State of Illinois
Department of Human Services
Office of the Inspector General

IDHS Office of the Inspector General
FY23 Annual Report

December 7, 2023

To Governor Pritzker and Members of the Illinois General Assembly:

FY23 was a year of transition for the Illinois Department of Human Services (IDHS) Office of Inspector General (OIG). After almost 4 years of distinguished service by Inspector General Peter Neumer, I was appointed Inspector General in July 2023, and I am excited to continue moving the office forward in the service of individuals with intellectual/developmental and mental disabilities.

In FY23, OIG's complaints rose considerably, from 2,991 to 3,494. This reflects a 17% increase from FY22, and a 36% increase from FY21 to FY23. Unfortunately, the rise in complaints during FY23 was coupled with a drop in personnel, as OIG's filled headcount decreased from 79 to 75. Accordingly, staffing remains a significant barrier to completing investigations in a timely manner.

Given the major and ongoing challenges posed by rising caseloads and decreased staffing, OIG's work in FY23 has been significant.

During FY23, OIG completed 2,539 cases, which resulted in 131 findings of abuse and 207 findings of neglect (including 6 egregious neglect findings) against accused parties and 46 findings of neglect against facilities and community agencies.

In FY23, OIG conducted a comprehensive report on Choate Mental Health and Developmental Center (commonly referred to as "Choate"), which was requested by IDHS after several OIG investigations shed light on a cycle of abuse and cover-up by Choate employees. In its report, OIG detailed its findings over the past several years, interviewed administration, and made several recommendations to IDHS regarding a path forward. Although evaluating the efficacy of IDHS's efforts to reduce abuse and neglect at Choate and other State Operated Developmental Center (SODC)'s will require time, OIG is hopeful that the installation of surveillance cameras in common areas will increase accountability and reduce instances of abuse and neglect. As of November 28, 2023, Choate has 160 internal and 32 external cameras that are live and recording, and the process of camera installation continues at the remaining 6 SODCs.

OIG also completed its FY23 site visit, which focused on whether SODCs were following their internal process for addressing and conducting root cause analyses of sentinel events, which are defined as "unexpected occurrence[s] involving death or serious physical or psychological injury, or the risk of thereof." As a result of its site visits, OIG identified several deficiencies at SODCs and made recommendations to DHS regarding a path forward.

OIG also successfully pushed for a change to its statute which should deter employees from interfering with OIG investigations through withholding information, altering evidence, impeding witness testimony and similar conduct. The new change, which was signed into law by Governor J.B. Pritzker on June 9, 2023, makes Material Obstruction of an OIG Investigation a Health Care Worker Registry reportable offense. As a result, employees who obstruct OIG investigations could be banned from working in health care settings throughout Illinois.

As OIG moves forward into FY24, our focus is to invest additional resources in addressing the root causes of abuse and neglect of individuals. As part of this effort, OIG is exploring a change to its statute that would give OIG authority to conduct reviews at facilities and agencies throughout the state and produce reports similar to its FY23 report on Choate. A review capacity would allow OIG to pair its investigative activities with a future-forward focus on systemic issues.

In addition, in FY24, OIG will continue to push to hire additional staff, with the goal of building an office that sustainably produces high-quality investigations in a timely manner. Unfortunately, retirements and transfers, together with the pace of statewide hiring have made keeping OIG appropriately staffed exceptionally challenging. That said, OIG's mission to protect individuals is too important to do anything but move forward.

Sincerely,

Charles Wright
Acting Inspector General

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Chapter 1: Summary of OIG's FY23

A. Notable FY23 Data

The FY23 data demonstrates that, despite the challenges OIG faced in terms of staffing vacancies, OIG was still able to remain steady with respect to case completions. Most notably, OIG:

- received a total of 3,494 allegations of abuse or neglect (including death reports), 503 more than in FY22, or 17%.
- experienced an increase of between 17.5% and 26.4% in allegations within three of the five investigative bureaus.
- completed 147 fewer cases than during FY22, which was anticipated due to continued staffing shortages.
- made 131 findings of abuse and 207 findings of neglect (6 of those being egregious neglect) against individual accuseds and 1 finding of abuse and 45 findings of neglect against facilities and community agencies.
- made final reports to the HCWR for 81 employees' names and 83 findings.

For a more complete detailing of OIG's FY23 metrics, *see infra* Chapters 2 & 3.

B. Hiring Challenges

Unfortunately, the delays in state hiring that effected OIG in FY22 continued to impact OIG operations in FY23. While OIG's approved headcount in FY23 was 89, OIG's staff numbers went down from 79 on July 1, 2022 to 75 as of June 30, 2023, as delays in hiring made it impossible to keep pace with retirements and attrition. That said, OIG has continued to post positions with the goal of reaching sustainable staffing levels. Since July 1, 2022, OIG submitted 27 hiring requests to DHS. As of September 2023, 12 of the 27 positions were filled, with the average time between the request and start date being 255 days. Of the 15 pending positions, 11 of the hiring requests were submitted six or more months ago, as shown below.

