reported 3,872 cases of abuse and neglect, an increase of 57 percent compared to FY10. **According to OIG data, during FY20 it took an average of 117 working days (or 170 calendar days) to complete an investigation. This is an increase of 208 percent from the average of 38 working days during FY10.** The last time the OIG had a case completion time comparable to 170 calendar days was during the FY00 OIG audit. The FY00 OIG audit reported an average of 152 calendar days to complete an investigation.

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

slower rate. During FY18, there were 1,172 allegations, or a 21 percent increase over the 967 FY10 State-operated facility allegations.

Exhibit 2-4 and Exhibit 2-5 show that there is some correlation between the overall increase of the number of allegations, and the length of time that it takes to complete an investigation.

Exhibit 2-4
AVERAGE WORKING DAYS TO COMPLETE INVESTIGATIONS AND TOTAL ALLEGATIONS
FY10 through FY20



Source: OAG analysis of OIG data.

Exhibit 2-5
TOTAL ALLEGATIONS BY FACILITY AND COMMUNITY AGENCY AND AVERAGE WORKING DAYS TO COMPLETE AN INVESTIGATION
FY10 through FY20

	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20
Agency Allegations	1,500	1,543	1,753	2,120	2,357	2,455	2,373	2,713	2,700	2,423	1,886
Facility Allegations	967	712	746	797	987	888	932	984	1,172	1,152	915
Total Allegations	2,467	2,255	2,499	2,917	3,344	3,343	3,305	3,697	3,872	3,575	2,801
Average Days To Complete	38	50	46	55	79	96	112	98	100	119	117

Source: OIG annual reports FY10 through FY17; OIG data FY18 through FY20.

Investigations Over 200 Days

The number of OIG investigations taking more than 200 calendar days to complete increased significantly from FY18 to FY20. Exhibit 2-6 shows the types of allegations taking more than 200 calendar days to complete for FY18, FY19, and FY20. The majority of cases taking over 200 days to complete were either physical abuse or neglect cases for all three fiscal years. In FY19, the number of cases taking over 200 days increased by 45 percent (395 cases) over FY18 (872 cases), and in FY20 there was an 18 percent decrease (228 cases) from FY19.

Exhibit 2-6
CLOSED CASES OVER 200 CALENDAR DAYS TO COMPLETE BY TYPE OF ALLEGATION
FY18 through FY20

Type of Allegation	FY18	FY19	FY20
Physical Abuse	262	408	376
Neglect	397	549	439
Verbal Abuse	49	45	70
Death	35	47	15
Sexual Abuse	17	35	21
Exploitation	45	65	44
Mental Injury/ Psychological Abuse	67	118	74
Totals	**872**	**1,267**	**1,039**

Note: Analysis excludes cases investigated by the Illinois State Police.
Source: OAG analysis of OIG data.

DCFS Investigative Standards

As previously stated, prior to 2002, the OIG was required to complete investigations within 60 calendar days. Since that time, the OIG has gradually relaxed the requirement within the rules to 60 working days (which is generally the equivalent of 80 calendar days), and then removed the requirement from the rules altogether. Currently, the only place that contains a timeliness requirement for completing investigations is within OIG's directives. Because completing investigations in a timely manner is crucial to conducting effective investigations, auditors decided to review the timeliness standards of another investigative agency with a similarly vulnerable population, the Department of Children and Family Services (DCFS).

Timeliness is Critical to Effective Investigations

- Victims who have disabilities or mental illness may forget what happened or be unable to recount what happened consistently.
- Physical evidence may be lost.
- The scene of the incident may no longer be intact.
- Injuries to the victim may have healed or no longer be visible.
- Witnesses may forget or "go missing."
- Alleged perpetrators have time to re-construct their "stories" of what occurred.
- Victims may feel abandoned by long delays in investigating.
- Delays in investigating may discourage reporters from filing reports.

Statutory and administrative rule timeliness requirements are in place for investigations of abuse and neglect against children. The Abused and Neglected Child Reporting Act (325 ILCS 5) sets forth timeliness requirements for DCFS investigations in Illinois. According to Section 7.12 of the Act, "the Child Protective Service Unit shall determine, within 60 days, whether the report is 'indicated' or 'unfounded'." In the DCFS administrative code, 89 Ill. Adm. Code 300, the timeliness requirements of investigations is further enforced. Section 300.90, entitled "Time Frames for the Investigation," again states that final investigative reports should be completed within 60 calendar days, adding that initial contact is to occur with

the victim within 24 hours but no later than seven calendar days, and contact with the alleged perpetrator and caretaker is to occur within seven calendar days.

Timely completion is essential in conducting effective investigations. As time passes, victims who have disabilities or mental illness may be more likely to forget what happened, or be unable to recount what happened accurately. There is a higher risk of evidence being lost or unobtainable. It may become more difficult to contact victims, witnesses, or perpetrators due to moving, or a change in employment. Injuries may have healed over time, creating a lack of critical evidence to build a case. It is crucial when dealing with the vulnerable population that resides within State-operated facilities or community agencies that investigations are started and completed as expeditiously as possible in order to have the most accurate outcome, and to ensure the safety and well-being of the residents.

CASE COMPLETION TIMELINESS STANDARDS	
RECOMMENDATION 3	***The OIG should take steps to improve the timeliness of investigative case completion, such as:*** • ***Considering the implementation of the timeliness standards of other investigative agencies with similarly vulnerable populations; and*** • ***A thorough internal review in order to identify where delays occur during the investigative process, as well as identify other weaknesses that may be impacting the timely completion of investigations.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	The Office of the Inspector General (OIG) accepts this recommendation. The OIG will review the standards in place at other investigative agencies and consider opportunities to implement those standards for the OIG consistent with the contents and/or bargaining requirements of Collective Bargaining Agreements. The OIG will also continue to perform an ongoing review of its investigative process to identify ways in which the OIG can improve timeliness and thoroughness of investigative work.

Clinical Coordinators

The OIG's Clinical Coordinators become involved in investigations for cases that involve medical issues, as well as death cases. For cases that involve a medical issue, a Clinical Coordinator may be assigned to provide technical assistance to the primary investigator, or they may be directly involved with formulating an investigative plan and actively assist in the investigation. For death cases with no indication of abuse or neglect, the Clinical Coordinator assumes the primary responsibility for the review. As of June 30, 2020, the OIG had five Clinical Coordinators (three full-time and two contractual staff).

Death Reviews and Investigations

The Department of Human Services Act requires the Inspector General to review all reportable deaths including those for which there is no allegation of abuse or neglect. Reportable deaths are required to be reported within 24 hours after initial discovery by phone to the OIG hotline for each of the following:

> (i) Any death of an individual occurring within 14 calendar days after discharge or transfer of the individual from a residential program or facility;
>
> (ii) Any death of an individual occurring within 24 hours after deflection from a residential program or facility; and
>
> (iii) Any other death of an individual occurring at an agency or facility or at any Department funded site.

Death reviews are usually assigned to a Clinical Coordinator but may also be assigned to investigative bureaus if there is an allegation of abuse or neglect. According to data provided by the OIG:

- Cases closed during FY18 included 190 death reviews and investigations (167 were assigned to Clinical and 23 to investigative bureaus). These 190 death reviews and investigations took on average 153 calendar days (104 working days) to complete. Of these 190 death cases, 11 were substantiated neglect. The 11 substantiated neglect cases took an average of 658 calendar days (448 working days) to complete.

- Cases closed during FY19 included 237 death reviews and investigations (205 were assigned to Clinical and 32 to investigative bureaus). These 237 death reviews and investigations took on average 174 calendar days (118 working days) to complete. Of these 237 death cases, 15 were substantiated neglect. The 15 substantiated neglect cases took an average of 535 calendar days (364 working days) to complete.

- Cases closed during FY20 included 188 death reviews and investigations (171 were assigned to Clinical and 17 to investigative bureaus). These 188 death reviews and investigations took on average 100 calendar days (68 working days) to complete, which is a substantial improvement compared to FY18 and FY19. Of these 188 death cases, 5 were substantiated neglect. The five substantiated neglect cases took an average of 609 calendar days (415 working days) to complete.

According to OIG officials, death cases can take longer to complete for several reasons, including:

- Records from hospitals and medical examiners often take a long time to obtain;

- Additional consultation may be needed;

- An allegation of neglect associated with the case;

- The cause of death;
- The location of the death (Chicago area vs. downstate); and
- The type of agency or facility where the death occurred.

Timeliness of Investigative Interviews

The time it takes to obtain a statement from or interview the alleged victim has increased since our last audit in FY17. Timely interviews of alleged victims and perpetrators are necessary because as time passes, recollection of events is not as clear, or witnesses may not be available for follow-up interviews. Delays in getting detailed interviews from those involved, especially from the alleged victim, increase the risk of losing information and weakening the evidence obtained.

For the FY20 cases sampled where a victim was interviewed and/or a statement was taken, it took an average of 46 days from the assignment date for the victim to have a statement taken or for an interview to be performed. Within the sample, there were 12 cases which took between 119 and 574 days for the OIG to interview the victim, and impacted the average time significantly. If these cases are excluded the average time is reduced to 15 days. Our FY17 audit found that it took an average of 26 days to obtain a statement or interview from the victim. **The OIG's timeliness to obtain interviews or statements has worsened by 77 percent since the last audit.** In 2 of 79 (about 3%) cases where a verbal victim was identified, statements and interviews from the alleged victim were not in the case file and, therefore, we could not document that the alleged victim was interviewed.

For FY20 cases sampled, it took an average of 45 days from the assignment date for the alleged perpetrator to be interviewed and/or a statement to be taken. Within the sample, there were 13 cases that took between 108 and 428 days for the OIG to interview the alleged perpetrator, which impacted the average time significantly. If these 13 cases are excluded, the average time is reduced to 16 days. For the FY17 audit, it took an average of 45 days from the reporting of an incident for the alleged perpetrator to be interviewed or a statement to be taken.

OIG directive INV-005 requires written statements to be taken by the facility or community agency liaison immediately, but no later than 72 hours from the time the allegation was reported. However, during our sample review of case files, auditors determined that more than 72 hours had passed before statements were taken from either the victim or alleged perpetrator in 27 instances.

Although the OIG directives establish a timeframe for facility and community agency liaisons to gather statements, no specific timeframes are given for OIG investigators to conduct interviews. The OIG directives state that the OIG investigator will… "*Conduct identified interviews within a timely manner, especially of victim, accused and primary witnesses*…" This is in sharp contrast with the specific timeframes set forth by administrative rule for DCFS child abuse and neglect investigators. The standards established for DCFS child abuse and neglect investigators by administrative rule state that ***"In-person contact with alleged child victim or in-person examination of the environment for inadequate shelter and environmental neglect…"***

are to occur within 24 hours. They further state that ***"In-person contacts with the alleged perpetrator, the children's caretaker and the alleged child victim if not completed sooner…"*** **are to occur within 7 days.** Because of the similarly vulnerable populations of the residents within State-operated facilities and community agencies and the children whom DCFS is charged with protecting, it is prudent to have similar standards in place for conducting investigations.

TIMELINESS OF INTERVIEWS AND STATEMENTS	
RECOMMENDATION 4	***The Office of the Inspector General should work to improve the timeliness of OIG conducted interviews, and facility and community agency liaison conducted statements, including:*** • ***Ensuring initial written statements are taken within 72 hours per OIG directive INV-005; and*** • ***Consider implementing specific timeframes for critical interviews to occur, especially for the victim, alleged perpetrator, and primary witnesses.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	The Office of the Inspector General (OIG) accepts the recommendation. The OIG is currently reviewing the Rule 50.30(f) process, which requires agencies and facilities to take initial steps to respond to an allegation of abuse or neglect, including ensuring the health and safety of individuals and staff, ensuring OIG is notified of the allegation in a timely manner, gathering initial statements from principles involved in the incident, and gathering basic documentation related to the incident, to identify how it can be more effectively implemented with community agencies. The OIG will continue to provide 50.30(f) training to agency and facility staff. The OIG will continue to evaluate its investigators as to whether they completed victim interviews within 21 days and will research revising its directives to include the requirement.

Timeliness of Supervisory Review and Approval

The timeliness of case file reviews has improved overall since our last audit in FY17. During FY17, it took the OIG 88 days on average to complete a supervisory review of substantiated cases. During this audit period, FY18 through FY20, it took 62, 58, and 41 days on average to review substantiated cases, respectively.

OIG directives require the Investigative Team Leader or Bureau Chief to review cases within 15 working days of receipt absent extenuating circumstances. For cases closed in FY20, 70 percent (2,524 of 3,582) were approved within 15 working days of submission. If the case is substantiated physical abuse, sexual abuse or egregious neglect, the case is reviewed by the Inspector General or his designee.

Exhibit 2-7
AVERAGE CALENDAR DAYS FROM DATE SUBMITTED FOR REVIEW TO FINAL APPROVAL
By Investigative Bureau
FY18 through FY20

	Cases Substantiated[1]			Cases Not Substantiated[1]		
Bureau	**FY18**	**FY19**	**FY20**	**FY18**	**FY19**	**FY20**
Cook	96	17	16	15	4	7
North	11	26	22	1	4	4
Metro	23	25	66	6	8	24
Central	54	58	39	22	36	25
South	101	109	62	39	30	19
Total Avg.[2]	**62**	**58**	**41**	**17**	**18**	**15**

Note:
1 Days may include time when the Bureau Chief sends the case back to the investigator for further investigation.
2 Calculated as weighted average.

Source: OAG analysis of OIG data.

Exhibit 2-7 shows the average calendar days to review for substantiated cases has decreased from an average of 62 days to review and approve in FY18 to 41 days in FY20. For the South Bureau, the average days to review for substantiated cases has improved from 101 days on average during FY18 to 62 days during FY20. The Cook County Bureau also improved supervisory review timeliness, going from an average of 96 days to review a substantiated case during FY18, to an average of 16 days during FY20. However, the Chicago Metro Bureau's timeliness decreased over the same time period, with a 66 day average in FY20, more than double the 23 day average during FY18.

The Investigative Team Leader or the Bureau Chief may send the case back to the investigator for further investigation. Once the Bureau Chief reviews and approves a substantiated case, OIG directives require that it be forwarded to the Deputy Inspector General for review and approval. The Inspector General is required to review all Health Care Worker Registry cases.

OIG's database does not track cases that were sent back for additional investigation. Therefore, our analysis only shows the total calendar days from date submitted for review until the Bureau Chief signed the case as reviewed. Improvements in the time it takes to review substantiated cases could have a substantial effect on the overall timeliness of case completion at the OIG.

TIMELINESS OF SUPERVISORY REVIEW	
RECOMMENDATION 5	***The Office of the Inspector General should ensure that investigations are reviewed by the Investigative Team Leader or Bureau Chief within fifteen working days of receipt, absent extenuating circumstances, as is required by OIG directives.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	The OIG accepts the recommendation. As noted in the recommendation, the requirement is 15 working days, absent extenuating circumstances. With respect to the cases for which OIG did not complete its review within 15 working days, most of those cases were either substantiated investigations or complex investigations which require additional review time to ensure the accuracy and quality of the investigation and the report. In addition, the OIG hired a second Investigative Team Leader for its South and Metro bureaus in 2020, which OIG expects will improve those Bureaus average case review times.

OTHER TIMELINESS ISSUES

There are several factors that may affect timeliness of case completion. Cases referred to either the Illinois State Police or to OIG's Clinical Coordinators may add to the overall time it takes the OIG to complete cases. In addition, investigator caseloads, timeliness of assignment, timeliness of investigative interviews, and timeliness of case file review may also increase the time it takes to complete cases.

Referrals to Illinois State Police and Local Law Enforcement

The Department of Human Services Act (20 ILCS 1305/1-17(l)) requires that:

"Within 24 hours after determining that there is credible evidence indicating that a criminal act may have been committed or that special expertise may be required in an investigation, the Inspector General shall notify the Department of State Police or other appropriate law enforcement authority, or ensure that such notification is made. The Department of State Police shall investigate any report from a State-operated facility indicating a possible murder, sexual assault, or other felony by an employee. All investigations

Exhibit 2-8
DISPOSITION OF CASES REFERRED TO STATE POLICE
FY18 through FY20

Disposition	Number of Cases		
	FY18	FY19	FY20
Referred back to OIG without investigation	12	28	17
Declined by Prosecutor	11	10	3
Not Sustained	0	0	0
Conviction	1	0	0
Unfounded	0	3	1
Dismissed	1	0	0
Admin. Closed	9	5	5
Open/Pending	7	9	33
Total	**41**	**55**	**59**

Source: Illinois State Police (unaudited) and OAG analysis of OIG data.

conducted by the Inspector General shall be conducted in a manner designed to ensure the preservation of evidence for possible use in a criminal prosecution."

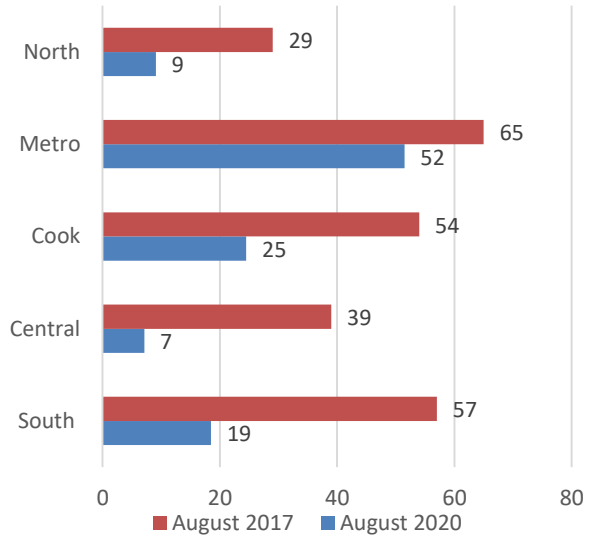
The Illinois State Police (ISP) either conducts an investigation or refers the case back to OIG. In some instances, the OIG will conduct an investigation in a case even if the ISP conducted an investigation. The ISP investigation is a criminal investigation and the OIG investigation is administrative. According to the OIG's investigative guidance, the OIG conducts no further investigative activity when the ISP accepts a case unless requested to do so by the ISP. Exhibit 2-8 shows the number of cases referred to the ISP and the disposition of those cases.

Open Cases and Investigator Caseloads

Open cases and average caseloads have decreased significantly since our 2017 audit. Overall, open cases decreased from 1,797 total cases as of August 2017 to 1,093 as of August 2020.

Exhibit 2-9 shows the caseloads by bureau for 2017 and 2020. Caseload averages as of August 2017 ranged from a high of 65 cases per investigator in the Chicago Metro Bureau to a low of 29 in the North Bureau. For August 2020, caseload averages ranged from a high of 52 cases per investigator in the Chicago Metro Bureau to a low of 7 in the Central Bureau. The average investigator caseload for each bureau has improved since our last audit. The largest percentage improvement for average investigator caseload is in the Central Bureau, with an 82 percent decrease in the average number of cases (39 per investigator in August of 2017, to 7 per investigator during August of 2020). The largest overall decrease in the average investigator caseload is the South Bureau, going from 57 cases per investigator on average during August of 2017, to an average of 19 cases per investigator during August of 2020 (a decrease of 38 cases).

Exhibit 2-9
AVERAGE INVESTIGATOR CASELOADS
By Bureau as of August 2017 and 2020



Source: OIG data summarized by OAG (unaudited).

Chapter Three

THOROUGHNESS OF ABUSE AND NEGLECT INVESTIGATIONS

CHAPTER CONCLUSIONS

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

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

INVESTIGATION THOROUGHNESS

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

Collection of Evidence

Evidence for OIG investigations includes items such as signed statements, interview summaries, documents, photographs, and other physical evidence. The case files we sampled from FY20 were generally thorough and contained the appropriate documentation, an improvement from our previous audit.

Prior to May 26, 2017, OIG administrative rules required that the case files contain all investigatory materials, including physical and documentary evidence, such as photographs, interview statements and records (59 Ill. Adm. Code 50.60 (c)). Effective May 26, 2017, the OIG's administrative rules were amended and all case file requirements were deleted.

OIG's Investigative Directives, however, still require the case file to contain investigatory evidence, including written statements, documentary evidence, and photographs. For example, the directives require photographs to be taken whenever an allegation of abuse or neglect is received alleging an injury, whether or not the injury is visible. However, the directives also state that when there is no visible injury consistent with the allegation, the OIG

investigator can exercise discretion in determining whether succeeding photographs are necessary.

During our testing, we checked for evidence including interviews, photographs, medical records/treatment plans/progress notes, injury reports (including documentation that no injury occurred), and restraint/seclusion records. In our testing we found:

- **Photographs:** Photographs were not in the case file for 2 of 20 (10%) investigations sampled where there was an injury sustained as a result of an abuse or neglect allegation; however, the OIG noted in both case reports that the facility or community agency had failed to take photographs at the time of the incident. A third case file contained a single photograph but the OIG case report stated that multiple photos had been reviewed during the investigation. Photographs may not have been necessary for three cases because of the nature of the injury (internal injury, no visible injury, refusal to be photographed, etc.).
- **Medical Records/Treatment Plans/Progress Notes:** Medical records, treatment plans, or progress notes were present in all of the 100 investigations sampled. Medical records, treatment plans, and progress notes may provide valuable information about an alleged victim that could not otherwise be collected. This information could lead to a deeper insight into how an incident adversely affected the alleged victim. Without relevant documentation about the alleged victim's diagnoses (i.e., phobias, supervision requirement, etc.), it would be much more difficult to assess whether certain actions are detrimental.
- **Injury Reports:** In the one case file missing an injury report, the OIG noted in its case report that the community agency had not prepared one at the time of the incident.
- **Restraint/Seclusion Records:** Of the 100 cases sampled, 5 (5%) involved the use of restraints. Documentation showing that the use of restraints was properly implemented and monitored was included in the case file.

Interview Thoroughness

Investigative interviews are essential fact finding instruments used by the investigators to determine what happened related to an allegation. Interviews often identify the involved parties (victims, perpetrators, and witnesses). At the completion of the investigation, an investigative report is produced that is based on the information obtained during the course of the investigation, including interviews and statements given by the victim, perpetrator, or witnesses.

We reviewed a sample of FY20 closed cases to see if they included a statement or interview with the alleged victim and the alleged perpetrator. Of the 79 cases we reviewed which had a victim that was verbal, 2 case files (about 3%) did not contain an interview with the alleged victim. In one case the OIG could not determine why no written statement was taken or interview conducted, and for a second case, the OIG indicated that the community agency made it difficult to schedule interviews at the time of the incident; the interviews were eventually conducted a few months later. In one other case the victim was discharged and sent to jail shortly after the case was opened and would not cooperate with the investigation.

Six cases (8%) also did not contain documentation of an interview with the alleged perpetrator. According to OIG responses: for five cases there were detailed written statements conducted by the facility/agency so no interview was necessary, and for the other case the alleged perpetrator was terminated before an interview could be conducted and did not respond to interview request.

CASE MONITORING AND SUPERVISORY REVIEW

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

According to the OIG Investigative Directives, it is the policy of the OIG to enhance the integrity and quality of investigations by conducting case reviews in a timely and consistent manner. A typical case will move through at least one level of review, and at least two levels for substantiated physical abuse, sexual abuse, or egregious neglect cases, before being sent to the facility or community agency.

Documentation of Case Monitoring and Review

The OIG requires that case files contain case monitoring and review documentation. This documentation includes the Case Tracking Form and the Case Closure Checklist.

The Case Tracking Form's main purpose is to track the OIG's actions throughout the investigation. The form identifies information such as the case number, investigative agency, bureau, and allegation. Dates for when the investigative report was received, when it was reviewed, and when the case was closed are all tracked on this form. It is also used to document the case finding and recommended action.

Although all case files in our sample contained a Case Tracking Form as required by OIG Investigative Directives, there were instances in which the information on the tracking sheet was incomplete. For 27 of 100 (27%) investigation files reviewed, the Case Tracking Form was not complete. In 25 cases, one section of the form was not completed, and the other two cases were missing dates.

The Case Closure Checklist is used as a quality assurance check of the case file before it is closed. It ensures that the necessary documents such as the intake form and completed case report are in the file and other documents such as the Case Tracking Form and Case Routing/Approval Form are completed. By design, two separate reviews are required – a case reviewer and the Bureau Chief.

All of the 100 cases reviewed contained a Case Closure Checklist. However, for 16 cases (16%), the form was incomplete. In all 16 cases, it appeared the Bureau Chief did not review the form as required. Instead the initial reviewer either signed off or initialed for the Bureau Chief, which circumvents the purpose of the second review. Further, not all bureaus were using the

form included in OIG's Investigative Directives, which requires sign-off on individual items to ensure they are in the file. Some bureaus used a form that only required sign-off after an overall review.

CASE TRACKING AND CLOSURE FORMS	
RECOMMENDATION 6	***The Office of the Inspector General should ensure that all Case Tracking Forms and Case Closure Checklists are completed. Additionally, the Office should ensure that each Bureau uses the forms included in its Investigative Directives.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	The Office of the Inspector General (OIG) accepts the recommendation. The OIG will ensure it includes the most recent version of the forms in the Investigative Directives. The OIG will also specifically address with Bureau Chiefs, Investigative Team Leaders, and administrative support staff, the need to appropriately complete these forms with all required data and signoffs and will periodically review such forms to ensure that the OIG is executing the forms appropriately.

Investigative Reports

All of the cases we reviewed contained an investigative report. The OIG investigative reports we tested were generally thorough, comprehensive, and addressed the allegation. A well-written investigative report is essential to an effective investigation because it often provides a basis for management's decision on the action recommended in the case. Once the investigator completes the investigative report, it is reviewed by management who must approve the case before a recommendation is sent to the facility or community agency. Therefore, it is important that the investigative report be clear and convincing. The report should address all relevant aspects of the investigation and reveal what the investigation accomplished.

Chapter Four

ACTIONS, SANCTIONS, AND RECOMMENDATIONS

CHAPTER CONCLUSIONS

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

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

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

SUBSTANTIATED ABUSE AND NEGLECT CASES

The number of abuse and neglect investigations closed has remained consistent when compared to FY17; however, the substantiation rate has decreased. As is shown in Exhibit 4-1, the substantiated rate for abuse and neglect investigations closed decreased from 13 percent overall for FY17 to 9 percent for FY20. Interestingly, FY19 had the highest number of closed cases and also had the lowest substantiation rates for agencies (10%) and overall (8%) for the four years.

For community agencies, the substantiation rate is between two and a half times and four times higher than for state facilities. For FY17, the state facility rate was 6 percent, with the community agency rate at 15 percent. In FY20, the community agency rate was at 12 percent, four times higher than the state facility rate of 3 percent.

Exhibit 4-1
ABUSE AND NEGLECT INVESTIGATIONS CLOSED AND SUBSTANTIATED
FY17 through FY20

Fiscal Year	Location	Closed Cases	Substantiated Cases	Substantiated Percent
FY17	State Facility	857	52	6%
FY17	Agency	2,744	419	15%
FY17	**Total**	**3,601**	**471**	**13%**
FY18	State Facility	1,063	39	4%
FY18	Agency	2,540	345	14%
FY18	**Total**	**3,603**	**384**	**11%**
FY19	State Facility	1,283	48	4%
FY19	Agency	2,708	267	10%
FY19	**Total**	**3,991**	**315**	**8%**
FY20	State Facility	1,057	33	3%
FY20	Agency	2,525	291	12%
FY20	**Total**	**3,582**	**324**	**9%**

Source: OAG analysis of OIG data.

RECOMMENDED ACTIONS

While the number of closed cases has remained consistent, there has been a decrease in the number of recommended actions for FY20, when compared to FY17. As is shown in Exhibit 4-2, for FY17, there were 482 substantiated cases. For FY20, there were 324 substantiated cases.

Exhibit 4-2
RECOMMENDED ACTIONS FOR SUBSTANTIATED CASES
(All Allegations Regardless of Category at Intake)
FY17 and FY20 Closed Cases

Recommended Action	FY17	FY20
No Action	116	117
Retraining	144	70
Policy Creation or Revision	36	21
Other Administrative Action	90	56
Referral to Other Agency	1	0
Health Care Worker Registry	95[1]	59
Total Substantiated	**482**[2]	**324**[3]

Notes:
[1] Includes one case investigated by the Illinois State Police.
[2] Exhibit 4-2 includes 11 cases not included in Exhibit 4-1 because they were not categorized as abuse or neglect at intake.
[3] One case did not list a recommended action, but is included in the total.

Source: OAG analysis of OIG data.

At the conclusion of an investigation, the OIG Investigative Team Leader or Bureau Chief determines whether the evidence in the case supports the finding that the allegation of abuse and neglect is substantiated, unsubstantiated, or unfounded. There may also be investigations that are unfounded or unsubstantiated with other issues that have a recommendation. The case is reviewed, and a preliminary report is sent to the State-operated facility or community agency notifying it of the results of the investigation.

If the allegation is substantiated or contains recommendations, the OIG report identifies the issues that should be addressed. Some examples of recommendations for actions in substantiated cases include retraining or policy creation/revision. The OIG may also report the individual to the Health Care Worker Registry. This is discussed later in this Chapter.

After the recommendation is sent, the facility or community agency generally takes some action to resolve the issues related to the case. Exhibit 4-2 shows substantiated cases in FY17 and FY20 by the type of recommended action.

For FY20, the most recommended action in substantiated cases was "no action." "No action" was recommended in 117 of 324 substantiated cases or 36 percent. We reviewed investigations data provided by the OIG for cases with a recommendation of "no action" and found that for 109 of the 117 (93%) there had been a written response approved, which means some action was taken. According to an OIG official, there is no reason for these cases to have a recommendation of "no action" in the database. The second most recommended action in FY20 was retraining; OIG recommended retraining for 70 of 324 (22%) substantiated investigations closed in FY20.

The number of cases in which the recommended action was a referral to the Health Care Worker Registry decreased from 95 in FY17 to 59 in FY20. Other administrative action was

recommended for 56 investigations closed in FY20. Appendix C shows the number of cases closed and a substantiation rate by facility and agency for FY18 through FY20.

ACTIONS TAKEN

Ensuring appropriate corrective actions are taken is critical to the effectiveness of investigations of abuse and neglect. Without the implementation of corrective actions, clients may remain in an unsafe environment.

The OIG provided data regarding the actions taken for the 324 investigations closed in FY20 where abuse, neglect, or exploitation was substantiated. Exhibit 4-3 shows the actions taken for these cases by the type of allegation (abuse, neglect, or exploitation). As a result of the OIG substantiating these cases, 151 employees were discharged, 27 employees were suspended, and 52 employees resigned. Other actions included re-trainings (100), group trainings (80), written reprimands (31), and policy/procedural changes (52).

Exhibit 4-3
SUBSTANTIATED INVESTIGATIONS BY TYPE OF ALLEGATION AND ACTIONS TAKEN
FY20 Cases Closed

	Substantiated Category			
Action Taken	**Abuse**	**Neglect**	**Exploitation**	**Total**
Administrative Change	0	7	1	**8**
Counseling	3	19	0	**22**
Discharged	74	72	5	**151**
Fired (other cause)	2	12	0	**14**
Group Training	21	59	0	**80**
Hab./Treatment Change	1	9	0	**10**
Nothing	0	2	0	**2**
Oral Reprimand	1	3	0	**4**
Performance Eval.	0	2	0	**2**
Policy/Procedural Change	3	47	2	**52**
Reassignment	0	4	0	**4**
Resignation	18	32	2	**52**
Retirement	0	0	0	**0**
Re-Training	23	76	1	**100**
Reviewed	4	26	0	**30**
Structural Repair/Upgrade	0	2	0	**2**
Supervision	1	2	0	**3**
Suspension	7	20	0	**27**
Transferred	0	6	0	**6**
Written Reprimand	9	22	0	**31**
Totals	**167**	**422**	**11**	**600**

Note: FY20 closed investigations included 324 substantiated cases of abuse, neglect, or exploitation. For these 324 substantiated cases there were 600 actions taken. Some cases may involve multiple actions or actions against multiple employees.

Source: OAG analysis of OIG data.

OIG SUBSTANTIATED CASES AND WRITTEN RESPONSES

For investigative reports, the Department of Human Services Act (Act) requires:

Upon completion of an investigation, the Office of Inspector General shall issue an investigative report identifying whether the allegations are substantiated, unsubstantiated, or unfounded. Within 10 business days after the transmittal of a completed investigative report substantiating an allegation, finding an allegation is unsubstantiated, or if a recommendation is made, the Inspector General shall provide the investigative report on the case to the Secretary and to the director of the facility or agency… (20 ILCS 1305/1-17(m)).

For written responses, the Act further states:

Within 30 calendar days from receipt of a substantiated investigative report or an investigative report which contains recommendations, absent a reconsideration request, the facility or agency shall file a written response that addresses, in a concise and reasoned manner, the actions taken to: (i) protect the individual; (ii) prevent recurrences; and (iii) eliminate the problems identified. The response shall include the implementation and completion dates of such actions. If the written response is not filed within the allotted 30 calendar day period, the Secretary shall determine the appropriate corrective action to be taken (20 ILCS 1305/1-17(n)(1)).

The Act requires that substantiated cases, as well as unsubstantiated or unfounded investigations where the OIG recommends administrative action, are reported to the Secretary of the Department of Human Services. The Secretary has the authority to accept or reject the written response and establish how DHS will determine if the facility or agency implemented the action in the written response. According to 59 Ill. Adm. Code 50.80(a), the facility or agency is directed to submit a written response to the respective DHS program division for approval.

The OIG is required by the Department of Human Services Act to monitor compliance through a random review of approved written responses. The Inspector General is also required to review any implementation that takes more than 120 days (20 ILCS 1305/1-17(q)). The OIG is required by rule to conduct compliance reviews, at a minimum, quarterly on a random 10 percent sample of approved written responses received. The OIG is also required to review all written responses that take more than 120 days after approval to complete (59 Ill. Adm. Code 50.80(d)).

Exhibit 4-4
WRITTEN RESPONSE COMPLIANCE REVIEWS CONDUCTED
FY17 through FY20

Location	FY17	FY18	FY19	FY20
Agency	132	180	153	111
Facility	38	36	44	27
Totals	**170**	**216**	**197**	**138**

Source: OIG compliance review data.

Exhibit 4-4 shows the number of reviews of written responses conducted by the OIG since FY17. For FY17, OIG received a total of 986 written responses approved by DHS. For

the same period, the OIG conducted reviews of 170 written responses (132 from community agencies and 38 from State-operated facilities). For FY19, OIG received a total of 1,050 written responses approved by DHS. As shown in Exhibit 4-4, for the same period, the OIG conducted reviews of 197 written responses (153 from community agencies and 44 from State-operated facilities).

DHS Approval of Written Responses

The Department of Human Services Act requires that within 30 calendar days from receipt of a substantiated investigative report or an investigative report which contains recommendations, absent a reconsideration request, the facility or agency must file a written response. The response includes the implementation and completion dates of the actions. The Secretary of DHS is required by the Act to accept or reject the written response. If the written response is not filed within the allotted 30 calendar day period, the Secretary of DHS shall determine the appropriate corrective action to be taken (20 ILCS 1305/1-17(n) and (p)).

It is the policy of the OIG to obtain, track, review, and monitor written responses for substantiated cases and for unsubstantiated or unfounded cases with recommendations. The Act requires that the OIG conduct a review of any written response that takes more than 120 days to implement.

In our sample of 100 investigations, there were 31 cases where a written response was required; OIG could not provide the written response in two cases. For the remaining 29 cases, the average time for DHS to receive the response after sending out the case report to the facility or agency was 42 days. About half of the responses (15) were received within the 30 days required by statute. It took an average of 55 days from the case report being sent until the response was approved by DHS. Six cases (19%) took 90 days or longer for DHS to receive and approve the response. All six were community agency cases.

Our previous audit contained a recommendation to DHS to ensure that written responses are approved in a timely manner. If DHS does not receive and approve written responses and corrective actions 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.

DHS APPROVAL OF WRITTEN RESPONSES	
RECOMMENDATION 7	***The Department of Human Services should continue its efforts to ensure that written responses from facilities and community agencies are received and approved in a timely manner.***
DEPARTMENT OF HUMAN SERVICES RESPONSE	The Illinois Department of Human Services (IDHS) accepts the recommendation. The IDHS Divisions of Developmental Disabilities and Mental Health will work with the OIG to consider the use of electronic signatures in order to ensure timeliness of approvals.

APPEALS PROCESS IN SUBSTANTIATED CASES

After the investigative report review process is completed and the report has been accepted by the Inspector General, the State-operated facility or community agency is notified of the investigation results and finding. A redacted copy of the report is also sent to the complainant, the individual who was allegedly abused or neglected or his or her legal guardian, and the person alleged to have committed the offense. When the OIG substantiates a finding of abuse or neglect against an individual at a facility or agency, there are several distinct levels of appeals that can be made. A substantiated finding can be appealed to the Inspector General for reconsideration or clarifications or an appeal can be made to DHS that the finding does not warrant reporting to the Health Care Worker Registry.

Reconsideration or Clarification

The OIG directives and administrative rules (59 Ill. Adm. Code 50.60) establish a reconsideration or clarification process that allows the notified parties 15 days to submit a reconsideration request after receipt of a report or notification of a finding. If the facility or community agency disagrees with the outcome of the investigation, it may either request that the Inspector General further explain the findings, or request the Inspector General to reconsider the findings. After a request for clarification is made, the Bureau Chief sends a response to the State-operated facility, agency, or individual making the request. After a request for reconsideration is received from an agency or State-operated facility, the Inspector General will notify the agency or State-operated facility of the decision to either accept or deny the request. The reconsideration of a finding is the only appeal process where an OIG substantiated finding against a person can be changed.

Public Act 100-943, signed by Governor Rauner on August 17, 2018, took effect on January 1, 2019. This Public Act essentially put into law all the practices the OIG had already put into place. The OIG uses a multi-level review process to make determinations regarding requests for reconsideration. One reviewer of the request will not have participated in the investigation or approval of the original report. Also, additional information is no longer required to file a request for reconsideration.

According to the FY19 OIG Annual Report, the OIG received 139 requests to reconsider the findings of 134 investigations. Of the 139 requests, the OIG granted 33 (involving 33 cases) and denied 99 (involving 96 cases) with seven cases pending. Of the 33 cases granted reconsiderations, the OIG revised all 33 case reports and revised 2 case reports where it denied the reconsideration. Some of these decisions may have been for requests that were received during the prior fiscal year.

OIG officials stated that during FY20, the OIG received 127 requests to reconsider the findings of 123 investigations. Of the 127 requests, the OIG granted 39 and denied 92. OIG revised all 39 case reports where reconsiderations were granted and 4 case reports where it denied the reconsideration. Some of these decisions may have been for requests that were received during the prior fiscal year.

HEALTH CARE WORKER REGISTRY

The Department of Public Health maintains the Health Care Worker Registry (Registry). The Registry lists individuals so background checks can be conducted pursuant to the Health Care Worker Background Check Act (225 ILCS 46). It shows training information for certified nursing assistants and other health care workers. The Registry also displays administrative findings of abuse, neglect, or misappropriations of property.