Position Title	# of Months Pending
ISI 2, Option A	13 months
Office Associate, Option 2	9 months
ISI 2, Option A	9 months
ISI 2, Option A	9 months
Administrative Assistant II	8 months
ISI 2, Option A	8 months
Office Administrator IV	8 months
ITL, PSA, Option 7	7 months
ISI 2, Option A	7 months
ITL, PSA, Option 7	6 months
ISI 2, Option A	6 months

During FY23, staff vacancies were significant,

- nine hiring requests for supervisory positions were submitted and five positions remained open;
- 13 hiring requests for investigative staff were submitted and seven positions remained open;
- four hiring requests for staff primarily responsible for processing cases and other office tasks and only one was hired.

OIG's North Bureau's is the starkest example of staffing shortages at OIG. While North Bureau would, when fully staffed, have seven investigators, one Bureau Chief and two Investigative Team Leaders, during the majority of FY23, North Bureau had only two full-time investigators. While OIG supplemented North Bureau's resources with contractual staff, temporary workers and help from other Bureaus, those resources could not replace the contributions of full-time OIG investigators, especially given a 26.4% year-over-year increase in allegations within North Bureau. See *infra* Chapter 2B.

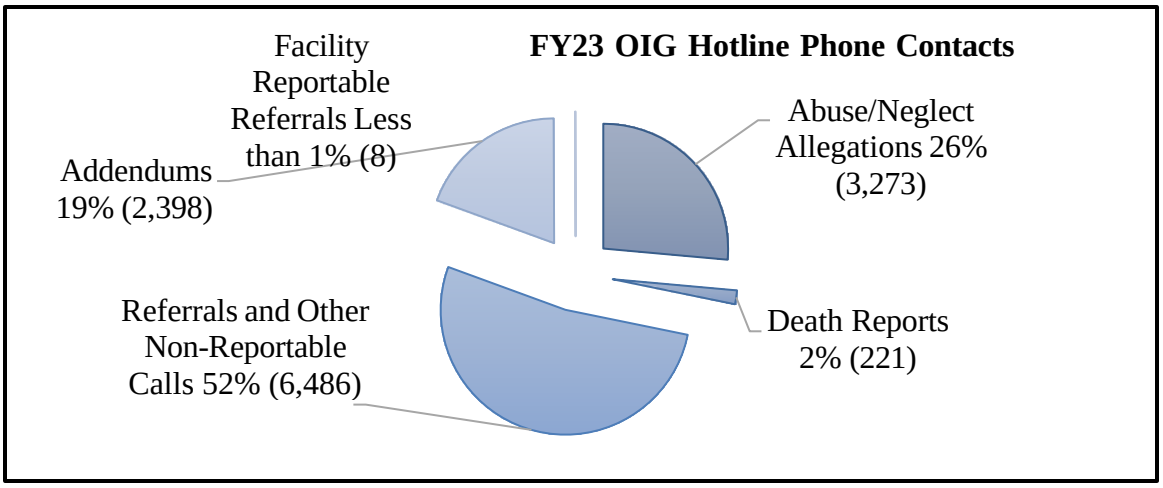
Chapter 2: OIG's FY23 in Numbers

A. OIG Hotline Calls and Referrals

During FY23, the OIG's Intake Bureau processed 12,386 calls, as reflected in the below chart, a 25% increase over FY22. As background, OIG's Intake Bureau is staffed by a Bureau Chief, an Investigative Team Leader, six Intake Investigators who answer calls during business hours, and a contracted answering service that answers calls during the evening and overnight hours. OIG management is available for after-hour calls regarding reports of deaths or serious incidents and calls coming from anonymous sources.

OIG receives and processes complaints alleging abuse (physical abuse, sexual abuse, and mental abuse), neglect, financial exploitation, and material obstruction of an investigation, as well as death reports (reports of death where abuse or neglect is not suspected) by employees of facilities and community agencies that provide mental health and/or developmental disabilities services and that are operated, licensed, funded or certified by IDHS.[1] OIG's Complaint Intake Bureau also receives thousands of non-reportable calls, which include complaints that do not fall under the definitions set forth in 59 Ill. Admin. Code 50 ("Rule 50"), or other reporting requirements.

[1] During FY23, OIG referred 8 reportable allegations to facilities for internal investigations. Rule 50 (59 Ill. Adm. Code 50.30) provides that a reportable allegation can be referred to a facility or agency when the primary facts relevant to the allegation have already been identified and additional investigative work by OIG would be of minimal value; the facility or agency is better positioned to immediately address the allegation; the allegation, if true, would be unlikely to result in a report to the Health Care Worker Registry; or the allegation does not indicate an emergency situation or that an individual is in imminent danger.