The Health Care Worker Background Check Act applies to all unlicensed individuals employed or retained by a health care employer as home health care aides, nurse aides, personal care assistants, private duty nurse aides, day training personnel, or an individual working in any similar health-related occupation where he or she provides direct care (e.g., resident attendants, child care/habilitation aides/developmental disabilities aides, and psychiatric rehabilitation service aides) or has access to long-term care resident's living quarters or financial, medical or personal records of long-term care residents. It also applies to all employees of licensed or certified long-term care facilities who have or may have contact with residents or access to their living quarters or the financial, medical, or personal records of residents. Individuals with disqualifying convictions as listed in this Act are generally prohibited from working in any of the above positions.

The Department of Human Services Act requires the OIG to report individuals with substantiated findings of physical or sexual abuse, financial exploitation, or egregious neglect to the Health Care Worker Registry. The purpose of the mandate is to protect the citizens of Illinois who are the most frail and persons with disabilities from possible harm. Agencies and facilities must verify registry status before hiring an employee to look for prior findings of physical, sexual abuse, or egregious neglect. These individuals are barred from working with people who have mental or developmental disabilities. The Illinois Department of Public Health (DPH) has a waiver process, but it does not apply to OIG findings, which are administrative and have a separate hearing process.

Health Care Worker Registry Appeals

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 purpose of the hearing is to determine whether or not the adverse finding against an employee will be reported on the Registry. The hearing does not overturn the substantiated finding at the OIG. The hearing must be requested no later than 30 calendar days from receipt of notice.

According to the OIG's FY19 Annual Report, the OIG made 48 referrals for substantiated cases to the Health Care Worker Registry in FY19. According to data provided by the OIG, 59 referrals were made in FY20.

Exhibit 4-5
HEALTH CARE WORKER REGISTRY APPEALS
FY19 and FY20

Appeal Outcome	FY19	FY20
Petitioner **Lost** Appeal (Referred to Registry)	5	3
Appeal **Dismissed** (Referred to Registry)	5	3
Petitioner **Won** Appeal (Not Referred)	14	4
Stipulation Order (Not Referred)	11	3
Appeal Withdrawn (Referred to Registry)	1	2
Pending	0	9
Totals	**36**	**24**

Source: OIG data.

Exhibit 4-5 shows the number of appeals for FY19 and FY20 and the disposition of the cases as of October 2020. Health Care Worker Registry appeals provided by the OIG show a total of 36 appeals for FY19 and 24 appeals for FY20.

Stipulated Motions to Dismiss Process

The stipulated motion to dismiss process is triggered by a petition under Section 50.90 of the OIG's administrative rules (Health Care Worker Registry Appeal) on certain physical abuse cases that, although they meet the definition of physical abuse, may not be severe enough to deserve placement on the Registry. As is shown in Exhibit 4-5, the OIG chose not to refer a case to the Registry based on a stipulation order for a total of 14 cases during FY19 and FY20.

RECOMMENDING SANCTIONS

The OIG's administrative rules allow the Inspector General to recommend to the Secretary of DHS that sanctions be imposed against State-operated facilities or community agencies to protect residents. The OIG may recommend sanctions including: termination of licensing, funding, or certification of a facility (59 Ill. Adm. Code 50.70 (g)).

If the Secretary of DHS issues a sanction, the DHS Act allows the Inspector General to seek the assistance of the Attorney General, or the State's Attorney for imposing sanctions (20 ILCS 1305/1-17(r)).

The Inspector General has established a directive that specifies criteria regarding when to recommend sanctions to the Secretary of DHS. The directive includes procedures the OIG is to

follow when recommending sanctions against an entity under the jurisdiction of the OIG. These procedures state that:

> *The Inspector General shall utilize the following criteria to make determinations about when to recommend sanctions to the Secretary of the Department of Human Services (DHS):*
>
> 1. *A determination of imminent danger to the well-being of the individual(s);*
> 2. *A community agency or a state-operated facility has repeatedly failed to respond to critical recommendations made by the Inspector General that impacts the well-being of individuals served;*
> 3. *A community agency or a state-operated facility has failed to cooperate with an investigation;*
> 4. *Other instances deemed necessary by the Inspector General.* (OIG Directive INV 033 IV. B.)

The OIG rarely recommends sanctions regarding community agencies or State-operated facilities. The OIG has not recommended a sanction related to a State-operated facility for at least the past 27 years (1994 – 2020). During FY09 the OIG recommended that DHS' Division of Developmental Disabilities take immediate action against one community agency, up to and including sanctions. This was due to the OIG's concern that a culture of abuse and neglect at the particular agency put the individuals receiving services at great risk of harm. During FY18 the OIG recommended sanctions against an agency to the Secretary of DHS. This recommendation for issuing sanctions is discussed below.

In July of 2017, the OIG completed two investigations involving the death of two individuals who were residents in a community agency. The investigations both resulted in substantiated findings of neglect against the agency and employees of the agency**. The OIG determined that the lack of care towards the two individuals directly contributed to the severe decline of their health and ultimately, their deaths.** Because of this, the OIG recommended sanctions to the Secretary of DHS against this agency on July 21, 2017. The letter to the Secretary recommended the following sanctions:

1. The Department freeze admissions of individuals with multiple serious medical needs to the community agency until the Division has determined they are capable of providing an appropriate level of care;

2. The Division conduct well-being checks of all individuals with serious multiple medical needs that are residing at the community agency's

OIG Recommended Sanctions Timeline

- **July 21, 2017** – OIG sends letter to DHS Secretary recommending sanctions. ***No response from Secretary.***
- **October 17, 2017 (88 days after initial letter from OIG)** – OIG sends status update request to DHS Secretary. ***No response from Secretary.***
- **December 5, 2017 (137 days after initial letter from OIG)** – OIG memo to file states that per DHS Chief of Staff, DHS DD is checking that the agency is implementing recommendations.
- **July 2, 2018 (346 days after initial letter from OIG)** – Secretary responds to OIG stating that sanctions will not be issued, and outlines steps taken to prevent further issues at agency.

CILAs and review all documentation to ensure their care plans are appropriate and their needs are being met.

3. The Division provides the necessary resources to provide this care and ensures appropriate oversight is implemented when the admission freeze is lifted. This should include regular and on-going visits by Division staff to any CILAs where these individuals live.

4. Any other action deemed necessary by the Department and Division to ensure the health and safety of all individuals residing at the community agency.

The OIG sent the Secretary a follow-up letter on October 17, 2017, requesting a status update because there was no response to the initial recommendation sent on July 21, 2017. On December 5, 2017, the OIG created a memo to file stating that per the DHS Chief of Staff, the Secretary "…has not yet made a decision on recommendations. The DHS Division of Developmental Disabilities is still reviewing to determine if [the agency] has implemented all the changes it indicate[sic] were to be made in response to these two investigations." **The Secretary of DHS did not respond to the Inspector General's recommendation to impose sanctions until July 2, 2018, almost a full year after the recommendations were made.**

The Secretary's letter to the Inspector General indicated that the Department had already taken some of the recommended actions. The Secretary declined to adopt the first recommendation, the admissions freeze, but said the Department was partially adopting the second and third recommendations, noting that the Division of Developmental Disabilities (DDD) had already conducted two well-being samplings of the residents. It further stated that the Department had directed DDD to continue its monitoring efforts. The letter said that the fourth recommendation was adopted, stating that meetings with the community agency concerning best practices for documentation and training had already occurred, and that DDD's site visit reports would be provided to the Department's licensing bureau for follow-up during licensure reviews.

Thus, while the Secretary did adopt some of the Inspector General's recommendations and showed that the Department had taken actions to protect the residents at the community agency during that time, the Secretary's response was nearly a year after the Inspector General first recommended the sanctions. **Because of the lack of communication from the Secretary of DHS to the OIG during this time, it is unclear if the residents at this agency were continuing to live in unsafe conditions.**

Chapter Five

OTHER ISSUES

CHAPTER CONCLUSIONS

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

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

The DHS Act requires the Inspector General to conduct unannounced site visits to each State-operated facility at least annually (20 ILCS 1305/1-17(i)). During the audit period, site visit information provided by the OIG showed a slight increase in time spent on site compared to the prior audit period, FY15 through FY17. Only three site visits occurred within one day during all three years. However, several site visits had significant gaps between the first and second on-site days. This may allow facilities to unfairly prepare for contingencies. Clinical Coordinators continued to be absent from all site visits except one following a removal of such a requirement from OIG directives. No longer requiring Clinical Coordinators to be a part of site visits may decrease the overall effectiveness of unannounced site visits because a reviewer with medical expertise may no longer be involved. OIG directives require that the site visit report be sent to OIG and DHS staff, including the DHS Secretary and Assistant Secretary, the Directors of Mental Health or Developmental Disabilities, and the OIG leadership team members. None of the reports were sent to the DHS Secretary or Assistant Secretary, and three reports in FY20 were also not sent to the OIG leadership team. Additionally, the OIG does not currently conduct unannounced site visits at community agencies. Although not required to do so, it would be beneficial to consider conducting unannounced site at visits community agencies because of the increased risk of noncompliance with the DHS Act or Rule 50.

Although the data provided by the OIG was generally complete and reliable enough for our analysis and sample selection for testing, we identified several instances in which the OIG

could improve the quality of its data. The issues identified include inaccurate discovery dates and times, a lack of report dates to law enforcement, substantiated cases with no associated recommendations, and an absence of reviewer dates. There were also issues with the OIG's training database, including incorrect or missing training dates and changes to training classes not being updated.

QUALITY CARE BOARD

Section 1-17(u) of the Department of Human Services Act establishes a Quality Care Board within the Department of Human Services' Office of the Inspector General. The Board is required to monitor and oversee the operations, policies, and procedures of the Inspector General to ensure the prompt and thorough investigation of allegations of neglect and abuse. In fulfilling these responsibilities, the Board may do the following:

The Department of Human Services Act requires that there be a Quality Care Board composed of seven members appointed by the Governor with the advice and consent of the Senate. Four members are needed for a quorum.

The Board continues to have vacancies. Although it has had at least four members during the audit period, it did not have a quorum during its FY18 meetings.

- Provide independent, expert consultation to the Inspector General on policies and protocols for investigations of alleged abuse and neglect;
- Review existing regulations relating to the operation of facilities;
- Advise the Inspector General on the content of training activities; and
- Recommend policies concerning methods for improving the intergovernmental relationships between the Office of the Inspector General and other State or federal offices (20 ILCS 1305/1-17(u)).

Board Membership

The Board continues to have problems maintaining seven members as required by statute. We recommended in our previous audit released in 2017 that the Secretary of the Department of Human Services and the Inspector General should continue to work with the Governor's Office to get members appointed to the Board as promptly as possible, in order to fulfill the statutory membership requirement. The Department of Human Services Act requires that there be a Quality Care Board composed of **seven members appointed by the Governor with the advice and consent of the Senate**.

The OIG has shown improvement in meeting the statutorily required Board membership. As reported in the FY17 audit, the Board had only four members, each serving on an expired term, and as of September 2017, one of these Board members had resigned, leaving only three members. As a result the Board was unable to conduct business because four members are needed for a quorum. During FY18 and FY19 the Board had four members; in October 2019, the Board had five new members appointed. Exhibit 5-1 shows the members currently serving on the Board, their term status, and expiration dates.

Exhibit 5-1
QUALITY CARE BOARD MEMBERSHIP
As of May 12, 2020

Board Member	Appointed	Expiration Date	Status
Brian Dunn (Chair)	10/18/2019	11/3/2023	Current
Jae Jin Park	11/8/2019	11/3/2021	Current
Shirley Perez	10/18/2019	6/14/2022	Current
Angela Hearts-Glass	10/18/2019	11/2/2021	Current
Megan Norlin	10/18/2019	11/2/2021	Current
Vacant	**N/A**	**N/A**	**Vacant**
Vacant	**N/A**	**N/A**	**Vacant**

Source: DHS Office of the Inspector General and Governor's website.

Two members of the Board are required to be persons with a disability or a parent of such person; all other members must have professional knowledge or experience in law, investigatory techniques, or care of the mentally ill or persons with developmental disabilities (20 ILCS 1305/1-17(u)). The Board consists of two people that are either a person with a disability or a parent of a person with a disability, one attorney, two industry members (one of which is also a person with a disability or a parent of a person with a disability), and one person with investigatory experience; therefore, the statutory requirement for full Board membership is not being met. The Board discussed the need to fill its vacancies during three meetings in FY18, and one during FY19.

Board meeting minutes show that Board members and the OIG staff have made attempts to urge the Governor's Office and the DHS Secretary to appoint individuals to the vacancies. According to the meeting minutes from the September 25, 2017 meeting, the Board Chairperson mentioned contacting the Governor's Office regarding appointments. It was also mentioned in this meeting that members with expired terms would continue their Board responsibilities. According to the meeting minutes from the December 14, 2017 meeting, the Board Chairperson again mentioned contacting the Governor's Office and the DHS General Counsel about Board appointments, and the Inspector General had already contacted the DHS Secretary about such appointments. A Board member was also asked to remain on the Board until a replacement could be appointed, even though he had announced his resignation at the last meeting due to accepting a job position that would create a conflict of interest. This Board member agreed to remain until a replacement could be found. According to the meeting minutes from the July 11, 2018 meeting, Board members were encouraged to suggest possible appointees from the southern Illinois region to meet membership requirements.

Statutory requirements regarding Board membership state that upon the expiration of each member's term, a successor shall be appointed; in the case of a vacancy in the office of any member, the Governor shall appoint a successor for the remainder of the unexpired term. The Board cannot fully function as directed by statute "to monitor and oversee the operations, policies, and procedures of the Inspector General" (20 ILCS 1305/1-17(u)) with chronic vacancies and neglected membership requirements.

QUALITY CARE BOARD	
RECOMMENDATION 8	***The Secretary of the Department of Human Services and the Inspector General should continue to work with the Governor's Office to appoint members to the Quality Care Board in order to fulfill statutory membership requirements in the Department of Human Services Act (20 ILCS 1305/1-17(u)).***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	The Office of the Inspector General (OIG) and the Illinois Department of Human Services (IDHS) accept the recommendation. The OIG addressed this recommendation with the Quality Care Board at the December 8, 2020 board meeting. The OIG and IDHS will continue to work with the Governor's Office to appoint qualified members to the Quality Care Board.

Quarterly Meetings

The Board did not always meet quarterly as is required by the Department of Human Services Act and did not have a quorum present in FY18 (see Exhibit 5-2). The Act requires four Board members to be present to constitute a quorum, which allows the Board to conduct its business (20 ILCS 1305/1-17(u)).

In FY18, the Board only held two of the four required meetings (all by teleconference). The meetings were held on September 25, 2017, and December 14, 2017. Both failed to have quorums.

The Board held three of the four required meetings during FY19 (all by teleconference). The meetings were held on July 11, 2018, November 9, 2018, and April 26, 2019. All meetings had a quorum.

The Board held five meetings during FY20 (all by teleconference). The meetings were held on January 14, 2020, February 4, 2020, March 10, 2020, April 14, 2020, and May 12, 2020.

Exhibit 5-2
QUALITY CARE BOARD MEETINGS
FY18, FY19, and FY20

Meeting Date	Members Attending	Quorum?
FY18		
09/25/2017	3	No
12/14/2017	2	No
FY19		
07/11/2018	4	Yes
11/09/2018	4	Yes
04/26/2019	4	Yes
FY20		
01/14/2020	5	Yes
02/04/2020	5	Yes
03/10/2020	5	Yes
04/14/2020	4	Yes
05/12/2020	5	Yes

Source: Quality Care Board Meeting Minutes.

OIG and Quality Care Board Interaction

The OIG appears to be keeping the Board informed and involved with significant actions taken and decisions made that impact the investigatory process, as well as other issues. According to the meeting minutes from September 25, 2017, directive changes regarding intake calls were discussed. At the November 9, 2018 meeting, the Inspector General stated that any changes to directives or the administrative rules would be shared. At the January 14, 2020 meeting, the Inspector General shared long- and short-term goals that included drafting a policy and revising report formats. At the February 4, 2020 meeting, the Inspector General said that the directives were being revised and would be sent to the Board for review. He also discussed revisions to the intake process and a new conflict of interest policy. These revisions were discussed at the next two meetings, along with the impacts made on OIG policies by the COVID-19 pandemic. The May 12, 2020 meeting also discussed COVID-19 impacts as well as a revised administrative leave policy.

Although the Board did not meet quarterly or have a full quorum during FY18 and FY19, it appears that it has started fulfilling these requirements in FY20. It also appears that the OIG is keeping the Board updated on policy changes. Doing so will ensure that the Board functions effectively and fulfills its statutory responsibilities to monitor and oversee the operations, policies, and procedures of the OIG.

TRAINING

The Department of Human Services Act (20 ILCS 1305/1-17(h)) contains requirements related to OIG training programs. The Act requires the Inspector General to:

- *Establish a comprehensive program to ensure that every person authorized to conduct investigations receives ongoing training relative to investigation techniques, communication skills, and the appropriate means of interacting with persons receiving treatment for mental illness, developmental disability, or both mental illness and developmental disability, and*

- *Establish and conduct periodic training programs for facility and agency employees concerning the prevention and reporting of any one or more of the following: mental abuse, physical abuse, sexual abuse, neglect, egregious neglect, or financial exploitation. Nothing in this Section shall be deemed to prevent the Office of Inspector General from conducting any other training as determined by the Inspector General to be necessary or helpful.*

Investigator Training

The OIG could not provide documentation to show that 22 employees had received the required initial and continuing training courses delineated in OIG directives. According to OIG officials, this is largely due to staffing and database issues, and many of the trainings had possibly taken place, but no documentation could be provided.

OIG directives contain training requirements for newly hired and continuing employees. New hire requirements include trainings in the DHS Act, OIG directives, Health Insurance

Portability and Accountability Act (HIPAA), and Rule 50 that must be taken within six months of hire. Continuing employees must take at least three training courses per fiscal year within the subjects of investigative skills, computer skills, or personal and professional growth. Additionally, all employees must receive annual trainings covering ethics, sexual harassment, HIPAA, and Rules 50, 115, 116, and 119. These trainings must be recorded in the training database through forwarding evaluation forms, attendance sheets, email verification, and online transcripts to the data-entry person.

Auditors received a download of OIG employees, the trainings they completed, the date of each training, and each employee's job title for FY18, FY19, and FY20. These trainings were reconciled with the requirements listed above. Auditors found 22 of 22 (100%) employees who did not have documentation for at least one of the required new hire trainings during the audit period, two of whom received some of the trainings outside of the required six month period. At least one of these employees was known by OIG officials to have had the required trainings, but no documentation could be provided. Five of the 22 were hired in calendar year 2020, and their trainings may have been impacted by the COVID-19 shutdown. The majority of the undocumented trainings were for HIV/AIDS in the Workplace, Alcohol and Substance Abuse Records, and Recipients of Public Benefits. Another 5 of the 61 employees that were required to have continuing training in FY20 did not complete it.

OIG officials gave several reasons that trainings were either not completed or undocumented. There was no staff dedicated to training for the audit period; instead, the Deputy Inspector General largely coordinated and conducted trainings during this time. This responsibility has now shifted to Bureau Chiefs. The lack of dedicated training staff resulted in a breakdown in documenting and recording trainings in OIG's database (further database entry issues are detailed in the last section of this chapter). Besides data entry issues, the OIG also stated that **the actual database, despite being "impressively self-coded by OIG staff over the past decade, is outdated, lacking in flexibility, and in need of an upgrade.**" For these reasons, the OIG generally believes that required training is being done, but not necessarily tracked. For the continuing employees missing trainings in FY20, OIG officials stated that they were unsure why this was so, despite several reminders being issued.

Confirming that new and continuing investigators receive the proper training is a crucial step in ensuring that investigations of abuse and neglect are being conducted effectively. Without proper training, the risk of overlooking a critical component of the investigation or arriving at an incorrect conclusion about an allegation is increased.