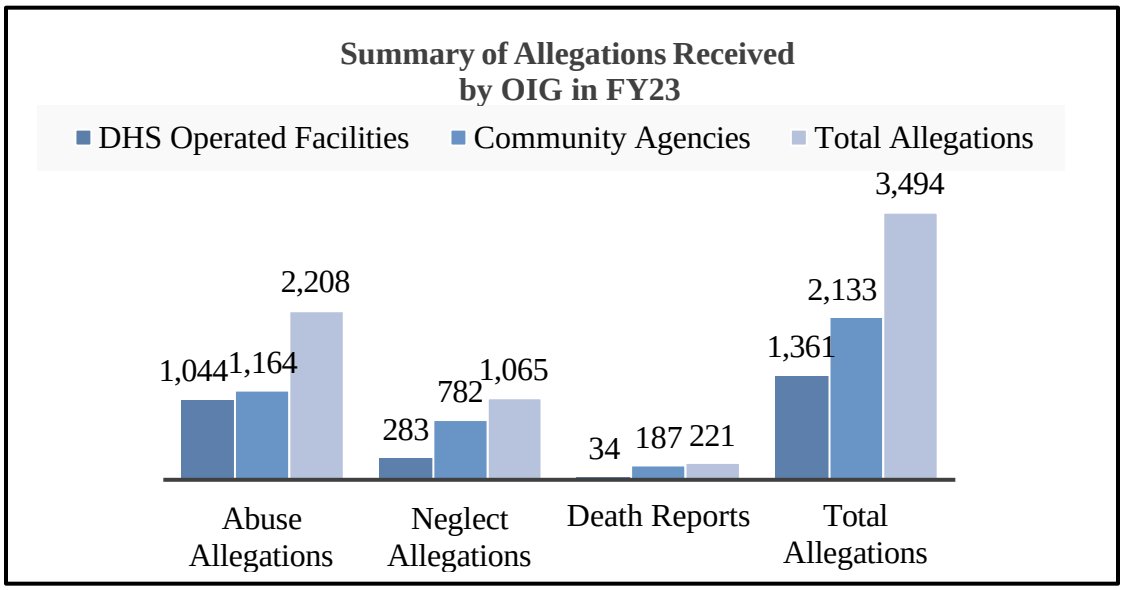


For referrals and other non-reportable calls, the Intake Investigator may either refer the caller to a more appropriate reporting entity or directly transfer the caller to that entity.[2] In FY23, OIG had 6,486 referrals and other non-reportable calls. The following table reflects the recipients of these calls:

Referral Location	Total Referred (%)
Local Community Agency or Facility	4,628 (71.4%)
Illinois Department of Public Health	349 (5.4%)
IDHS Division of Developmental Disabilities	220 (3.4%)
Department on Aging	87 (1.3%)
DHS BALC/OCAPS	65 (Less than 1%)
Law Enforcement	44 (Less than 1%)
IDHS Division of Mental Health	42 (Less than 1%)
Department of Healthcare and Family Services	39 (Less than 1%)
Department of Children and Family Services	35 (Less than 1%)
IDHS Division of Rehabilitation Services	24 (Less than 1%)
Department of Alcohol and Substance Abuse	14 (Less than 1%)
Department of Financial and Professional Regulation	4 (Less than 1%)
Other	935 (14%)
Total Referred	6,486

[2] Referrals and other non-reportable calls are calls which do not rise to the level of a reportable offense, e.g. facility food is cold on a particular day, an individual wants to be discharged from a facility, an incident which happens while the individual is on a home visit, an incident that happens on a PACE bus, or a Link card is inoperable.