INVESTIGATOR TRAINING	
RECOMMENDATION 9	***The Office of the Inspector General should:*** • ***Ensure that employees are receiving all required trainings; and*** • ***Update internal databases to more effectively track training to ensure that each employee has received the required training.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	The OIG accepts the recommendation. The OIG will review the process for documenting training to ensure all employees receive required trainings and that the trainings are appropriately tracked. The OIG will continue to work with DoIT and IDHS to consider alternatives to better track employee training. The OIG is in the process of trying to hire a Chief Administrative Officer, who would be responsible for reviewing the OIG's training processes.

Rule 50 Training

DHS should ensure that all employees at State-operated facilities and community agencies receive training in prevention and reporting of abuse and neglect (Rule 50). Training information provided by the DHS Division of Mental Health and the Division of Developmental Disabilities showed that some employees at facilities operated by the State did not receive Rule 50 training. Although provider agreements and the Illinois Administrative Code require community agencies to ensure that staff are provided training in Rule 50, DHS was unable to provide information regarding community agency employees and Rule 50 training.

The Department of Human Services Act (20 ILCS 1305/1-17 (h)) states that *"The Inspector General shall… establish and conduct periodic training programs for facility and agency employees concerning the prevention and reporting of any one or more of the following: mental abuse, physical abuse, sexual abuse, neglect, egregious neglect, or financial exploitation."* The OIG provides State-operated facilities and community agencies with Rule 50 training materials through PowerPoint presentations on the DHS website, and the agency or facility provides the training for its employees. All employees at community agencies and State-operated facilities are required to have Rule 50 training upon being hired, and then at least biennially thereafter (59 Ill. Adm. Code 50.20(d)(2)).

The Act does not require the OIG to monitor compliance with training; it only requires that the OIG establish and conduct training concerning prevention and reporting of abuse and neglect. For State-operated facilities, the DHS Division of Developmental Disabilities and the DHS Division of Mental Health monitor training. According to DHS officials, compliance with training requirements for Rule 50 is monitored through the use of its OneNet system.

DHS State-Operated Facility Rule 50 Training

Documentation provided by DHS showed that employees at State-operated facilities did not always receive the statutorily required Rule 50 training. Only four of the 14 State–operated facilities reported 100 percent compliance with Rule 50 training for the audit period.

We requested information from DHS' Division of Developmental Disabilities and the Division of Mental Health related to Rule 50 training. Both divisions provided us with summaries of staff training in Rule 50 (Abuse and Neglect Training) for each facility for FY18, FY19, and FY20 (see Exhibit 5-3). Information provided by the Division of Mental Health showed that only 1 of 7 facilities had 100 percent of staff trained in Rule 50 in all three fiscal years. Information provided by the Division of Developmental Disabilities showed that only 3 of 7 facilities had 100 percent of staff trained in Rule 50 for all three fiscal years.

Exhibit 5-3
DHS RULE 50 TRAINING BY FACILITY
FY18, FY19, and FY20

Facility	% of Staff Trained in Rule 50		
MH Facilities	**FY18**	**FY19**	**FY20**
Alton	100%	95%	100%
Chester	94%	95%	95%
Chicago-Read	94%	94%	92%
Choate	88%	89%	94%
Elgin	99%	98%	97%
Madden	90%	91%	91%
McFarland	100%	100%	100%
DD Facilities	**FY18**	**FY19**	**FY20**
Choate	100%	100%	100%
Fox	95%	93%	93%
Kiley	100%	100%	100%
Ludeman	98%	48%	91%
Mabley	82%	73%	12%
Murray	97%	96%	92%
Shapiro	100%	100%	100%

Source: DHS Division of Mental Health and Division of Developmental Disabilities (unaudited).

In our previous audit, we reported that the Division of Mental Health provided information for the period July 1, 2016, to June 30, 2017, showing that of the 7 State-operated mental health facilities, 2 had 100 percent of staff trained in Rule 50, while the other 5 facilities ranged from 92 percent to 99 percent of staff trained. The Division of Developmental Disabilities provided information that showed that of the 7 State-operated developmental disability facilities, 2 had 100 percent of staff trained in Rule 50, while the other 5 facilities ranged from 82 percent to 99 percent of staff trained.

FACILITY PREVENTION AND REPORTING TRAINING	
RECOMMENDATION 10	***The Department of Human Services should ensure that all employees at State-operated facilities receive training in prevention and reporting of abuse, neglect, and exploitation as is required by the Department of Human Services Act (20 ILCS 1305/1-17(h)).***
DEPARTMENT OF HUMAN SERVICES RESPONSE	The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will continue to work to ensure compliance with training requirements. IDHS requires training on Rule 50 to be completed annually as a proactive measure to ensure that employees are well versed regarding Rule 50 and the expectations regarding treatment of and for residents/patients.

Community Agency Rule 50 Training

DHS was unable to provide documentation showing that community agencies were in compliance with the requirement that all community agency employees be trained in Rule 50. Community agency training is mandated through agency contractual agreements with DHS; the DHS divisions of Mental Health and Developmental Disabilities along with the Bureau of Accreditation, Licensure, and Certification are responsible for ensuring compliance with contractual agreements. Additionally, Section 50 of Chapter 59 of the Illinois Administrative Code requires all community agency employees to be trained in Rule 50, along with State facility employees.

COMMUNITY AGENCY PREVENTION AND REPORTING TRAINING	
RECOMMENDATION 11	***The Department of Human Services should ensure that all employees at community agencies receive training in prevention and reporting of abuse, neglect, and exploitation as is required by the Department of Human Services Act (20 ILCS 1305/1-17(h)).***
DEPARTMENT OF HUMAN SERVICES RESPONSE	The Illinois Department of Human Services (IDHS) accepts the recommendation. Contractually, providers are required to ensure training on Rule 50. The IDHS Division of Developmental Disabilities, as part of the monitoring process for community providers/services, completes provider reviews through the Division's Bureau of Quality Management (BQM). BQM, via a yearly random sample pull, reviews background checks for employees. Following BQM background audits of employees, providers are notified of deficiencies and must complete corrective action plans. The IDHS Division of Mental Health, similarly, samples community Mental Health providers that are part of the waiver for compliance. In addition, the Bureau of Licensing and Accreditation (BALC) also monitors providers for compliance for continued licensure. IDHS will work to begin compiling the results of the sampling of the compliance monitoring for training on Rule 50, going forward.

Rule 50.30(f) Training

The majority of community agencies do not have an employee trained in Rule 50.30(f). The Administrative Code requires an authorized representative to initiate the preliminary steps of an investigation, unless otherwise directed by the OIG (59 Ill. Adm. Code 50.30(f)). These preliminary steps include securing the scene of the incident, identifying witnesses, taking statements, and photographing the scene.

According to 59 Ill. Adm. Code 50.30(f), an authorized representative or a designee of an agency or facility is required to ***"initiate the preliminary steps of an investigation by a designated employee who has been trained in the OIG-approved methods…,"*** unless otherwise directed by the OIG. "Authorized representative" is defined in the Administrative Code as "[t]he administrative head or executive director of a community agency…or the facility director or hospital administrator of a Department facility." Taken at face value, the Administrative Code indicates that both facilities and agencies are required to have at least one employee who is trained in Rule 50.30(f).

OIG directives, however, only require an OIG Facility Liaison to fulfill these responsibilities. "OIG Facility Liaison" is defined as "an employee designated by the authorized representative who is trained in Rule 50 and the responsibilities of Section 50.30(f)." **There is no mention of an "OIG Agency Liaison" in the OIG directives even though agency employees are expected to complete many of the initial investigative steps.** However, OIG officials did state that they prefer an agency to have an employee trained in Rule 50.30(f). Rule 50.30(f) training is sent to agency and facility employees by request.

Auditors obtained a list of employees who took Rule 50.30(f) training from both agencies and facilities. All State facilities appear to have at least one employee who is trained in Rule 50.30(f). Conversely, **335 out of the 426 (79%) community agencies that we received training data for <u>did not</u> have a certified employee**.

The purpose of Rule 50.30(f) is to outline preliminary investigative steps that secure and preserve statements, photographs, the scene of the allegation, and other sources of evidence before an OIG investigator can reasonably begin to conduct an investigation. If community agencies are not required to have employees that are certified in Rule 50.30(f), it is more likely that preliminary investigative steps will not be fulfilled or will be done incorrectly. Without fulfilling these responsibilities in a timely and accurate manner, evidence that is essential to the investigation may be lost, incomplete, or mishandled.

RULE 50.30(f) TRAINING	
RECOMMENDATION 12	***The Office of the Inspector General should consider establishing an "OIG Agency Liaison" at each community agency who is trained in Rule 50.30(f) (59 Ill. Adm. Code 50.30(f)).***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	The Office of the Inspector General (OIG) accepts the recommendation. The OIG will continue to work with IDHS's Divisions of Mental Health and Developmental Disabilities to determine how best to achieve this goal.

UNANNOUNCED SITE VISITS

The Department of Human Services Act (20 ILCS 1305/1-17(i)) requires the Inspector General to conduct unannounced site visits to each State-operated facility at least annually for the purpose of reviewing and making recommendations on systematic issues relative to preventing, reporting, investigating, and responding to all of the following: mental abuse, physical abuse, sexual abuse, neglect, egregious neglect, or financial exploitation.

The site visit information provided by the OIG shows a slight increase in time spent on a review compared to the prior audit period, FY15 through FY17. Most site visits during the audit period were performed over two days; only three were conducted in just one day (see Exhibit 5-4). However, several site visits in FY19 had large gaps between site visit days. For instance, the site visit to Choate had 37 days between the first and last on-site day. According to OIG officials, these gaps were time periods where employees were reviewing and analyzing documents and conducting follow-up interviews. The reports for these site visits do show new recommendations, suggesting more time was necessary to review issues that had not needed attention before; however, allowing significant time to pass before a second on-site day allows facilities to unfairly prepare for contingencies.

Although no longer a requirement, we checked to see if unannounced site visits were conducted in the same month as those visits conducted in the two preceding years. According to OIG directive BCE 003 (prior to February 27, 2017), an unannounced site visit must be planned at the beginning of the fiscal year and scheduled so that no site visit is in the same month as the previous two fiscal years. This directive made the timing of the site visits less predictable, which would impact a facility's ability to prepare for the visit in advance. Advanced preparation may give a different representation of the facility's practices relative to preventing, reporting, investigating, and responding to abuse, neglect, and exploitation versus everyday practices without advanced preparation for review. Chester, Kiley, Ludeman, Madden, Murray, and Shapiro all had visits in repeat months during FY18. During FY19, Murray had a site visit that was in the same month as FY18. Site visits during FY20 were not held in repeat months.

As can be seen in Exhibit 5-4, nine site visits were not completed in FY20. This was due to OIG personnel not being considered essential for the purpose of entering facilities to conduct site visits during the COVID-19 pandemic; this decision was believed to have been made at the DHS executive level. Although unannounced site visits are required by the DHS Act (20 ILCS 1305/1-17(i)), because OIG personnel were barred from facilities by DHS, the nine remaining unannounced site visits were not completed. We will follow up on site visit completion during the next audit period.

Exhibit 5-4
UNANNOUNCED SITE VISIT DATES
FY18, FY19, and FY20

Facility	FY18	FY19	FY20
Alton Mental Health Center	February 2-3	March 6 & 26	-
Chester Mental Health Center	June 27-28	February 6-7	-
Chicago-Read Mental Health Center	April 18-19	May 8-9	October 9-10
Choate Developmental Center	June 20-22	March 20 & April 26	-
Choate Mental Health Center	June 20-22	March 20 & April 26	-
Elgin Mental Health Center	March 14-15	May 22-23	-
Fox Developmental Center	March 8	October 17	December 12-13
Kiley Developmental Center	May 1-2	April 24-25	-
Ludeman Developmental Center	May 22 & June 5	February 27 & March 18	-
Mabley Developmental Center	March 14-15	June 12-13	-
Madden Mental Health Center	December 14-15	October 3-4	September 26-27
McFarland Mental Health Center	June 7-8	November 14-15	December 4-5
Murray Developmental Center	June 12	June 18 & 25	-
Shapiro Developmental Center	May 21-22	April 10-11	November 6-7
Total Recommendations	**37**	**53**	**9**

Note: Site visits that were not conducted in FY20 were due to COVID-19 procedures that barred OIG employees from facilities.

Source: OIG Annual Reports and OAG analysis of site visits.

For all unannounced site visits except one conducted during the audit period, a Clinical Coordinator was not present as was required by previous OIG directives. The OIG removed the requirements that Clinical Coordinators attend unannounced site visits from its directives effective February 27, 2017. The absence of a medical professional from planning and attending site visits impacts the types of areas that can be examined. Reducing the number and types of areas examined during site visits decreases the depth of the reviews conducted and may increase the risk that some areas may be overlooked or not included for review for a substantial amount of time. No longer requiring Clinical Coordinators to be a part of site visits may decrease the overall effectiveness of unannounced site visits because a reviewer with medical expertise may no longer be involved.

Timeliness of Site Visits

OIG directives require that within 60 days of the completion of the site visit, a draft report is to be sent to the facility director or hospital administrator. Our review found two reports were submitted outside of 60 working days, one in FY18 and one in FY20. However, for the FY20 report that was late, the OIG stated that there was a scheduling conflict, and the timeframe was not updated to reflect the conflict. This report was received 64 days after the completion of the site visit.

Site Visit Reports

None of the site visit reports were sent to the DHS Secretary or Assistant Secretary as required by OIG directives. OIG directives require that the final site visit report be sent to OIG and DHS staff, including the DHS Secretary and Assistant Secretary, the Directors of Mental Health or Developmental Disabilities, and the OIG leadership team members. Three reports in FY20 were not sent to the OIG leadership team. However, the OIG leadership team was cc'd on the emails that contained the reports.

UNANNOUNCED SITE VISIT REPORTS	
RECOMMENDATION 13	***The Office of the Inspector General should ensure that unannounced site visit reports are sent to all of the officials required in OIG directives.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	The Office of the Inspector General (OIG) accepts the recommendation. The OIG will work to ensure that unannounced site visit reports are sent to the required officials.

Agency Site Visits

The OIG does not currently conduct unannounced site visits at community agencies. Although the DHS Act does not require unannounced site visits at community agencies, it gives the OIG the authority to conduct them. The Act states that **"The Inspector General shall at all times be granted access to any facility or agency for the purpose of…conducting unannounced site visits…"** Because the vast majority of residents live in a community agency setting, and the majority of allegations are from community agencies, there is a much higher risk of non-compliance issues. **Community agency allegations made up 70 percent of allegations in FY18, 68 percent in FY19, and 67 percent in FY20**, **and there are approximately 4,400 locations of community agencies throughout the state compared to 14 State-operated facilities**. Additionally:

- Community agencies are less likely to report an allegation in the required time frame of 4 hours than State facilities (**16% of agency reporting was late vs 10% of facility reporting in FY20**);

- They have a higher percentage of substantiated cases (**agencies had a substantiation rate of 12% in FY20 compared to a 3% rate at State-operated facilities**); and

- They are not required by the OIG to have an employee who is trained in Rule 50.30(f), as discussed previously in this chapter.

The purpose of a site visit is to review and make recommendations on systematic issues such as these.

Not conducting site visits at community agencies may result in systematic issues being overlooked, as discussed in the previous paragraph. Additionally, by utilizing its statutory authority to conduct unannounced site visits at community agencies, the OIG may be able to

prevent potential instances of abuse or neglect, or improve unsafe living conditions, as well as identify other potential issues.

AGENCY SITE VISITS	
RECOMMENDATION 14	***The Office of the Inspector General should consider conducting unannounced site visits at community agencies as allowed by the Department of Human Services Act (20 ILCS 1305/1-17(i)(1)).***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	The Office of the Inspector General (OIG) accepts the recommendation. The OIG will consider the possibility of conducting unannounced site visits at community agencies.

OIG ANNUAL REPORTS

The Department of Human Services Act does not contain any reporting requirements for community agencies even though the vast majority of allegations are from community agencies.

The Department of Human Services Act requires the OIG to provide to the General Assembly and the Governor a summary of reports and investigations for the prior fiscal year no later than January 1 of each year. The report is to contain:

- The imposition of sanctions, if any;
- The final disposition of any corrective or administrative action directed by the Secretary;
- Objective data identifying trends in the number of reported allegations;
- The timeliness of the OIG's investigations, and their disposition for each facility and Department-wide for the most recent 3-year time period;
- Staff-to-patient ratios by facility, taking into account the direct care staff only; and
- Detailed recommended administrative actions and matters for consideration for the General Assembly.

As seen in Exhibits 1-5 and 1-6 in Chapter One, from FY10 through FY20, community agencies made up 70 percent of the total allegations on average. Additionally, there are only 14 State-operated facilities compared to 518 community agencies, which have approximately 4,400 program sites throughout the state. The need for reporting on the staff-to-patient ratios at community agencies, the timeliness of community agency investigations, as well as other metrics at community agencies is paramount for the General Assembly to have a complete understanding of the totality of the OIG's responsibilities. Additionally, more in-depth reporting of community agency statistics would help the General Assembly ensure the health, safety, and welfare of the community agency residents.

OIG ANNUAL REPORTS	
RECOMMENDATION 15	***The Office of the Inspector General should consider including within its annual report:*** • ***Staff-to-patient ratios by community agency, taking into account the direct care staff only;*** • ***Timeliness of the completion of community agency cases vs. State-operated facility cases;*** • ***The annual abuse and neglect allegations, as well as death cases by individual agency (not in the aggregate); and*** • ***Any other metric that the OIG believes may benefit the General Assembly regarding community agencies.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	The Office of the Inspector General (OIG) accepts the recommendation. To the extent the OIG's current data tracking capabilities and the law allows, the OIG will work to include this information in its Annual Report.

OIG DATA

The OIG was able to provide auditors with downloads from its investigations database for FY18, FY19, and FY20. Although the data provided by the OIG was generally complete and reliable enough for our analysis and sample selection for testing, auditors identified several instances in which the OIG could improve the quality of its data. Auditors found that:

- The discovery date and time (the date and time an allegation was identified by a required reporter) in the OIG database is not always specific or accurate. In some cases the date and time were recorded in the wrong field, while in others a range of time or an estimated time ("around") is given. There were also cases in which reported times (the date and time a required reporter reports an allegation to the OIG) occurred before discovery times, or in which there was no discovery date. This makes it impossible to determine timeliness for many cases. This was also an issue in the 2017 audit.

- There were three cases in which the incident was reported to local law enforcement or Illinois State Police (ISP), but the report date was not entered. This was also an issue in the 2017 audit.

- There were 117 investigations closed in FY20 that were substantiated in which the recommendation was "No Action" in the database. For substantiated investigations there should, with few exceptions, be an associated recommended action. This was also an issue in the 2017 audit.

- There were 251 cases in FY20 in which the agency name was left blank.

- Date fields were often left blank or were entered incorrectly. There were 22 cases in FY20 in which the assigned date was left blank. After testing a sample of 100 cases for the same time period, 30 were found to have either blank or incorrect assignment, submitted, completed, or closed dates.

The OIG also provided auditors with downloads from its employee training database for the same time period. Although the data provided was generally complete and reliable enough for our analysis, OIG officials noted that there was a lack of staff and an outdated database, resulting in "database entry and coordination issues." These issues included the following:

- Training was not always recorded or documented. OIG officials stated that the office was significantly understaffed, including not having a full-time training coordinator. Training was largely done by the Deputy Inspector General, and is now done by the Bureau Chiefs. With no dedicated training staff, there was a breakdown in documenting and recording trainings. For many trainings that appeared to be missing, the OIG stated that they had not been consistently entered into or forwarded to the database.

- In 2018, the OIG combined required trainings pertaining to the DHS Act and 59 Ill. Admin. Code 50 into one training for new hires. The training database has not been updated to reflect such a change.

- The database included employees who had left employment or retired from their positions, making it appear that there were employees who did not complete their continuing training requirements.

- Auditors found that 11 employees appeared to receive 11 to 28 trainings in one day on 15 separate occasions in FY20. The OIG explained that "investigators and staff often completed trainings over a period of weeks or months but OIG entered all those trainings into its database on the same day, thus giving the false impression that the trainings were all taken on one day." Because these dates did not reflect the date of training, it was impossible to determine if these trainings occurred within the timeframes required by OIG directives.

OIG DATA	
RECOMMENDATION 16	***The Office of the Inspector General should work to improve the quality and accuracy of the information contained in the OIG investigative database and employee training database. Specifically, the OIG should:*** • ***Ensure that required fields are filled out completely and accurately, including discovery, report, assigned, submitted, completed, and closed times and/or dates in order to track timeliness requirements; and*** • ***Ensure training classes are recorded timely and accurately in order to confirm that employees are meeting requirements.***
OFFICE OF THE INSPECTOR GENERAL RESPONSE	The Office of the Inspector General (OIG) accepts the recommendation. The OIG will reinforce with all staff the need to ensure all information is entered into the OIG's database timely and accurately. The OIG will also continue to review and revise its quality assurance processes for database entries. The OIG will also review its process for documenting all received training to ensure such trainings are accurately entered, appropriately maintained and reflect that staff have received required training or note where they have not completed required trainings. The OIG will also continue to work with the Illinois Department of Innovation and Technology (DoIT) and the Illinois Department of Human Services (IDHS) to consider alternatives to better track employee training.

APPENDICES

APPENDIX A

DEPARTMENT OF HUMAN SERVICES ACT

20 ILCS 1305/1-17

Appendix A

DEPARTMENT OF HUMAN SERVICES ACT

20 ILCS 1305/1-17

(w) Program audit. The Auditor General shall conduct a program audit of the Office of the Inspector General on an as- needed basis, as determined by the Auditor General. The audit shall specifically include the Inspector General's compliance with the Act and effectiveness in investigating reports of allegations occurring in any facility or agency. The Auditor General shall conduct the program audit according to the provisions of the Illinois State Auditing Act and shall report its findings to the General Assembly no later than January 1 following the audit period.

APPENDIX B

SCOPE, SAMPLING, AND ANALYTICAL METHODOLOGY

Appendix B

SCOPE, SAMPLING, AND ANALYTICAL METHODOLOGY

The Department of Human Services Act (Act) directs the Auditor General to conduct a program audit of the Department of Human Services, Office of the Inspector General (OIG) on an as-needed basis. The Act specifically requires the audit to include the Inspector General's compliance with the Act and effectiveness in investigating reports of allegations occurring in any State-operated facility or community agency. Detailed audit objectives include:

- Following up on previous recommendations;
- Reviewing the OIG's organizational structure including its staffing, mission, strategic plans, vision, and goals;
- Analyzing investigative data to determine the number of allegations reported, timeliness of investigations, and substantiation rates for allegations;
- Testing investigative files to determine the adequacy of investigations; and
- Testing compliance with requirements in the Department of Human Services Act including establishing training, conducting unannounced site visits, and Quality Care Board membership and meetings.

This audit covers the period FY18, FY19, and FY20. Initial work began on this audit in January 2020 and fieldwork was concluded in September 2020. We interviewed or contacted representatives from the DHS Inspector General's Office, DHS Division of Developmental Disabilities, DHS Division of Mental Health, and the Illinois State Police. We also reviewed documents and data from the Inspector General's Office, the DHS Division of Developmental Disabilities, the DHS Division of Mental Health, and the Illinois State Police. We examined the current OIG organizational structure, policies and procedures, and investigation requirements. We also reviewed internal controls over the investigation process. Additionally, our audit work included follow-up on any previous OIG audit recommendations.

We analyzed investigations data provided by the OIG from its electronic database from FY18 through FY20. We analyzed the electronic data and tested a sample of cases closed from FY20.

We also analyzed training data provided by the OIG from its electronic database for FY18 through FY20. We reviewed OIG's compliance with training requirements outlined in their directives and the Department of Human Services Act (20 ILCS 1305/17(h)).

We assessed risk by reviewing recommendations from previous OIG audits conducted by the Office of the Auditor General, OIG internal documents, policies and procedures, management controls, and the OIG's administrative rules. We reviewed management controls relating to the audit objectives that were identified in section 1-17(w) of the Department of Human

Services Act (20 ILCS 1305) (see Appendix A). The audit reports on any weaknesses in those controls and includes them as recommendations.

In conducting the audit, we reviewed applicable State statutes, administrative rules, and OIG policies. We reviewed compliance with these laws, rules, and policies to the extent necessary to meet the audit's objectives. Any instances of non-compliance we identified are noted as recommendations in this report.

Testing and Analytical Procedures

From cases closed in FY20, we selected a random sample of 100 cases with a proportionate distribution by Bureau, and by facility and agency. The distribution of cases in this manner allowed us to focus more specifically on areas that have a higher risk associated with them. For FY20, 70.5 percent of total abuse and neglect allegations were from community agencies, and 29.5 percent were from State-operated facilities. By using this methodology, the sample more accurately reflects the overall population of case distribution at the OIG, and additionally allows more in depth audit reporting where there is greater risk. Using a data collection instrument, we gathered certain information from case files and developed a database of sample information to analyze. That information included verification of data from the OIG electronic system. The sample distribution of our sample between facilities and agencies is below:

- The total population of investigations closed at State facilities in FY20 was 1,057. We sampled 29 of these investigations; and

- The total population of investigations closed at community agencies in FY20 was 2,525. We sampled 71 of these investigations.

Testing results cannot be extrapolated to the overall population.

We also performed analyses based on an electronic database of OIG reported cases from FY18 through FY20 and did comparisons of similar data from prior OIG audits. These databases represent a snapshot at the time we received the information. The validity of electronic data was verified as part of our case file testing described above.

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. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The Office of the Auditor General has conducted 12 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, 2006, 2008, 2010, and 2017.

An exit conference to discuss the draft audit report was held with officials from the Department of Human Services Office of the Inspector General on December 15, 2020. Those in attendance included:

DHS Office of the Inspector General:
Peter Neumer, Inspector General
Bill Diggins, Deputy Inspector General
Brian Dunn, Chair, Quality Care Board

Department of Human Services:
Grace Hou, Secretary
Robert Brock, Chief Fiscal Officer
Amy Macklin, Chief Internal Auditor
Albert Okwuegbunam, Internal Audit
Alison Stark, Director, Developmental Disabilities
Brock Dunlap, Deputy Director / Business Policy and Fiscal Operations, Mental Health
Christine McLemore, Chief of Staff, Mental Health

Office of the Auditor General:
Patrick Rynders, Audit Manager
Bill Helton, Audit Manager
Megan Chrisler, Audit Supervisor
Angela Coleman, Audit Staff
Joshua Kuhl, Audit Staff

APPENDIX C

RATE OF SUBSTANTIATED ABUSE OR NEGLECT CASES BY FACILITY AND AGENCY

FY18, FY19, and FY20

Appendix C
RATE OF SUBSTANTIATED ABUSE OR NEGLECT CASES BY AGENCY
(Includes Allegations Categorized as Abuse, Neglect, or Death at Intake)
FY18, FY19, and FY20

Facility/Agency	Fiscal Year 2018			Fiscal Year 2019			Fiscal Year 2020		
	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate
State Facilities									
Alton	107	1	1%	130	3	2%	91	1	1%
Chester	166	3	2%	162	12	7%	205	7	3%
Chicago-Read	32	0	0%	34	0	0%	46	0	0%
Choate	125	13	10%	202	6	3%	164	6	4%
Elgin	164	0	0%	168	2	1%	175	3	2%
Fox	21	3	14%	25	3	12%	14	0	0%
Kiley	133	5	4%	79	2	3%	88	6	7%
Ludeman	65	6	9%	92	7	8%	74	2	3%
Mabley	36	4	11%	44	1	2%	29	1	3%
Madden	39	1	3%	71	3	4%	26	2	8%
McFarland	48	0	0%	132	2	2%	50	4	8%
Murray	44	1	4%	51	6	12%	48	1	2%
Shapiro	83	2	2%	93	1	1%	47	0	0%
Community Agencies									
A Step Forward	0	0	0%	2	1	50%	1	0	0%
Abilities Plus	4	1	25%	2	0	0%	8	0	0%
Achieve Development Association	1	0	0%	2	0	0%	0	0	0%
Achievement Unlimited, Inc.	59	9	15%	65	9	14%	53	8	15%

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FY18, FY19, and FY20

Facility/Agency	Fiscal Year 2018			Fiscal Year 2019			Fiscal Year 2020		
	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate
Active Visions, Inc.	0	0	0%	7	0	0%	7	2	29%
Ada S. McKinley Community Service, Inc.	8	1	13%	9	1	11%	9	0	0%
Adapt of Illinois, Inc.	0	0	0%	0	0	0%	2	0	0%
Alexian Brothers Center for Mental Health	1	0	0%	0	0	0%	3	0	0%
Allendale Association	1	0	0%	0	0	0%	0	0	0%
Alpha Omega Consulting, Inc.	9	2	22%	4	1	25%	1	0	0%
Alvin Eades Center, Inc.	0	0	0%	0	0	0%	1	0	0%
American Residential Care, Inc.	0	0	0%	2	0	0%	0	0	0%
American Warriors	2	0	0%	5	1	20%	0	0	0%
Anixter Center, Lester and Rosalie	22	3	14%	18	2	11%	15	3	20%
Apostolic Christian Home for the Handicapped	4	0	0%	3	0	0%	0	0	0%
Arc of Iroquois County	11	1	9%	8	1	13%	8	3	38%
Arc of the Quad Cities Area	31	3	10%	19	0	0%	29	4	14%
Aspire	12	1	8%	16	3	19%	24	1	4%

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FY18, FY19, and FY20

Facility/Agency	Fiscal Year 2018			Fiscal Year 2019			Fiscal Year 2020		
	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate
Association f/t Betterment of Retarded Adults	4	0	0%	1	0	0%	4	2	50%
Association for DD in Woodford County	1	0	0%	0	0	0%	1	0	0%
Association for Individual Development	42	1	2%	41	3	7%	48	2	4%
Association House of Chicago	5	0	0%	1	0	0%	1	0	0%
Austin Special Chicago	1	0	0%	1	0	0%	1	0	0%
Avancer Homes, LLC	31	3	10%	14	2	14%	13	1	8%
Avenues to Independence	5	1	20%	5	1	20%	4	1	25%
Barbara Olson Center of Hope	3	0	0%	4	0	0%	1	0	0%
Bartlett Learning Center	1	0	0%	0	0	0%	0	0	0%
Bethesda Lutheran Communities, Inc.	25	2	8%	45	5	11%	36	3	8%
Bethshan Association	0	0	0%	0	0	0%	1	0	0%
Beverly Farm Foundation	6	0	0%	4	1	25%	3	1	33%
Beverly Hills Home Care, Inc.	0	0	0%	0	0	0%	1	0	0%

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Facility/Agency	Fiscal Year 2018			Fiscal Year 2019			Fiscal Year 2020		
	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate
Beverlyfarm Living Options	0	0	0%	2	0	0%	0	0	0%
Blue Island Citizens for Persons w/ DD	1	0	0%	3	0	0%	3	0	0%
Bobby E. Wright Comprehensive CMHC, Inc.	1	0	0%	1	0	0%	0	0	0%
Breath of Life Professional Services, NFP	1	0	0%	0	0	0%	0	0	0%
Bridgeway, Inc.	18	0	0%	17	1	6%	12	0	0%
Brooke Hill Management, Inc.	0	0	0%	1	1	100%	3	0	0%
Call for Help, Inc.	0	0	0%	1	0	0%	1	0	0%
Career Development Center	3	0	0%	6	0	0%	1	0	0%
Cass County Mental Health Association	0	0	0%	2	0	0%	3	0	0%
CCAR Industries	7	3	43%	10	2	20%	8	1	13%
Center for Disability Services (UCP Prairieland)	16	2	13%	7	0	0%	3	1	33%
Center on Deafness	1	0	0%	3	0	0%	1	0	0%
Centerstone of Illinois	22	2	9%	30	2	7%	38	8	21%
Challenge Unlimited	7	1	14%	3	0	0%	6	0	0%

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Facility/Agency	Fiscal Year 2018			Fiscal Year 2019			Fiscal Year 2020		
	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate
Chamness Care, Inc.	2	0	0%	2	0	0%	3	0	0%
Chestnut Health Systems	2	0	0%	7	1	14%	8	0	0%
Chicago Department of Public Health Division of MH	1	0	0%	0	0	0%	0	0	0%
Christian County Mental Health Association	2	1	50%	3	0	0%	3	0	0%
Christian Social Services of Illinois (Caritas)	5	1	20%	3	1	33%	8	1	13%
CILA Corporation	11	2	18%	14	2	14%	15	1	7%
Circle of Support, Inc.	1	0	0%	0	0	0%	1	0	0%
Clay County Rehabilitation Center, Inc.	4	0	0%	0	0	0%	3	0	0%
Clearbrook	43	8	19%	46	9	20%	77	12	16%
Coleman Tri-County Services	9	1	11%	8	3	38%	4	1	25%
Coles County Mental Health Association, Inc.	2	0	0%	2	0	0%	2	0	0%
Community Alternatives Illinois, Inc.	139	25	18%	196	42	21%	73	8	11%

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Facility/Agency	Fiscal Year 2018			Fiscal Year 2019			Fiscal Year 2020		
	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate
Comm. Counseling Center of Chicago	4	0	0%	0	0	0%	2	0	0%
Community Integrated Living, Inc.	4	0	0%	4	0	0%	7	1	14%
Community Link	15	6	40%	23	2	9%	18	3	17%
Community Living Options, Inc.	4	0	0%	3	1	33%	4	1	25%
Community Resource Center	0	0	0%	3	0	0%	1	0	0%
Community Support Services, Inc.	7	3	43%	12	3	25%	9	0	0%
Community Support Systems	3	1	33%	3	0	0%	1	0	0%
Community Workshop and Training Center	4	1	25%	4	0	0%	3	2	67%
Compassion CILA Homes, Inc.	2	0	0%	1	1	100%	0	0	0%
Comprehensive Behavioral Health Center of St Clair Co	2	0	0%	2	1	50%	1	0	0%
Comprehensive Connections	1	1	100%	1	0	0%	2	0	0%
Cornerstone Services, Inc.	40	5	13%	51	3	6%	75	6	8%
Countryside Association for People w Disabilities	1	0	0%	0	0	0%	0	0	0%

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Facility/Agency	Fiscal Year 2018			Fiscal Year 2019			Fiscal Year 2020		
	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate
Covenant Enabling Residences of Illinois	1	1	100%	4	0	0%	6	0	0%
CP of Southwestern Illinois	1	0	0%	2	0	0%	5	0	0%
Crosspoint Human Services	1	1	100%	3	0	0%	0	0	0%
CTF ILLINOIS	54	10	19%	32	6	19%	30	2	7%
Developmental Foundations, Inc.	5	0	0%	4	0	0%	7	1	14%
Developmental Services Center	6	2	33%	9	1	11%	4	0	0%
Diane Home Care Inc.	4	0	0%	4	1	25%	2	0	0%
Disability Services of Illinois	3	0	0%	0	0	0%	0	0	0%
Divine Center, Inc.	0	0	0%	1	0	0%	0	0	0%
Dominion CILA Homes, Inc.	4	0	0%	9	0	0%	3	0	0%
Douglas Center	0	0	0%	1	0	0%	3	1	33%
Dubois-Douglas Centres	8	2	25%	6	0	0%	6	0	0%
DuPage County Health Department	6	0	0%	2	0	0%	5	0	0%
Easter Seals Joliet Region	14	1	7%	16	0	0%	16	0	0%

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Facility/Agency	Fiscal Year 2018			Fiscal Year 2019			Fiscal Year 2020		
	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate
Easter Seals Metropolitan Chicago, Inc.	0	0	0%	1	0	0%	0	0	0%
Ecker Center for Mental Health	3	0	0%	4	0	0%	6	0	0%
El Valor Corporation	3	0	0%	11	1	9%	9	1	11%
Elim Christian Services	1	0	0%	0	0	0%	3	2	67%
Elm City Rehabilitation Center	5	1	20%	1	0	0%	5	0	0%
Encore Developmental Services	0	0	0%	3	0	0%	2	0	0%
Envisions, Unlimited	71	16	23%	62	3	5%	128	10	8%
EPIC	22	8	36%	31	3	10%	19	2	11%
Epilepsy Foundation of Greater Southern Illinois	4	0	0%	5	0	0%	13	4	31%
Esperanza Community Services	16	4	25%	20	3	15%	10	1	10%
Families Building Dreams, LLC	10	1	10%	2	0	0%	12	2	17%
Family Counseling Center, Inc.	3	0	0%	2	0	0%	1	0	0%
FAYCO Enterprises, Inc.	26	5	19%	31	4	13%	14	0	0%
Five Star Industries, Inc.	9	2	22%	11	0	0%	20	3	15%

Appendix C
RATE OF SUBSTANTIATED ABUSE OR NEGLECT CASES BY AGENCY
(Includes Allegations Categorized as Abuse, Neglect, or Death at Intake)
FY18, FY19, and FY20

Facility/Agency	Fiscal Year 2018			Fiscal Year 2019			Fiscal Year 2020		
	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate
Frances House, Inc.	1	0	0%	0	0	0%	1	0	0%
Fulton County Rehabilitation Center, Inc.	1	0	0%	0	0	0%	1	1	100%
Futures Unlimited, Inc.	3	0	0%	3	0	0%	4	2	50%
Garden Center Services	2	1	50%	4	1	25%	4	0	0%
Gateway Services, Inc.	12	1	8%	8	0	0%	7	0	0%
Gateway to Learning	1	0	0%	0	0	0%	0	0	0%
Gentle Hands Rehabilitation, Inc.	4	0	0%	2	0	0%	1	0	0%
Glen Brook of Vienna, Inc.	0	0	0%	1	0	0%	3	0	0%
Glenkirk	20	3	15%	18	3	17%	22	7	32%
Goldie Floberg	15	3	20%	18	0	0%	11	2	18%
Good Shepherd Manor, Inc.	8	0	0%	9	1	11%	6	1	17%
Grand Prairie Services	6	0	0%	3	0	0%	1	0	0%
Grundy County Health Department	0	0	0%	0	0	0%	1	0	0%
Habilitative Systems, Inc.	4	0	0%	6	0	0%	2	0	0%
HAH Holdings LLC	19	2	11%	91	6	7%	154	14	9%
Health Care Management Corp.	7	0	0%	9	0	0%	18	3	17%

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FY18, FY19, and FY20

Facility/Agency	Fiscal Year 2018			Fiscal Year 2019			Fiscal Year 2020		
	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate
Heart to Hearts Services, Inc.	5	0	0%	0	0	0%	0	0	0%
Heartland Health Outreach, Inc.	7	1	14%	14	0	0%	16	0	0%
Heartland Human Services	0	0	0%	1	0	0%	1	0	0%
Helping Hand Center	2	0	0%	3	0	0%	5	0	0%
Heritage Behavioral Health Center, Inc.	10	0	0%	14	1	7%	3	0	0%
Homes of Hope, Inc.	2	0	0%	5	0	0%	1	0	0%
Horizon House of Illinois Valley, Inc.	6	2	33%	8	0	0%	22	3	14%
Human Resource Development Institute	9	2	22%	8	1	13%	3	0	0%
Human Resources Center of Edgar and Clark Counties	2	0	0%	0	0	0%	2	0	0%
Human Service Center	2	0	0%	2	0	0%	1	0	0%
Human Service Center of South Metro-East	0	0	0%	5	0	0%	6	2	33%
Human Support Services	3	0	0%	0	0	0%	7	0	0%
Illinois Mentor Community Services, Inc.	21	3	14%	9	1	11%	4	0	0%