B. Allegations of Abuse and Neglect Received

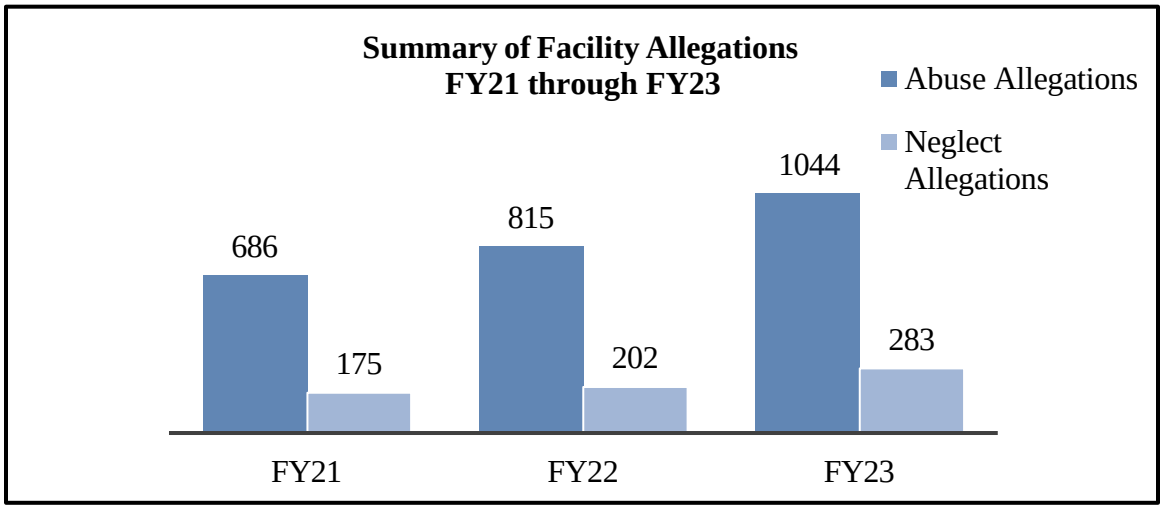


During FY23, OIG received a total of 3,494 allegations of abuse[3] or neglect (including death reports), 503 more than in FY22, or 17%. The following tables provide a detailed breakdown of the allegations OIG received in FY23,by type and location. Total abuse allegations in IDHS-operated facilities and community agencies increased from 815 in FY22 to 1044 in FY23, or 28%. Allegations of financial exploitation also increased by 26% FY22 to FY23. Similarly, neglect allegations in IDHS-operated facilities and community agencies increased by 182 from FY22 to FY23, or 21%.

Facilities

During FY23, OIG received 1,327 allegations of abuse and neglect at the IDHS-operated facilities, an increase of 31% from FY22. 1,044 of the 1,327 facility allegations were allegations of abuse (which allegations included 38 allegations of financial exploitation). Abuse allegations accounted for 79% of the total allegations at facilities, which is approximately 1% less than FY22. 283 of the 1,329 facility allegations OIG received in FY23 were allegations of neglect. The number of FY23 neglect allegations increased by less than approximately 1% from FY22.

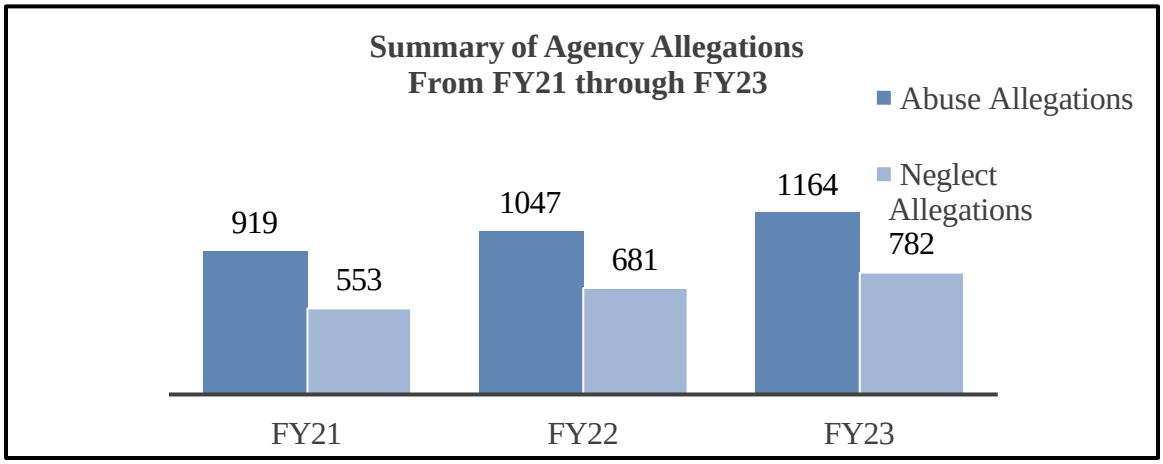
[3] For the purposes of this chart, OIG includes Financial Exploitation allegations within the category of Abuse.



Community Agencies

During FY23, OIG received 1,946 allegations of abuse and neglect at community agencies, a 13% increase from FY22. Of the 1,946 community agency allegations, there were 1,164 allegations of abuse, including 118 allegations of financial exploitation. From FY21 to FY23, the total abuse allegations at community agencies increased 1% yearly from 60% to 62%. OIG received 782 allegations of neglect at community agencies in FY23, a 15% increase from the 681 neglect allegations OIG received in FY22.

In FY23, allegations at community agencies accounted for 61% of the total allegations OIG received. This number is generally reflective of the fact that significantly more individuals receive MH/DD services at community agencies than at State-operated Facilities.



Allegation Type

The following tables show the allegations of abuse and neglect and the death reports that OIG received during FY23, categorized by the type of allegation and program location. In addition to the above-described abuse and neglect allegations that OIG received, during FY23, OIG received death reports regarding 221 individuals who were or had been receiving MH/DD services in facility or community agency programs.