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FY18, FY19, and FY20

Facility/Agency	Fiscal Year 2018			Fiscal Year 2019			Fiscal Year 2020		
	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate
Illinois Valley Economic Development Corporation	2	0	0%	0	0	0%	0	0	0%
Independence Center	1	0	0%	0	0	0%	0	0	0%
Independent Living Services, Inc.	8	2	25%	19	6	32%	6	1	17%
Individual Advocacy Group	58	4	7%	50	5	10%	62	8	13%
Janaston Management and Development Corporation	0	0	0%	2	0	0%	4	0	0%
Jewish Child and Family Service	1	0	0%	0	0	0%	0	0	0%
Joseph Rehabilitation Center, LLC	1	0	0%	2	0	0%	3	0	0%
Josselyn Center for Mental Health	0	0	0%	2	0	0%	2	0	0%
JRs Centre, Inc.	2	0	0%	2	1	50%	3	1	33%
Kankakee County Training Center for the Disabled	20	2	10%	17	2	12%	12	1	8%
Kaskaskia Workshop, Inc.	2	0	0%	5	2	40%	3	0	0%
KCCDD, Inc.	5	0	0%	4	1	25%	5	1	20%
Kenneth Young Center	1	0	0%	0	0	0%	0	0	0%
Kreider Services, Inc.	10	2	20%	8	1	13%	8	1	13%

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Facility/Agency	Fiscal Year 2018			Fiscal Year 2019			Fiscal Year 2020		
	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate
Krypton, Inc.	3	0	0%	9	1	11%	1	0	0%
Kwanza Suites Corporation	3	0	0%	3	0	0%	3	0	0%
L'Arche Chicago	1	0	0%	1	0	0%	0	0	0%
Lambs Farm, Inc.	4	0	0%	2	0	0%	5	2	40%
Land of Lincoln Goodwill Industries, Inc.	0	0	0%	0	0	0%	1	1	100%
Lansing Association for Retarded Citizens	6	0	0%	6	0	0%	3	0	0%
Lawrence County Health Dept./OtPt Counseling Ctr.	1	0	0%	0	0	0%	0	0	0%
Lawrence/Crawford Assn. for Exceptional Citizens	2	0	0%	1	0	0%	1	0	0%
LEEDA Services of Illinois, Inc.	27	4	15%	13	1	8%	17	0	0%
Leydan Family Service and Mental Health Center	1	0	0%	1	0	0%	0	0	0%
Liberty Enterprises, Inc.	2	0	0%	7	0	0%	4	0	0%
Lincoln Square, Inc.	0	0	0%	3	1	33%	1	0	0%
Little City Foundation	0	0	0%	0	0	0%	16	4	25%
Little Friends, Inc.	21	1	5%	27	1	4%	15	1	7%

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FY18, FY19, and FY20

Facility/Agency	Fiscal Year 2018			Fiscal Year 2019			Fiscal Year 2020		
	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate
Living in a Family Environment Management Corp.	1	0	0%	1	0	0%	2	2	100%
Locust Street Resource Center	1	1	100%	1	0	0%	1	1	100%
Lutheran Social Services of Illinois	10	0	0%	9	1	11%	5	1	20%
Macon Resources, Inc.	2	1	50%	13	1	8%	25	2	8%
Malcolm Eaton Enterprises	2	0	0%	4	0	0%	2	0	0%
Marcfirst	25	1	4%	23	2	9%	14	3	21%
Marion County Horizon Center	24	6	25%	21	3	14%	25	0	0%
Marklund Childrens Home	1	0	0%	1	1	100%	0	0	0%
Massac County Mental Health	0	0	0%	2	0	0%	0	0	0%
Massac/Alexander/ Pulaski Training Center	1	0	0%	0	0	0%	1	0	0%
McLean County Center for Human Services	2	0	0%	3	0	0%	5	0	0%
Mental Health Centers of Western Illinois	2	0	0%	0	0	0%	2	0	0%
Metropolitan Family Services	1	0	0%	0	0	0%	1	0	0%

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Facility/Agency	Fiscal Year 2018			Fiscal Year 2019			Fiscal Year 2020		
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MH Centers of Central IL (Mem. Behav. Hlth.)	12	0	0%	6	0	0%	1	0	0%
Midwest Care, Inc. dba Kin Care, Inc.	3	0	0%	0	0	0%	2	0	0%
Milestone, Inc.	16	2	13%	18	2	11%	8	0	0%
Millennium Gardens, Inc.	5	0	0%	5	0	0%	2	1	50%
Misericordia Heart of Mercy	0	0	0%	0	0	0%	2	0	0%
Mosaic	95	9	9%	114	4	4%	93	11	12%
Moultrie County Beacon, Inc.	13	1	8%	25	0	0%	13	3	23%
Mulford Homes, Inc.	1	1	100%	0	0	0%	1	0	0%
Neighborhood Services	1	0	0%	0	0	0%	0	0	0%
Neumann Family Services	61	7	11%	34	5	15%	27	7	26%
New Opportunities, Inc.	0	0	0%	1	0	0%	2	0	0%
New Star, Inc.	28	3	11%	27	0	0%	12	1	8%
Northpointe Resources, Inc.	27	3	11%	16	0	0%	3	0	0%
NuCare, Inc.	13	1	8%	13	0	0%	2	0	0%

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Facility/Agency	Fiscal Year 2018			Fiscal Year 2019			Fiscal Year 2020		
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Oak/Leyden Developmental Services, Inc.	9	1	11%	15	1	7%	3	0	0%
Open Door Rehabilitation Center	7	3	43%	3	0	0%	6	0	0%
Opportunity House,Inc.	9	1	11%	2	0	0%	9	2	22%
Orchard Village	13	2	15%	11	0	0%	18	0	0%
Ottawa Friendship House	0	0	0%	0	0	0%	2	0	0%
Our Directions, Inc.	9	1	11%	4	0	0%	5	1	20%
PACTT Learning Center	7	1	14%	1	1	100%	3	0	0%
Parents & Friends of the Community Integration Svc	0	0	0%	1	0	0%	3	0	0%
Park Lawn School & Activity Center	1	0	0%	7	0	0%	6	1	17%
Pathway House, Inc.	1	0	0%	0	0	0%	2	0	0%
Pathway Services Unlimited	17	2	12%	11	1	9%	13	0	0%
Patterson House, Inc.	1	0	0%	2	0	0%	0	0	0%
Perry County Counseling Center, Inc.	1	0	0%	8	0	0%	1	0	0%
Pilot House	2	1	50%	1	1	100%	0	0	0%

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Facility/Agency	Fiscal Year 2018			Fiscal Year 2019			Fiscal Year 2020		
	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate
Pilsen-Little Village CMHC	2	0	0%	0	0	0%	0	0	0%
Pinnacle Opportunities, Inc.	0	0	0%	3	0	0%	1	0	0%
Pioneer Center for Human Services	14	1	7%	6	0	0%	13	2	15%
Pioneer Concepts, Inc.	6	0	0%	5	0	0%	0	0	0%
Presence Behavioral Health, Pro Care Centers	2	0	0%	0	0	0%	2	0	0%
Progress Management, Inc.	19	4	21%	17	2	12%	28	7	25%
Progress Port, Inc.	6	1	17%	27	1	4%	6	1	17%
Progressive Housing, Inc.	21	11	52%	33	2	6%	18	0	0%
Progressive Therapeutic Services	3	0	0%	4	0	0%	3	0	0%
R & J Enterprises Country Living	3	0	0%	2	0	0%	1	0	0%
Random Act of Kindness Developmental Agency, Inc.	2	0	0%	6	0	0%	2	0	0%
Ray Graham Association for People w/ Disabilities	19	2	11%	13	1	8%	3	0	0%
RCAP Enterprise, Inc.	4	0	0%	9	0	0%	5	0	0%

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Facility/Agency	Fiscal Year 2018			Fiscal Year 2019			Fiscal Year 2020		
	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate
Rehabilitation and Vocational Education, Inc.	10	1	10%	2	0	0%	6	0	0%
Residential Developers, Inc.	11	2	18%	26	3	12%	22	6	27%
Residential Options, Inc.	3	0	0%	4	1	25%	2	1	50%
Rimland Services, NFP	7	5	71%	4	2	50%	12	2	17%
Rincon Family Services	1	0	0%	0	0	0%	0	0	0%
Riverside Foundation	2	2	100%	1	0	0%	0	0	0%
Rock River Valley Self Help Enterprises, Inc.	5	1	20%	3	0	0%	2	0	0%
Rosecrance	37	0	0%	19	1	5%	26	0	0%
Royal Living Center, Inc.	29	3	10%	20	7	35%	20	4	20%
Saze Community Services, Inc.	4	0	0%	6	0	0%	9	0	0%
Search Inc.	13	1	8%	13	1	8%	30	4	13%
Sertoma Centre, Inc.	8	1	13%	24	0	0%	11	1	9%
Shamrock Services	11	1	9%	6	0	0%	12	0	0%
Shelby County Community Services, Inc.	1	0	0%	3	0	0%	2	0	0%

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Facility/Agency	Fiscal Year 2018			Fiscal Year 2019			Fiscal Year 2020		
	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate
SHORE Community Services, Inc.	4	1	25%	5	0	0%	2	0	0%
Sinnissippi Centers, Inc.	1	0	0%	0	0	0%	0	0	0%
Skystar Residential Services	6	2	33%	10	1	10%	15	2	13%
Soledad Social Services Corporation	2	0	0%	10	0	0%	8	1	13%
South Central Community Services, Inc.	1	0	0%	0	0	0%	0	0	0%
South Chicago Parents & Friends	18	0	0%	10	0	0%	6	1	17%
South Side Office of Concern	3	0	0%	1	0	0%	0	0	0%
Southeastern Illinois Counseling Centers, Inc.	0	0	0%	0	0	0%	1	0	0%
Southeastern Residential Alternatives, Inc.	9	2	22%	7	0	0%	10	1	10%
Southern Illinois Community Support Services	2	0	0%	9	0	0%	11	2	18%
Southwest Disabilities Services and Support, NFP	1	0	0%	0	0	0%	0	0	0%
SPARC	17	5	29%	35	5	14%	20	0	0%

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Facility/Agency	Fiscal Year 2018			Fiscal Year 2019			Fiscal Year 2020		
	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate
Specialized Training for Adult Rehabilitation	5	1	20%	4	0	0%	10	0	0%
Springfield Developmental Center, Inc.	0	0	0%	2	0	0%	2	0	0%
St. Clair Associated Vocational Enterprises, Inc.	5	1	20%	7	0	0%	12	2	17%
St. Coletta of Wisconsin	3	0	0%	6	0	0%	4	0	0%
St. Coletta's of Illinois, Inc.	24	5	21%	11	2	18%	11	1	9%
Stepping Stones of Rockford	3	0	0%	2	0	0%	1	0	0%
Streator Unlimited, Inc.	9	1	11%	4	0	0%	9	1	11%
Support Systems and Services	16	3	19%	38	3	8%	38	10	26%
Sylvia Homes, Inc.	7	0	0%	7	0	0%	4	0	0%
TASH Incorporated	2	0	0%	2	0	0%	4	0	0%
Tazewell County Resource Centers, Inc.	3	0	0%	7	3	43%	7	2	29%
Tazwood Mental Health Center, Inc.	1	0	0%	0	0	0%	1	0	0%
TDL Group, Inc.	20	3	15%	18	3	17%	31	4	13%
There's No Place Like Home	0	0	0%	1	0	0%	1	0	0%

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FY18, FY19, and FY20

Facility/Agency	Fiscal Year 2018			Fiscal Year 2019			Fiscal Year 2020		
	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate
Thresholds	17	2	12%	15	2	13%	16	2	13%
Topview Corporation	0	0	0%	3	0	0%	0	0	0%
TRADE Industries	3	1	33%	9	3	33%	4	2	50%
Transitions of Western Illinois	4	1	25%	7	0	0%	6	0	0%
Transitions, N.F.P.	3	0	0%	1	0	0%	0	0	0%
TRI-CARE, Inc.	5	0	0%	0	0	0%	1	0	0%
Trilogy, Inc.	22	1	5%	28	1	4%	14	0	0%
Trinity Services, Inc.	87	18	21%	52	5	10%	59	11	19%
Turning Point	1	0	0%	1	0	0%	1	0	0%
UCP Land of Lincoln	21	1	5%	71	10	14%	31	4	13%
UCP Seguin of Greater Chicago	101	25	25%	101	14	14%	66	8	12%
Union County Counseling Service, Inc.	2	1	50%	3	0	0%	2	0	0%
Villa House, Inc.	6	0	0%	1	0	0%	2	1	50%
Village Inn of Cobden, Inc.	8	1	13%	7	0	0%	3	0	0%
Vintage Support Group, Inc.	2	1	50%	11	2	18%	7	1	14%
Wabash Area Vocational Enterprises	1	0	0%	0	0	0%	3	1	33%

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Facility/Agency	Fiscal Year 2018			Fiscal Year 2019			Fiscal Year 2020		
	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate	Number Closed	Number Substantiated by OIG	Substantiated Rate
Warren Achievement Center, Inc.	3	0	0%	4	0	0%	2	0	0%
Washington County Vocational Workshop	0	0	0%	1	0	0%	2	1	50%
William M. BeDell Achievement and Resource Center	1	0	0%	2	0	0%	2	0	0%
Willowglen Academy of Illinois, Inc.	17	1	6%	17	2	12%	8	2	25%
The Workshop	1	0	0%	0	0	0%	0	0	0%
WorkSource Enterprises	0	0	0%	0	0	0%	4	4	100%
Unknown Agencies	98	6	6%	63	3	5%	41	1	2%
State Facility Totals	**1,063**	**39**	**4%**	**1,283**	**48**	**4%**	**1,057**	**33**	**3%**
Community Agency Totals	**2,540**	**345**	**14%**	**2,708**	**267**	**10%**	**2,525**	**291**	**12%**
Combined Totals	**3,603**	**385**	**11%**	**3,991**	**315**	**8%**	**3,582**	**324**	**9%**

Note: Some community agencies have multiple locations, and consequently have larger allegation totals compared to smaller agencies; the number of allegations should not be interpreted as an indicator of the quality of service provided.

Source: OAG analysis of OIG data.

APPENDIX D

NUMBER OF ALLEGATIONS BY FACILITY AND AGENCY

FY18, FY19, and FY20

Appendix D
NUMBER OF ALLEGATIONS BY FACILITY AND AGENCY
FY18, FY19, and FY20

Location	Allegations								
	Abuse Allegations			Neglect Allegations			Death Allegations		
	FY18	FY19	FY20	FY18	FY19	FY20	FY18	FY19	FY20
State Facilities									
Alton	114	93	61	23	9	13	0	0	0
Chester	147	138	114	24	21	24	2	1	0
Chicago-Read	23	28	34	2	7	16	0	0	3
Choate	133	150	125	33	26	14	0	2	3
Elgin	127	125	136	33	32	36	1	4	3
Fox	8	2	0	9	6	6	9	7	5
Kiley	105	86	36	21	19	14	1	4	6
Ludeman	64	55	41	32	33	17	2	5	12
Mabley	14	34	18	17	11	7	3	3	4
Madden	35	28	27	12	13	7	1	0	1
McFarland	61	80	32	14	15	15	1	1	1
Murray	33	33	43	18	11	13	3	4	6
Shapiro	66	92	61	5	4	5	7	7	12
Community Agencies									
A Step Forward	0	3	0	0	0	2	0	0	0
Abilities Plus	2	5	3	1	1	0	0	0	1
Achieve Development Association	1	0	0	1	0	0	0	0	0
Achievement Unlimited, Inc.	21	19	26	26	17	12	13	14	8
Active Visions, Inc.	1	0	5	3	4	2	1	1	0
Ada S. McKinley Community Service, Inc.	11	6	5	2	0	3	0	0	0
Adapt of Illinois, Inc.	1	1	0	0	0	0	0	0	0
Alexian Brothers Center for Mental Health	0	1	1	1	0	0	0	0	1
Allendale Association	0	0	0	0	0	0	0	0	0

Appendix D
NUMBER OF ALLEGATIONS BY FACILITY AND AGENCY
FY18, FY19, and FY20

Location	Allegations								
	Abuse Allegations			Neglect Allegations			Death Allegations		
	FY18	FY19	FY20	FY18	FY19	FY20	FY18	FY19	FY20
Alpha Omega Consulting, Inc.	3	0	4	2	1	1	1	0	0
Alvin Eades Center, Inc.	0	0	0	0	0	0	0	0	1
American Residential Care, Inc.	0	0	1	1	0	0	1	0	0
American Warriors	2	5	0	0	1	0	0	0	0
Anixter Center, Lester and Rosalie	8	7	2	9	9	1	2	2	2
Apostolic Christian Home for the Handicapped	3	1	0	0	0	0	0	0	0
Arc of Iroquois County	3	2	5	1	0	2	4	1	3
Arc of the Quad Cities Area	14	12	16	11	7	8	2	2	4
Aspire	13	14	12	10	1	7	1	0	1
Association f/t Betterment of Retarded Adults	2	0	1	0	3	1	1	0	0
Association for DD in Woodford County	0	0	0	1	0	1	0	0	0
Association for Individual Development	22	28	28	21	12	17	2	4	3
Association House of Chicago	2	1	0	1	0	0	0	0	0
Austin Special Chicago	0	0	1	0	0	0	1	0	0
Avancer Homes, LLC	13	5	6	13	9	2	0	2	1
Avenues to Independence	4	0	1	2	3	1	1	2	1

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Location	Allegations								
	Abuse Allegations			Neglect Allegations			Death Allegations		
	FY18	FY19	FY20	FY18	FY19	FY20	FY18	FY19	FY20
Barbara Olson Center of Hope	1	3	0	0	3	0	0	0	0
Bartlett Learning Center	0	0	0	1	0	0	0	0	0
Bethesda Lutheran Communities, Inc.	21	14	15	14	17	18	3	3	3
Bethshan Association	0	0	1	0	0	0	0	0	0
Beverly Farm Foundation	2	4	1	1	2	1	1	0	0
Beverly Hills Home Care, Inc.	0	0	0	0	0	0	0	0	1
Beverlyfarm Living Options	0	0	0	0	2	0	0	0	0
Blue Island Citizens for Persons w/ DD	1	4	3	1	1	1	0	0	0
Bobby E. Wright Comprehensive CMHC, Inc.	0	0	1	0	0	1	0	0	0
Breath of Life Professional Services, NFP	0	0	0	1	0	0	0	0	0
Bridgeway, Inc.	4	12	9	6	3	1	1	0	0
Brooke Hill Management, Inc.	0	0	2	0	0	1	1	0	1
Call for Help, Inc.	1	0	2	0	0	0	0	0	0
Career Development Center	4	0	0	1	2	0	0	0	0
Cass County Mental Health Association	0	0	1	2	0	2	0	0	0

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Location	Allegations								
	Abuse Allegations			Neglect Allegations			Death Allegations		
	FY18	FY19	FY20	FY18	FY19	FY20	FY18	FY19	FY20
CCAR Industries	6	0	11	3	1	6	2	1	0
Center for Disability Services (UCP Prairieland)	8	9	0	5	5	0	0	0	0
Center on Deafness	2	0	1	0	0	0	1	0	1
Centerstone of Illinois	25	21	21	6	8	6	0	0	5
Challenge Unlimited	2	4	2	2	1	2	0	0	0
Chamness Care, Inc.	0	0	0	0	1	1	3	1	1
Chestnut Health Systems	3	4	4	1	1	1	1	1	1
Chicago Department of Public Health Division of MH	0	1	0	0	0	0	0	0	0
Christian County Mental Health Association	4	0	1	0	0	2	2	0	0
Christian Social Services of Illinois (Caritas)	0	4	3	3	4	7	1	0	1
CILA Corporation	2	8	3	4	2	0	2	5	3
Circle of Support, Inc.	0	0	0	0	1	0	0	0	0
Clay County Rehabilitation Center, Inc.	1	1	0	1	2	0	0	0	0
Clearbrook	19	30	29	30	14	25	3	0	3
Coleman Tri-County Services	6	1	1	0	1	0	3	1	2

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Location	Allegations								
	Abuse Allegations			Neglect Allegations			Death Allegations		
	FY18	FY19	FY20	FY18	FY19	FY20	FY18	FY19	FY20
Coles County Mental Health Association, Inc.	2	3	0	0	0	0	0	0	0
Community Alternatives Illinois, Inc.	68	67	22	101	75	28	0	3	2
Community Counseling Center of Chicago	2	2	0	0	0	0	0	0	0
Community Integrated Living, Inc.	2	4	4	0	1	1	2	0	2
Community Link	10	5	11	12	11	6	1	1	0
Community Living Options, Inc.	2	0	2	1	1	2	1	0	0
Community Resource Center	1	2	0	0	0	2	0	0	1
Community Support Services, Inc.	5	10	3	3	0	1	0	0	1
Community Support Systems	2	0	0	0	0	0	0	2	1
Community Workshop and Training Center	4	2	3	0	1	0	0	0	0
Compassion CILA Homes, Inc.	1	0	2	2	0	0	0	0	0
Comprehensive Behavioral Health Center of St Clair Co	1	0	0	0	0	0	1	1	1
Comprehensive Connections	1	1	0	0	0	1	0	0	0
Cornerstone Services, Inc.	41	56	40	12	23	12	0	5	5

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Location	Allegations								
	Abuse Allegations			Neglect Allegations			Death Allegations		
	FY18	FY19	FY20	FY18	FY19	FY20	FY18	FY19	FY20
Countryside Association for People w Disabilities	0	0	0	0	0	0	0	0	0
Covenant Enabling Residences of Illinois	2	2	3	3	9	3	0	0	0
CP of Southwestern Illinois	2	3	3	1	1	2	1	0	0
Crosspoint Human Services	1	1	0	1	0	2	0	0	0
CTF ILLINOIS	33	20	17	16	13	13	1	2	2
Developmental Foundations, Inc.	5	6	1	0	1	0	1	1	0
Developmental Services Center	3	5	4	2	1	1	0	0	0
Diane Home Care Inc.	3	1	5	1	2	1	0	0	0
Disability Services of Illinois	2	0	0	0	0	0	0	0	0
Divine Center, Inc.	1	0	0	0	0	0	0	0	0
Dominion CILA Homes, Inc.	5	3	1	1	3	1	0	0	0
Douglas Center	1	1	1	0	0	1	0	0	0
Dubois-Douglas Centres	4	3	8	1	2	0	0	1	0
DuPage County Health Department	4	1	2	1	1	0	0	2	2
Easter Seals Joliet Region	15	17	4	2	5	5	0	0	0

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Location	Allegations								
	Abuse Allegations			Neglect Allegations			Death Allegations		
	FY18	FY19	FY20	FY18	FY19	FY20	FY18	FY19	FY20
Easter Seals Metropolitan Chicago, Inc.	1	0	0	0	0	0	0	0	0
Ecker Center for Mental Health	3	4	2	0	0	2	0	1	1
El Valor Corporation	1	9	6	1	1	3	0	0	1
Elim Christian Services	0	1	0	1	0	1	0	0	0
Elm City Rehabilitation Center	2	0	3	1	2	2	0	1	0
Encore Developmental Services	0	2	2	0	1	0	0	0	0
Envisions, Unlimited	48	67	94	21	47	37	2	3	1
EPIC	7	7	9	15	12	3	6	1	7
Epilepsy Foundation of Greater Southern Illinois	1	5	3	7	3	0	0	0	0
Esperanza Community Services	13	7	0	6	6	2	0	0	0
Families Building Dreams, LLC	5	6	0	8	1	1	0	0	0
Family Counseling Center, Inc.	1	0	3	1	0	0	1	1	1
FAYCO Enterprises, Inc.	17	13	7	12	2	8	3	1	2
Five Star Industries, Inc.	12	4	8	2	8	6	2	0	0
Frances House, Inc.	1	1	0	0	0	0	0	0	0

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Location	Allegations								
	Abuse Allegations			Neglect Allegations			Death Allegations		
	FY18	FY19	FY20	FY18	FY19	FY20	FY18	FY19	FY20
Fulton County Rehabilitation Center, Inc.	0	0	1	0	0	0	0	0	0
Futures Unlimited, Inc.	1	3	1	1	1	0	0	0	0
Garden Center Services	1	2	2	0	2	0	0	1	1
Gateway Services, Inc.	8	7	4	3	1	0	1	1	0
Gateway to Learning	0	0	0	0	0	0	0	0	0
Gentle Hands Rehabilitation, Inc.	1	0	1	1	0	0	0	0	0
Glen Brook of Vienna, Inc.	0	0	2	0	0	1	2	0	0
Glenkirk	10	8	4	13	13	8	1	0	0
Goldie Floberg	1	4	9	15	11	5	1	0	1
Good Shepherd Manor, Inc.	8	0	3	7	1	0	2	1	3
Grand Prairie Services	1	2	0	1	3	0	1	0	1
Grundy County Health Department	0	0	0	0	0	0	0	1	0
Habilitative Systems, Inc.	2	2	0	2	2	0	2	0	0
HAH Holdings LLC	27	64	70	31	54	68	0	0	2
Health Care Management Corporation	1	8	2	10	7	4	2	1	2
Healthcare Alternative Systems, Inc.	0	1	0	0	0	0	0	0	0

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Location	Allegations								
	Abuse Allegations			Neglect Allegations			Death Allegations		
	FY18	FY19	FY20	FY18	FY19	FY20	FY18	FY19	FY20
Heart to Hearts Services, Inc.	1	0	0	0	0	0	0	0	0
Heartland Health Outreach, Inc.	4	11	8	2	4	1	3	0	2
Heartland Human Services	1	0	0	0	0	1	0	0	0
Helping Hand Center	1	2	3	2	1	0	1	0	0
Heritage Behavioral Health Center, Inc.	12	4	2	5	1	0	1	1	0
Homes of Hope, Inc.	2	1	1	1	2	0	0	1	0
Horizon House of Illinois Valley, Inc.	4	5	8	1	4	8	2	1	1
Human Resource Development Institute	4	2	1	1	2	0	0	0	0
Human Resources Center of Edgar and Clark Counties	0	2	0	0	0	0	0	0	0
Human Service Center	1	0	0	0	2	0	0	0	0
Human Service Center of South Metro-East	1	6	1	1	0	1	0	0	1
Human Support Services	5	2	2	1	1	0	0	0	0
Illinois Mentor Community Services, Inc.	8	5	2	5	5	0	1	0	1
Illinois Valley Economic Development Corporation	0	0	0	0	0	0	0	0	0

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Location	Allegations								
	Abuse Allegations			Neglect Allegations			Death Allegations		
	FY18	FY19	FY20	FY18	FY19	FY20	FY18	FY19	FY20
Independence Center	0	0	0	0	0	0	1	0	0
Independent Living Services, Inc.	7	4	2	4	1	1	1	4	2
Individual Advocacy Group	49	28	29	17	17	14	4	1	0
Janaston Management and Development Corporation	1	2	1	0	1	1	0	1	1
Jane Addams, d/b/a FHN Family Counseling Center	0	0	0	0	0	1	0	0	0
Jewish Child and Family Service	0	0	0	0	0	0	0	0	0
Joseph Rehabilitation Center, LLC	0	5	2	1	3	1	0	0	1
Josselyn Center for Mental Health	1	2	0	0	0	0	0	0	1
JRs Centre, Inc.	2	2	4	0	1	0	0	0	0
Kankakee County Training Center for the Disabled	10	10	14	8	5	1	1	0	4
Kaskaskia Workshop, Inc.	1	5	2	1	2	0	0	0	0
KCCDD, Inc.	1	3	4	3	0	0	0	0	0
Kenneth Young Center	1	0	1	0	0	0	0	0	0
Kreider Services, Inc.	6	6	2	2	5	0	1	2	2
Krypton, Inc.	6	1	0	1	1	1	0	1	1

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Location	Allegations								
	Abuse Allegations			Neglect Allegations			Death Allegations		
	FY18	FY19	FY20	FY18	FY19	FY20	FY18	FY19	FY20
Kwanza Suites Corporation	1	3	1	1	3	1	0	0	0
L'Arche Chicago	1	0	0	0	0	0	1	0	0
Lambs Farm, Inc.	3	3	2	0	2	0	0	0	0
Land of Lincoln Goodwill Industries, Inc.	0	0	0	0	1	0	0	0	0
Lansing Association for Retarded Citizens	4	5	4	0	2	3	0	0	1
Lawrence County Health Dept./OtPt Counseling Ctr.	0	0	0	0	0	0	0	0	0
Lawrence/Crawford Assn. for Exceptional Citizens	0	2	0	0	0	0	0	0	0
LEEDA Services of Illinois, Inc.	13	7	5	13	5	4	0	0	0
Leyden Family Service and Mental Health Center	0	0	0	2	0	0	0	0	0
Liberty Enterprises, Inc.	3	3	0	4	2	1	0	0	0
Lincoln Square, Inc.	1	0	0	0	1	1	0	1	0
Little City Foundation	0	0	3	0	0	4	0	0	2
Little Friends, Inc.	20	19	9	5	2	5	1	1	1
Living in a Family Environment Management Corp.	0	2	0	0	1	1	0	0	0
Locust Street Resource Center	0	1	3	0	0	0	0	0	0

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Location	Allegations								
	Abuse Allegations			Neglect Allegations			Death Allegations		
	FY18	FY19	FY20	FY18	FY19	FY20	FY18	FY19	FY20
Lutheran Social Services of Illinois	9	0	2	6	1	0	0	0	0
Macon Resources, Inc.	2	13	10	2	4	9	1	0	2
Malcolm Eaton Enterprises	2	3	1	1	1	0	0	0	0
Marcfirst	13	4	3	11	9	3	1	2	3
Marion County Horizon Center	7	14	11	6	8	3	2	4	1
Marklund Childrens Home	0	0	0	2	0	0	0	0	0
Massac County Mental Health	1	0	0	1	0	0	0	0	0
Massac/Alexander/ Pulaski Training Center	1	0	1	0	0	0	0	0	0
McLean County Center for Human Services	1	2	4	0	0	0	1	1	2
Mental Health Centers of Western Illinois	1	0	0	0	0	1	0	0	2
Metropolitan Family Services	0	0	1	0	0	0	0	0	0
MH Centers of Central IL (Mem. Behav. Hlth.)	7	1	0	0	0	2	1	0	0
Midwest Care, Inc. dba Kin Care, Inc.	0	1	1	1	0	0	1	0	0
Milestone, Inc.	7	4	7	10	4	1	3	3	3
Millennium Gardens, Inc.	5	1	3	2	1	2	0	0	0

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Location	Allegations								
	Abuse Allegations			Neglect Allegations			Death Allegations		
	FY18	FY19	FY20	FY18	FY19	FY20	FY18	FY19	FY20
Misericordia Heart of Mercy	0	1	1	0	0	0	0	0	0
Mosaic	58	47	37	51	49	31	2	6	3
Moultrie County Beacon, Inc.	7	8	5	13	9	4	0	2	0
Mulford Homes, Inc.	0	1	0	1	0	0	0	0	0
Neighborhood Services	0	0	0	0	0	0	0	0	0
Neumann Family Services	45	8	0	26	3	1	3	0	0
New Opportunities, Inc.	1	1	0	0	0	1	0	0	0
New Star, Inc.	16	11	13	16	6	5	0	1	2
Northpointe Resources, Inc.	12	7	1	16	3	0	2	2	1
NuCare, Inc.	1	16	4	2	3	0	0	0	0
Oak-Leyden Developmental Services, Inc.	3	6	1	6	4	4	2	2	0
Open Door Rehabilitation Center	6	1	0	0	2	2	2	1	1
Opportunity House, Inc.	4	1	8	2	3	3	0	1	0
Orchard Village	5	11	10	6	5	10	0	1	2
Ottawa Friendship House	0	2	0	0	0	0	0	0	0
Our Directions, Inc.	1	5	1	1	1	1	1	0	1
PACTT Learning Center	1	2	1	4	1	0	0	0	0

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Location	Allegations								
	Abuse Allegations			Neglect Allegations			Death Allegations		
	FY18	FY19	FY20	FY18	FY19	FY20	FY18	FY19	FY20
Parents & Friends of the Community Integration Svc	0	0	2	1	0	0	0	2	0
Park Lawn School & Activity Center	1	3	1	2	2	3	0	1	2
Pathway House, Inc.	0	0	1	1	0	1	0	0	0
Pathway Services Unlimited	3	5	5	8	2	2	7	1	3
Patterson House, Inc.	1	0	0	0	1	0	0	0	0
Perry County Counseling Center, Inc.	7	0	0	1	1	0	0	0	0
Pilot House	1	0	0	1	0	0	0	0	0
Pilsen-Little Village CMHC	1	0	0	1	0	0	0	0	0
Pinnacle Opportunities, Inc.	1	1	0	1	0	0	0	0	0
Pioneer Center for Human Services	10	10	4	3	2	2	0	0	1
Pioneer Concepts, Inc.	6	5	3	0	0	0	0	0	1
Presence Behavioral Health, Pro Care Centers	1	0	0	0	0	0	0	0	2
Progress Management, Inc.	12	7	11	7	13	9	1	1	1
Progress Port, Inc.	15	19	2	0	1	0	0	0	0
Progressive Housing, Inc.	17	10	17	14	15	14	1	0	4

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Location	Allegations								
	Abuse Allegations			Neglect Allegations			Death Allegations		
	FY18	FY19	FY20	FY18	FY19	FY20	FY18	FY19	FY20
Progressive Therapeutic Services	5	2	0	0	1	1	0	0	0
R & J Enterprises Country Living	3	2	0	0	0	0	0	0	1
Random Act of Kindness Developmental Agency, Inc.	3	0	2	3	5	4	0	0	0
Ray Graham Association for People w/ Disabilities	12	4	0	10	3	1	2	0	1
RCAP Enterprise, Inc.	4	3	5	3	1	1	0	0	0
Rehabilitation and Vocational Education, Inc.	2	2	3	0	0	2	0	0	0
Residential Developers, Inc.	6	12	7	1	13	5	6	3	5
Residential Options, Inc.	2	3	4	1	0	2	1	0	0
Rimland Services, NFP	2	4	4	8	6	4	1	0	0
Rincon Family Services	0	0	0	0	0	0	0	0	0
Riverside Foundation	2	0	0	0	0	0	0	0	0
Rock River Valley Self Help Enterprises, Inc.	5	1	1	0	1	1	0	0	0
Rosecrance	30	16	21	3	1	1	0	0	0
Royal Living Center, Inc.	10	3	6	9	10	12	1	0	1

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Location	Allegations								
	Abuse Allegations			Neglect Allegations			Death Allegations		
	FY18	FY19	FY20	FY18	FY19	FY20	FY18	FY19	FY20
Saze Community Services, Inc.	3	4	4	2	4	1	0	0	0
Search Inc.	13	14	8	10	6	5	1	1	2
Sertoma Centre, Inc.	6	16	2	8	3	4	0	0	2
Shamrock Services	6	6	2	0	2	5	0	2	1
Shelby County Community Services, Inc.	1	2	0	1	0	1	0	0	0
SHORE Community Services, Inc.	1	5	2	2	2	3	0	0	0
Sinnissippi Centers, Inc.	1	0	0	0	0	0	0	0	0
Skystar Residential Services	6	3	4	5	5	7	2	1	0
Soledad Social Services Corporation	4	4	2	4	1	2	1	1	0
South Central Community Services, Inc.	0	0	0	0	0	0	0	0	0
South Chicago Parents & Friends	10	4	2	5	2	2	0	0	0
South Side Office of Concern	1	0	0	0	0	0	2	0	0
Southeastern Illinois Counseling Centers, Inc.	0	0	0	1	0	0	0	0	0
Southeastern Residential Alternatives, Inc.	5	7	4	3	3	3	1	1	3

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Location	Allegations								
	Abuse Allegations			Neglect Allegations			Death Allegations		
	FY18	FY19	FY20	FY18	FY19	FY20	FY18	FY19	FY20
Southern Illinois Community Support Services	4	4	4	3	1	4	2	3	0
Southwest Disabilities Services and Support, NFP	0	0	0	0	0	0	0	0	0
SPARC	10	8	5	16	13	10	3	1	0
Specialized Training for Adult Rehabilitation	3	3	3	1	2	3	0	1	0
Springfield Developmental Center, Inc.	1	0	2	0	1	0	0	0	0
St. Clair Associated Vocational Enterprises, Inc.	7	7	0	5	3	1	0	1	0
St. Coletta of Wisconsin	4	2	3	1	2	1	0	0	0
St. Coletta's of Illinois, Inc.	21	6	8	6	4	2	2	1	1
Stepping Stones of Rockford	0	1	0	0	0	0	1	1	1
Streator Unlimited, Inc.	7	5	5	2	0	0	1	1	1
Support Systems and Services	26	29	3	11	6	1	1	0	0
Sylvia Homes, Inc.	4	0	0	9	0	0	0	0	0
T. O. C. Incorporated of Illinois	0	0	1	0	0	0	0	0	0
TASH Incorporated	0	1	1	1	2	0	0	0	0

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Location	Allegations								
	Abuse Allegations			Neglect Allegations			Death Allegations		
	FY18	FY19	FY20	FY18	FY19	FY20	FY18	FY19	FY20
Tazewell County Resource Centers, Inc.	2	3	6	2	3	0	3	0	1
Tazwood Mental Health Center, Inc.	1	0	1	0	0	0	0	0	0
TDL Group, Inc.	7	7	8	10	8	9	1	6	6
There's No Place Like Home	1	6	4	0	0	1	0	0	0
Thresholds	6	17	9	3	5	2	2	3	1
Topview Corporation	2	0	1	0	0	1	0	1	0
TRADE Industries	7	3	0	4	1	0	0	0	0
Transitions of Western Illinois	5	0	3	1	2	1	0	1	3
Transitions, N.F.P.	1	0	1	2	0	0	1	0	0
TRI-CARE, Inc.	1	0	0	1	0	0	0	0	2
Trilogy, Inc.	22	12	10	3	2	2	1	1	0
Trinity Services, Inc.	35	33	47	33	19	22	3	3	3
Turning Point	1	1	0	0	1	0	0	0	0
UCP Land of Lincoln	8	18	2	36	38	1	0	1	0
UCP Seguin of Greater Chicago	66	69	42	31	31	18	5	3	2
Union County Counseling Service, Inc.	2	0	2	0	1	0	0	0	0
Villa House, Inc.	2	0	0	1	1	0	0	1	0

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Location	Allegations								
	Abuse Allegations			Neglect Allegations			Death Allegations		
	FY18	FY19	FY20	FY18	FY19	FY20	FY18	FY19	FY20
Village Inn of Cobden, Inc.	8	0	2	1	1	1	2	0	1
Vintage Support Group, Inc.	4	8	1	2	2	0	0	0	0
Wabash Area Vocational Enterprises	0	1	0	0	1	0	1	1	0
Warren Achievement Center, Inc.	1	4	0	0	0	0	1	1	1
Washington County Vocational Workshop	1	1	2	0	0	0	0	0	0
William M. BeDell Achievement and Resource Center	1	1	4	0	0	0	0	0	1
Willowglen Academy of Illinois, Inc.	10	7	7	4	9	2	0	0	0
The Workshop	0	0	0	1	0	0	0	0	0
WorkSource Enterprises	0	0	0	0	3	1	0	0	0
Unknown Agencies	48	46	30	44	19	15	2	1	1
State Facilities	**930**	**944**	**728**	**243**	**207**	**187**	**30**	**38**	**56**
Community Agencies	**1,573**	**1,476**	**1,188**	**1,127**	**948**	**698**	**187**	**157**	**187**
Totals	**2,503**	**2,420**	**1,916**	**1,370**	**1,155**	**885**	**217**	**195**	**243**

Note: Some community agencies have multiple locations, and consequently have larger allegation totals compared to smaller agencies; the number of allegations should not be interpreted as an indicator of the quality of service provided.