FY23 Allegations and Death Reports Received by Mental Health Location							
Location	**Allegations Received**						**Death Reports**
	Physical Abuse	**Sexual Abuse**	**Mental Abuse**	**Financial Exploitation**	**Neglect**	**Total**	
Mental Health Centers:							
Alton	22	16	20	4	12	74	0
Chester	66	1	16	0	16	100	1
Chicago-Read	21	7	23	6	29	86	0
Choate	10	4	3	2	1	20	0
Elgin	95	31	68	16	50	262	2
Madden	15	6	7	0	6	35	1
Packard	26	4	6	2	7	45	0
Facility Totals	**255**	**69**	**143**	**30**	**121**	**622**	**4**
Community Agencies:							
Residential	17	10	28	15	17	105	18
Non-Residential	6	9	19	18	12	69	5
Agency Totals	**23**	**19**	**47**	**33**	**29**	**174**	**23**
Total Allegations and Reports	**278**	**88**	**190**	**63**	**150**	**796**	**27**

FY23 Allegations and Death Reports Received by Developmental Center Location							
Location	**Allegations Received**						**Death Reports**
	Physical Abuse	**Sexual Abuse**	**Mental Abuse**	**Financial Exploitation**	**Neglect**	**Total**	
Developmental Centers:							
Choate	133	12	54	3	38	240	0
Fox	1	0	1	0	3	10	5
Kiley	68	7	19	3	53	151	1

Ludeman	49	0	11	0	18	87	9
Mabley	15	0	2	0	9	27	1
Murray	58	3	8	2	24	105	10
Shapiro	79	4	15	0	17	119	4
Center Totals	**403**	**26**	**110**	**8**	**162**	**739**	**30**
Community Agencies:							
Residential	510	38	282	79	697	1,765	159
Non-Residential	65	7	55	6	56	194	5
Agency Totals	**575**	**45**	**337**	**85**	**753**	**1,959**	**164**
Total Allegations and Reports	**978**	**71**	**447**	**93**	**915**	**2,698**	**194**

Allegations by Bureau

Bureau	Deaths	Financial Exploitation	Mental Abuse	Neglect	Physical Abuse	Sexual Abuse	Grand Total
Central	67	29	133	229	183	33	674
Cook	33	34	101	192	161	37	558
Metro	38	9	98	153	256	11	565
North	33	49	174	287	290	53	886
South	50	35	131	204	366	25	811
Total	**221**	**156**	**637**	**1,065**	**1,256**	**159**	**3,494**

Percent Increase in Abuse and Neglect Allegations from FY22 to FY23, by Bureau

Bureau	% Increase in Allegations
Central	2%
Cook	17.5%
Metro	10.8%
North	26.4%
South	26.1%

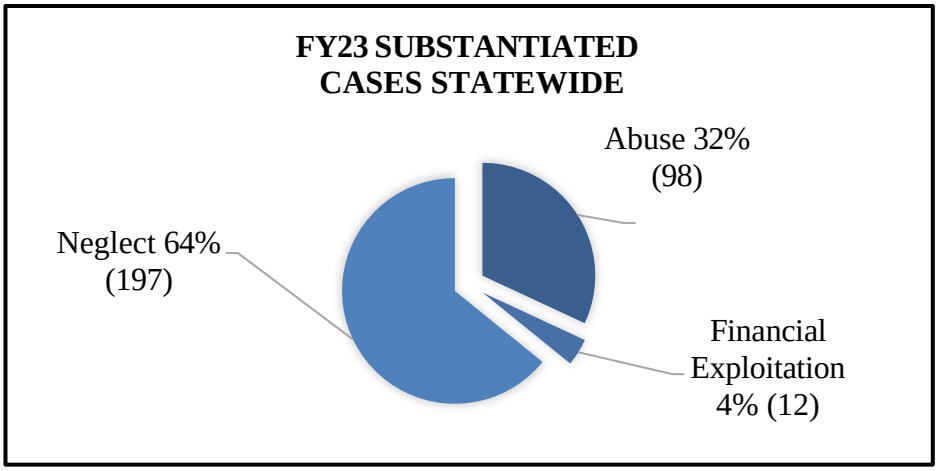
C. Findings

Pursuant to Illinois statute, OIG makes three types of findings in its investigative case reports:

Substantiated	• OIG determined that the preponderance of the evidence supports a finding of abuse or neglect.
Unsubstantiated	• OIG determined that there is credible evidence to support a finding of abuse or neglect, but not a preponderance of the evidence.
Unfounded	• OIG determined that no credible evidence exists to support the allegation of abuse or neglect.

OIG substantiated abuse or neglect in 307 of the 2,539 investigations it completed in FY23, including 197 substantiated neglect cases, 98 substantiated abuse cases, as well as 12 substantiated financial exploitation cases. Of the 307 cases where OIG substantiated abuse or neglect, OIG made a total of 378 findings (in some cases OIG will substantiate abuse or neglect against multiple employees or entities), which includes 338 total findings against accused employees and 40 findings against agencies or facilities.

The below tables reflect: (1) FY23 Substantiated Cases Statewide by Category; (2) FY23 Substantiated Finding Types by Accused Employee; (3) FY23 Substantiated Findings Against Agencies and Facilities; (4) Substantiation Rates for FY21 through FY23; (5) Substantiated Abuse and Neglect Cases by MH Location; and (6) Substantiated Abuse and Neglect Cases by Developmental Location.



FY23 Substantiated Finding Types Against Accused Employee						
	Physical Abuse	**Sexual Abuse**	**Mental Abuse**	**Financial Exploitation**	**Neglect**	**Egregious Neglect**
Agency Employees						
DD	40	5	36	7	156	6
MH	1	0	4	5	1	0
Total	**41**	**5**	**40**	**12**	**157**	**6**
Facility Employees						
DD	18	0	8	0	34	0
MH	2	2	3	0	10	0
Total	**20**	**2**	**11**	**0**	**44**	**0**
Total	**61**	**7**	**51**	**12**	**201**	**6**

FY23 Substantiated Findings Against Agencies and Facilities	
Agency Substantiated Findings[4]	
DD	
Neglect	34
MH	
Neglect	1
Total Agency Substantiated Findings	**35**
Facility Substantiated Findings	
DD	
Neglect	4
MH	
Neglect	1
Total Facility Substantiated Findings	**5**
Total Substantiated Findings Against Agencies and Facilities	**40**

FY21 through FY23 Substantiated Case Trends

OIG's overall substantiation rate went up slightly - in FY22 the substantiation rate was 11.51% and in FY23 it was 12.1%. OIG substantiated 6 fewer abuse, neglect, and financial exploitation cases at DD community agencies in FY23 but substantiated 13 more abuse, financial exploitation, and neglect cases at State-operated DD facilities.

[4] During FY23, there were no substantiated findings of financial exploitation against agencies or facilities. Although the data pull reflected one physical abuse against a DD agency, this was a data entry error. In fact, the case had a neglect finding against the agency and is so reflected in this chart.

Substantiation Rate – FY21 through FY23			
Location	**FY21**	**FY22**	**FY23**
MH State Facility	4.55%	3.41%	3.3%
DD State Facility	5.65%	7.05%	7.9%
MH Community Agency	8.78%	4.81%	12%
DD Community Agency	15.33%	15.79%	16.7%
Total	**11.55%**	**11.51%**	**12.1%**

FY23 Findings by Mental Health Location					
Location	**Abuse Substantiated**	**Financial Exploitation Substantiated**	**Neglect Substantiated**	**Not Substantiated[5]**	**Findings Total**
Mental Health Centers					
Alton MHC	1	0	3	70	74
Chester MHC	1	0	2	82	84
Chicago-Read MHC	1	0	0	67	68
Choate MHC	0	0	0	19	19
Elgin MH	0	0	0	146	146
Madden MHC	2	0	0	14	16
Packard MHC	1	0	3	44	48
Center Totals	**5**	**0**	**7**	**442**	**455**
Community Agencies					
Residential	0	0	1	15	16
Non-Residential	5	5	1	62	73
Agency Totals	**5**	**5**	**2**	**77**	**89**
Finding Totals	**11**	**5**	**9**	**519**	**544**

[5] OIG made recommendations in 104 of the 519 MH cases it did not substantiate.

FY23 Findings by Developmental Location					
Location	**Abuse Substantiated**	**Financial Exploitation Substantiated**	**Neglect Substantiated**	**Not Substantiated[6]**	**Findings Total**
Developmental Centers					
Choate DC	9	0	10	197	216
Fox DC	0	0	1	4	5
Kiley DC	3	0	7	127	137
Ludeman DC	1	0	3	27	31
Mabley DC	3	0	1	22	26
Murray DC	2	0	3	75	80
Shapiro DC	2	0	0	58	60
Center Totals	**20**	**0**	**25**	**510**	**555**
Community Agencies					
Residential	56	6	138	931	1,131
Non-Residential	11	1	14	113	139
Agency Totals	**67**	**7**	**152**	**1,044**	**1,270**
Finding Totals	**87**	**7**	**177**	**1,554**	**1,825**

FY23 Substantiated Death Cases

OIG closed 170 death cases (this includes 147 death reviews and 23 full death investigations) during FY23, a decrease from the 240 death cases OIG closed during FY22. Of the 170 closed death cases, OIG determined that there was no suspicion of abuse or neglect in 147 of the cases. With respect to the 23 death cases where OIG subsequently opened an abuse or neglect investigation, OIG substantiated 11 cases for neglect. As to the other 12 cases that OIG did not substantiate, OIG identified issues that required a written response from the agency or facility in 3 of those cases.

D. OIG's Efforts to Reduce the Number of IDHS Employees on Paid Administrative Leave

Over the last several fiscal years, one of OIG's priorities has been to reduce the number of facility employees that are on paid administrative leave as a result of OIG investigations.