Source: OAG analysis of OIG data.

APPENDIX E

COUNT OF AGENCY SITES, FACILITIES, INVESTIGATORS, AND ALLEGATIONS BY COUNTY AND BUREAU

Appendix E
POPULATION OF AGENCIES, FACILITIES, INVESTIGATORS, AND ALLEGATIONS BY COUNTY/BUREAU
FY20

North Bureau					
#	**County**	**Number of Agencies[3]**	**Number of Facilities**	**Number of Investigators**	**Number of Allegations[2,3]**
1	Boone	5	-	-	1
2	Bureau	26	-	-	5
3	Carroll	11	-	-	6
4	DeKalb	76	-	-	40
5	DuPage	166	-	-	37
6	Henry	11	-	-	3
7	Jo Daviess	10	-	-	1
8	Kane	131	1	4	217
9	Lake	116	1	1	72
10	Lee	22	1	1	27
11	Marshall	2	-	-	-
12	McHenry	61	-	-	9
13	Mercer	-	-	-	-
14	Ogle	12	-	-	3
15	Putnam	-	-	-	-
16	Rock Island	60	-	-	35
17	Stark	2	-	-	-
18	Stephenson	27	-	-	27
19	Whiteside	22	-	-	9
20	Winnebago	115	-	1	61
Totals		**875**	**3**	**7**	**553**

Cook Bureau					
#	**County**	**Number of Agencies[3]**	**Number of Facilities**	**Number of Investigators**	**Number of Allegations[2,3]**
21	Cook	1573	2	8	735
Totals		**1573**	**2**	**8**	**735**

Metro Bureau					
#	County	Number of Agencies[3]	Number of Facilities	Number of Investigators	Number of Allegations[2,3]
22	Grundy	5	-	-	-
23	Kankakee	62	1	-	115
24	Kendall	25	-	-	7
25	LaSalle	33	-	-	20
26	Will	277	-	-	130
Totals		**402**	**2[4]**	**9[1]**	**272**

Central Bureau					
#	County	Number of Agencies[3]	Number of Facilities	Number of Investigators	Number of Allegations[2,3]
27	Adams	20	-	-	4
28	Brown	6	-	-	1
29	Calhoun	1	-	-	1
30	Cass	12	-	-	7
31	Champaign	43	-	-	18
32	Christian	15	-	-	3
33	Clark	2	-	-	-
34	Coles	83	-	1	26
35	Crawford	6	-	-	1
36	Cumberland	3	-	-	-
37	DeWitt	6	-	-	4
38	Douglas	7	-	-	1
39	Edgar	7	-	-	-
40	Effingham	28	-	-	1
41	Fayette	16	-	-	8
42	Ford	3	-	-	-
43	Fulton	9	-	-	4
44	Greene	-	-	-	-
45	Hancock	6	-	-	-
46	Henderson	-	-	-	-
47	Iroquois	29	-	-	9
48	Jasper	1	-	-	-
49	Jersey	3	-	-	-
50	Knox	39	-	-	23
51	Livingston	25	1	-	32
52	Logan	22	-	-	10
53	Macon	65	-	-	28

Central Bureau					
#	County	Number of Agencies[3]	Number of Facilities	Number of Investigators	Number of Allegations[2,3]
54	Macoupin	9	-	-	2
55	Madison	66	1	1	100
56	Mason	5	-	-	1
57	McDonough	29	-	-	32
58	McLean	37	-	4	13
59	Menard	1	-	-	1
60	Montgomery	5	-	-	3
61	Morgan	33	-	1	13
62	Moultrie	17	-	-	9
63	Peoria	114	-	-	49
64	Piatt	10	-	-	2
65	Pike	1	-	-	-
66	Sangamon	88	1	2	95
67	Schuyler	2	-	-	2
68	Scott	-	-	-	-
69	Shelby	15	-	-	1
70	Tazewell	59	-	-	12
71	Vermilion	32	-	-	26
72	Warren	10	-	-	-
73	Woodford	5	-	-	1
Totals		**995**	**3**	**9**	**543**

South Bureau					
#	County	Number of Agencies[3]	Number of Facilities	Number of Investigators	Number of Allegations[2,3]
74	Alexander	4	-	-	-
75	Bond	9	-	-	6
76	Clay	18	-	-	8
77	Clinton	29	1	1	91
78	Edwards	-	-	-	-
79	Franklin	17	-	-	7
80	Gallatin	2	-	-	-
81	Hamilton	12	-	-	3
82	Hardin	4	-	-	1
83	Jackson	44	-	-	47
84	Jefferson	26	-	1	10
85	Johnson	10	-	-	3

South Bureau					
#	County	Number of Agencies[3]	Number of Facilities	Number of Investigators	Number of Allegations[2,3]
86	Lawrence	6	-	-	2
87	Marion	31	-	-	18
88	Massac	6	-	-	1
89	Monroe	12	-	-	2
90	Perry	18	-	-	13
91	Pope	4	-	-	2
92	Pulaski	5	-	-	2
93	Randolph	13	1	1	141
94	Richland	14	-	-	6
95	Saline	25	-	-	7
96	St. Clair	109	-	2	63
97	Union	50	2	3	158
98	Wabash	6	-	-	-
99	Washington	4	-	-	8
100	Wayne	16	-	-	6
101	White	8	-	-	4
102	Williamson	46	-	-	29
Totals		**548**	**4**	**8**	**638**

Note:

[1] The Metro Bureau had nine investigators located in Cook County. Therefore, totals do not add up.
[2] Allegations include abuse and neglect allegations.
[3] There were eight community agency sites in our data that did not contain a location. Additionally, there were 60 allegations that were in unknown counties.
[4] Ludeman Developmental Center is located within Cook County, but is in the Metro Bureau.

Source: OAG analysis of OIG data.

APPENDIX F

Agency Responses

JB Pritzker, *Governor*

Illinois Department of Human Services

Grace B. Hou, *Secretary*

Office of the Inspector General
401 S. Clinton, 7th Floor ● Chicago, Illinois 60607

December 21, 2020

VIA EMAIL

Patrick Rynders
Performance Audit Manager
State of Illinois Office of the Auditor General
Iles Park Plaza
740 East Ash
Springfield, IL 62703

RE: Performance Audit of Illinois Department of Human Services Office of the Inspector General

Dear Mr. Rynders:

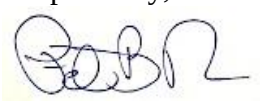
I would like to thank you and your team for your efforts in conducting the performance audit of the Illinois Department of Human Services Office of the Inspector General ("OIG"). The OIG has already begun implementing certain of the recommendations contained within the audit and will continue to do so over the next weeks and months. The OIG is confident that it will improve its overall operations by making changes as suggested by the audit.

The OIG further notes that, as evidenced by its forthcoming FY20 Annual Report, OIG made progress in several of the areas discussed in the audit. More specifically, in FY20, OIG:

- Reduced its overall caseload from 1,869 to 1,392, a reduction of 25.5 percent;
- Reduced the number of OIG investigations that have been open more than 60 days from 1,181 to 1,032, a reduction of 13 percent; and
- Increased the percentage of cases completed within 60 days from 39 percent in FY19 to 47 percent in FY20.

OIG encourages anyone interested in OIG's important mission to review the entirety of the FY20 Annual Report when it is publicly available in January 2021.

Respectfully,



Peter Neumer
Acting Inspector General
Illinois Department of Human Services

DHS RESPONSE TO 2020 PROGRAM AUDIT OF THE DHS OFFICE OF THE INSPECTOR GENERAL FINDINGS

Chapter 2 - Timeliness of Abuse and Neglect Investigations

Recommendation 1 - Allegation Reporting

Recommendation:

The Office of the Inspector General Should:

- Improve the collection of information regarding the date and time an incident is discovered; and
- Continue to work with State-operated facilities and community agencies to improve the number of allegations of abuse and neglect that are reported within the four-hour time frame specified in the Department of Human Services Act and OIG's administrative rules.

Department Response:

The Office of the Inspector General (OIG) accepts the recommendation. The OIG will direct its Bureau Chief to brief intake staff on the importance of obtaining specific information from callers, including the time of discovery of an alleged incident of abuse and neglect. The OIG will also review its training materials and directives and assess whether the OIG needs to further emphasize this aspect of the intake process. In addition, the OIG will continue to make recommendations to agencies and facilities in its final investigative reports regarding late reporting or failure to report and continue to require the Illinois Department of Human Services (IDHS) program divisions to approve written responses provided by agencies and facilities in response to such recommendations. *See* 20 ILCS 1305 1-17(n). On a monthly basis, the OIG will continue to provide the IDHS program divisions with a report of untimely "self-reports" the OIG received in the previous month. The report will identify each late report, the number of days each report was late, and the overall percentage of reports that were late. Furthermore, when there is a pattern of late reporting or failure to report by an agency or facility, the OIG will continue to notify the appropriate IDHS division. Agency and facility staff will continue to be trained biannually on the reporting requirements through Rule 50 training. The OIG will continue to work with IDHS to identify additional ways in which to improve the timeliness of IDHS' reporting.

Chapter 2 - Timeliness of Abuse and Neglect Investigations

Recommendation 2 - Investigator Assignment

Recommendation:

The Office of the Inspector General should work to improve the timeliness of:

- Initial entry of cases into the OIG database; and
- Case notification to Bureau Chiefs and Investigative Team Leaders as required by OIG directives.

Department Response:

The Office of the Inspector General (OIG) accepts the recommendation. The OIG is in the process of hiring an Investigative Team Leader for its Intake Bureau. In addition, the OIG has posted a position for a Chief Administrative Officer who will be tasked with reviewing the intake process from a technological perspective to identify any unnecessary delays. The OIG will also work with the Intake Bureau to identify additional efficiencies to improve the process.

Chapter 2 - Timeliness of Abuse and Neglect Investigations

Recommendation 3 - Case Completion Timeliness Standards

Recommendation:

The OIG should take steps to improve the timeliness of investigative case completion, such as:

- Considering the implementation of the timeliness standards of other investigative agencies with similarly vulnerable populations; and
- A thorough internal review in order to identify where delays occur during the investigative process, as well as identify other weaknesses that may be impacting the timely completion of investigations.

Department Response:

The Office of the Inspector General (OIG) accepts this recommendation. The OIG will review the standards in place at other investigative agencies and consider opportunities to implement those standards for the OIG consistent with the contents and/or bargaining requirements of Collective Bargaining Agreements. The OIG will also continue to perform an ongoing review of its investigative process to identify ways in which the OIG can improve timeliness and thoroughness of investigative work.

Chapter 2 - Timeliness of Abuse and Neglect Investigations

Recommendation 4 - Timeliness of Interviews and Statements

Recommendation:

The Office of the Inspector General should work to improve the timeliness of OIG conducted interviews, and facility and community agency liaison conducted statements including:

- Ensuring initial written statements are taken within 72 hours per OIG directive INV-005; and
- Consider implementing specific timeframes for critical interviews to occur, especially for the victim, alleged perpetrator, and primary witnesses.

Department Response:

The Office of the Inspector General (OIG) accepts the recommendation. The OIG is currently reviewing the Rule 50.30(f) process, which requires agencies and facilities to take initial steps to respond to an allegation of abuse or neglect, including ensuring the health and safety of individuals and staff, ensuring OIG is notified of the allegation in a timely manner, gathering initial statements from principles involved in the incident, and gathering basic documentation related to the incident, to identify how it can be more effectively implemented with community agencies. The OIG will continue to provide 50.30(f) training to agency and facility staff. The OIG will continue to evaluate its investigators as to whether they completed victim interviews within 21 days and will research revising its directives to include the requirement.

Chapter 2 - Timeliness of Abuse and Neglect Investigations

Recommendation 5 - Timeliness of Supervisory Review

Recommendation:

The Office of the Inspector General should ensure that investigations are reviewed by the Investigative Team Leader or Bureau Chief within fifteen working days of receipt, absent extenuating circumstances, as is required by OIG directives.

Department Response:

The OIG accepts the recommendation. As noted in the recommendation, the requirement is 15 working days, absent extenuating circumstances. With respect to the cases for which OIG did not complete its review within 15 working days, most of those cases were either substantiated investigations or complex investigations which require additional review time to ensure the accuracy and quality of the investigation and the report. In addition, the OIG hired a second Investigative Team Leader for its South and Metro bureaus in 2020, which OIG expects will improve those Bureaus average case review times.

Chapter 3 - Thoroughness of Abuse and Neglect Investigations

Recommendation 6 - Case Tracking and Closure Forms

Recommendation:

The Office of the Inspector General should ensure that all Case Tracking Forms and Case Closure Checklists are completed. Additionally, the Office should ensure that each Bureau uses the forms included in its Investigative Directives.

Department Response:

The Office of the Inspector General (OIG) accepts the recommendation. The OIG will ensure it includes the most recent version of the forms in the Investigative Directives. The OIG will also specifically address with Bureau Chiefs, Investigative Team Leaders, and administrative support staff, the need to appropriately complete these forms with all required data and signoffs and will periodically review such forms to ensure that the OIG is executing the forms appropriately.

Chapter 4 - Actions, Sanctions, and Recommendations

Recommendation 7 - DHS Approval of Written Responses

Recommendation:

The Department of Human Services should continue its efforts to ensure that written responses from facilities and community agencies are received and approved in a timely manner.

Department Response:

The Illinois Department of Human Services (IDHS) accepts the recommendation. The IDHS Divisions of Developmental Disabilities and Mental Health will work with the OIG to consider the use of electronic signatures in order to ensure timeliness of approvals.

Chapter 5 - Other Issues

Recommendation 8 - Quality Care Board

Recommendation:

The Secretary of the Department of Human Services and the Inspector General should continue to work with the Governor's Office to appoint members to the Quality Care Board in order to fulfill statutory membership requirements in the Human Services Act (20 ILCS 1305/1-17 (u)).

Department Response:

The Office of the Inspector General (OIG) and the Illinois Department of Human Services (IDHS) accept the recommendation. The OIG addressed this recommendation with the Quality Care Board at the December 8, 2020 board meeting. The OIG and IDHS will continue to work with the Governor's Office to appoint qualified members to the Quality Care Board.

Chapter 5 - Other Issues

Recommendation 9 - Investigator Training

Recommendation:

The Office of the Inspector General should:

- Ensure that employees are receiving all required trainings; and
- Update internal databases to more effectively track training to ensure that each employee has received the required training.

Department Response:

The OIG accepts the recommendation. The OIG will review the process for documenting training to ensure all employees receive required trainings and that the trainings are appropriately tracked. The OIG will continue to work with DoIT and IDHS to consider alternatives to better track employee training. The OIG is in the process of trying to hire a Chief Administrative Officer, who would be responsible for reviewing the OIG's training processes.

Chapter 5 - Other Issues

Recommendation 10 - Facility Prevention and Reporting Training

Recommendation:

The Department of Human Services should ensure that all employees at State-operated facilities receive training in prevention and reporting of abuse, neglect, and exploitation as required by the Department of Human Services Act (20 ILCS 1305/1-17 (h)).

Department Response:

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will continue to work to ensure compliance with training requirements. IDHS requires training on Rule 50 to be completed annually as a proactive measure to ensure that employees are well versed regarding Rule 50 and the expectations regarding treatment of and for residents/patients.

Chapter 5 - Other Issues

Recommendation 11 - Community Agency Prevention and Reporting Training

Recommendation:

The Department of Human Services should ensure that all employees at community agencies receive training in prevention and reporting of abuse, neglect, and exploitation as required by the Department of Human Services Act (20 ILCS 1305/1-17 (h)).

Department Response:

The Illinois Department of Human Services (IDHS) accepts the recommendation. Contractually, providers are required to ensure training on Rule 50. The IDHS Division of Developmental Disabilities, as part of the monitoring process for community providers/services, completes provider reviews through the Division's Bureau of Quality Management (BQM). BQM, via a yearly random sample pull, reviews background checks for employees. Following BQM background audits of employees, providers are notified of deficiencies and must complete corrective action plans. The IDHS Division of Mental Health, similarly, samples community Mental Health providers that are part of the waiver for compliance. In addition, the Bureau of Licensing and Accreditation (BALC) also monitors providers for compliance for continued licensure. IDHS will work to begin compiling the results of the sampling of the compliance monitoring for training on Rule 50, going forward.

Chapter 5 - Other Issues

Recommendation 12 - Rule 50.30(f) Training

Recommendation:

The Office of the Inspector General should consider establishing an "OIG Agency Liaison" at each community agency who is trained in Rule 50.30(f) (59 Ill. Adm. Code 50.30 (f)).

Department Response:

The Office of the Inspector General (OIG) accepts the recommendation. The OIG will continue to work with IDHS's Divisions of Mental Health and Developmental Disabilities to determine how best to achieve this goal.

Chapter 5 - Other Issues

Recommendation 13 - Unannounced Site Visit Reports

Recommendation:

The Office of the Inspector General should ensure that unannounced site visit reports are sent to all of the officials required in OIG directives.

Department Response:

The Office of the Inspector General (OIG) accepts the recommendation. The OIG will work to ensure that unannounced site visit reports are sent to the required officials.

Chapter 5 - Other Issues

Recommendation 14 - Agency Site Visits

Recommendation:

The Office of the Inspector General should consider conducting unannounced site visits at community agencies as allowed by the Department of Human Services Act (20 ILCS 1305/117(i)(1)).

Department Response:

The Office of the Inspector General (OIG) accepts the recommendation. The OIG will consider the possibility of conducting unannounced site visits at community agencies.

Chapter 5 - Other Issues

Recommendation 15 - OIG Annual Reports

Recommendation:

The Office of the Inspector General should consider including within its annual report:

- Staff-to-patient ratios by community agency, taking into account the direct care staff only;
- Timeliness of the completion of community agency cases vs. State-operated facility cases;
- The annual abuse and neglect allegations, as well as death cases by individual agency (not in the aggregate); and
- Any other metric that the OIG believes may benefit the General Assembly regarding community agencies.

Department Response:

The Office of the Inspector General (OIG) accepts the recommendation. To the extent the OIG's current data tracking capabilities and the law allows, the OIG will work to include this information in its Annual Report.

Chapter 5 - Other Issues

Recommendation 16 - OIG Data

Recommendation:

The Office of the Inspector General should work to improve the quality and accuracy of the information contained in the OIG investigative database and employee training database. Specifically, the OIG should:

- Ensure that required fields are filled out completely and accurately, including discovery, report, assigned, submitted, completed, and closed times and/or dates in order to track timeliness requirements; and
- Ensure training classes are recorded timely and accurately in order to confirm that employees are meeting requirements.

Department Response:

The Office of the Inspector General (OIG) accepts the recommendation. The OIG will reinforce with all staff the need to ensure all information is entered into the OIG's database timely and accurately. The OIG will also continue to review and revise its quality assurance processes for database entries. The OIG will also review its process for documenting all received training to ensure such trainings are accurately entered, appropriately maintained and reflect that staff have received required training or note where they have not completed required trainings. The OIG will also continue to work with the Illinois Department of Innovation and Technology (DoIT) and the Illinois Department of Human Services (IDHS) to consider alternatives to better track employee training.

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