As background, a 2001 memorandum of understanding between IDHS and AFSCME provides that employees who are the subject of a complaint alleging abuse or neglect will be placed on paid administrative leave if OIG's investigation of the allegation extends beyond 60 days. When a facility has a significant number of employees on paid administrative leave, it can create staffing challenges for the facility, resulting in increased overtime and extended shifts for other employees. Thus, whenever possible, OIG attempts to complete its investigations within 60 days to ensure optimal facility staffing and the most efficient use of the State's fiscal resources.

Notably, facility employees are also placed on paid administrative leave when they are the subject of criminal law enforcement investigations that extend beyond 60 days. As investigatory best practices dictate that OIG suspend its administration investigation until the criminal investigation and any

[6] OIG made recommendations in 947 of the 1,554 DDD cases it did not substantiate.

ensuing proceedings are completed, OIG has limited ability to reduce the number of facility employees who are on paid administrative leave due to ongoing criminal investigations, which can often take over a year to complete. Accordingly, with respect to the below metrics, the figure that is most reflective of OIG's performance in this area is the number of facility employees who are on paid administrative leave as a result of an OIG administrative investigation.

OIG has taken several actions in an effort to reduce the number of facility employees who are placed on paid administrative leave as a result of an OIG investigation, including, perhaps most notably, amending 405 ILCS 5/3-210 of the Mental Health and Developmental Disabilities Code to allow employees to return to work once OIG has determined that the allegation or allegations against the employee will be unsubstantiated or unfounded in OIG's final investigative report. Previously, employees could not return to work until *after* OIG had actually issued its final report, which could add weeks or months to the employee's return date if OIG's investigation was still ongoing with respect to other subjects.

As a result of this amendment, OIG has been able return employees to work more quickly, which helps with staffing levels at the facilities. More specifically, during FY23, OIG authorized the return to work of at least 45 facility employees using this legislative amendment. During this reporting period, OIG also formalized its 405 ILCS 5/3-210 processes, both for informing IDHS when employees can be returned to work, and to better track the number of employees OIG has authorized to return to work using this amendment.

The below table the reflects the number of employees on paid administrative leave due to ongoing OIG investigations from May 2019 through June 2023 (as explained above, that number does not include employees on paid administrative leave who are the subjects of ongoing criminal investigation or prosecution).

Facility Employees on Paid Administrative Leave Due to OIG Investigations[1]	
May 2019	108
July 2020	55
June 2021	39
August 2022	46
June 2023	53

Although the long-term trend remains positive, there was an increase in employees on paid administrative leave due to ongoing OIG investigations in FY23. OIG will continue to work diligently to reduce the number of facility employees on paid administrative leave due to OIG investigations.

[1] These numbers reflect the number of IDHS Division of Developmental Disabilities employees on paid administrative leave due to OIG Investigations.

E. Reconsiderations of OIG Findings

In FY23, OIG received and reviewed 71 requests for reconsideration of OIG's investigative findings or recommendations, in connection with 65 investigations (an investigation will sometimes result in multiple requests for reconsideration). As background, pursuant to Illinois statutory law, facilities, agencies, victims, guardians, or subject employees can request that OIG reconsider the findings or recommendations OIG made in its investigative report. Upon receipt, OIG conducts a multi-layer review of the request, which review includes at least one OIG employee who did not participate in the investigation or approval of the investigative report at issue. OIG reviews the information provided in the reconsideration request and all evidence gathered during the original investigation. The Inspector General ultimately makes the final determination as to whether the request should be:

- Denied;
- Denied, with the issuance of an amended report to correct errors or address issues that OIG identified during its review;
- Granted, with an amended report to follow with no additional investigation; or
- Granted to re-open for further investigation.

The reconsideration process ensures that OIG's investigations are complete, thorough, and accurate and therefore serves an important quality assurance function.

In FY23, OIG received 28 fewer reconsiderations than in FY22. Of the 71 reconsiderations OIG received in FY23, OIG denied 75% and granted 25%, as reflected in the below table. In comparison, of the 99 reconsiderations OIG received in FY22, OIG denied 78% and granted 22%.

FY23 Reconsideration Outcomes	Number of Cases	Outcomes in Percentages
Denied	48	68%
Denied, with the Issuance of an Amended Report	5	7%
Granted, with the Issuance of an Amended Report	9	13%
Granted, and Reopened Investigation	9	13%
Total Reconsiderations	**71**	

FY22 Reconsideration Outcomes	Number of Cases	Outcomes in Percentages
Denied	65	66%
Denied, with the Issuance of an Amended Report	12	12%
Granted, with the Issuance of an Amended Report	12	12%
Granted, and Reopened Investigation	10	10%
Total Reconsiderations	**99**	

F. Written Responses

When OIG substantiates an allegation, or if a recommendation is made in an investigative report, the facility or agency must respond to the substantiated finding and/or recommendation in writing, setting forth the action(s) that the facility or agency has taken or will take to: (1) protect the individual from future occurrences of abuse, neglect or financial exploitation; (2) prevent reoccurrences of the substantiated allegation(s) generally; and (3) eliminate any other problem(s) identified during the investigation.

The facility or agency has 30 calendar days from the date OIG sends the investigative report to submit a written response to the appropriate IDHS program division (DDD or DMH). *See* Department of Human Services Act, 20 ILCS1305/1-17(n). The program division then reviews and approves the written responses and sends the written response to OIG.

In FY23, OIG received 178 approved written responses from State-operated facilities and 442 from community agencies for a total of 620 written responses, regarding OIG's findings and recommendations.[7] With respect to the above-described written responses, facilities and agencies detailed the following actions related to OIG's findings and recommendations:

FY23 Actions Taken			
Personnel Action		**Administrative Actions**	
Discharged	203	**Individual Retraining**	207
Written Reprimand	54	**Group Training**	164
Resignation	51	**Policy/Procedural Change**	92
Suspension	28	**Reviewed**	54
Transferred	28	**Treatment Plan Change**	39
Counseling	19	**Administrative Change**	30
Retirement	7	**Structural Repair/Upgrade**	18
Oral Reprimand	6	**No Action**	11
		Supervision	2

G. Compliance Reviews

Once IDHS' DD and MH Divisions approve the facilities' and agencies' written responses to OIG's findings and recommendations, OIG conducts compliance reviews to ensure that the facilities and agencies took action as set forth in those responses. OIG selects a random sample of at least 10% of the written responses approved by the respective divisions during the prior month. If necessary, OIG can request additional documents/records or conduct telephone interviews to confirm that the facility or agency implemented or executed the detailed corrective action.

The table below reflects the percentage of compliance reviews OIG conducted in FY23 by location and program division:

[7] These numbers include approved written responses OIG received in FY23 regarding cases it completed in FY22.

FY23 Percentage of Approved Written Responses for which OIG Completed Compliance Reviews						
	DD Programs			MH Programs		
	Written Responses	Compliance Reviews	%	Written Responses	Compliance Reviews	%
DHS Facilities	123	20	16.3%	55	14	25.5%
Community Agencies	427	72	16.9%	15	4	26.7%
Totals	**550**	**92**	**16.7%**	**70**	**18**	**25.7%**

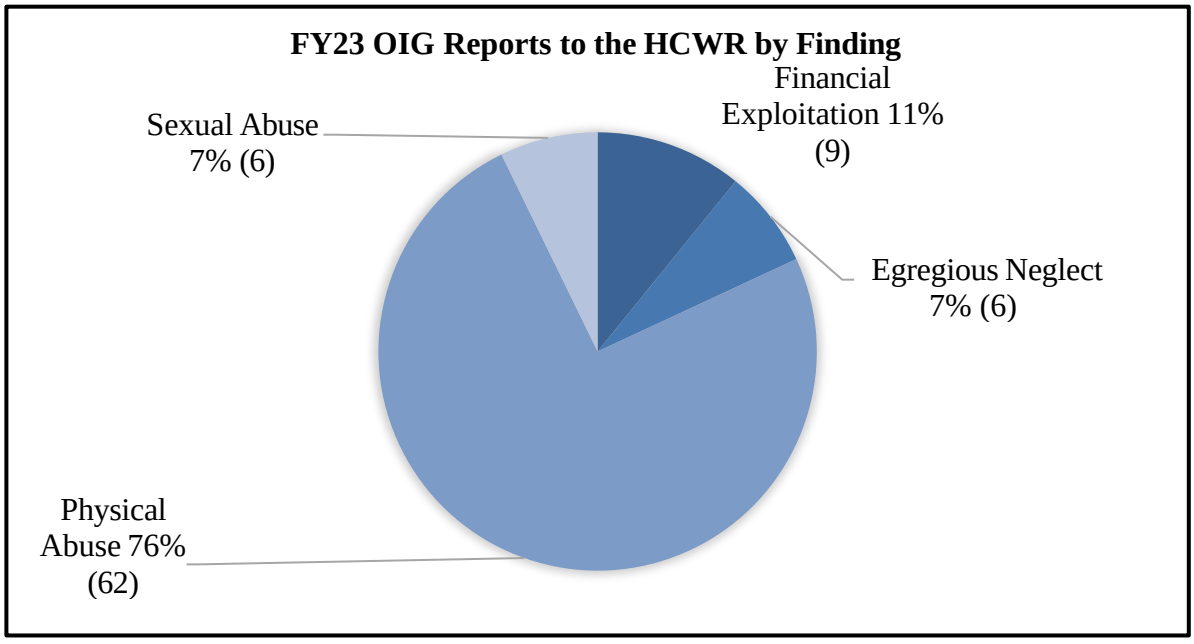
With respect to these compliance reviews, OIG did not issue any "Out of Compliance" letters in FY23.

H. Health Care Worker Registry

Following the completion of an OIG investigative report that contains a substantiated finding of physical abuse, sexual abuse, financial exploitation, or egregious neglect against an employee, OIG, pursuant to Illinois statute, makes an initial report to the Illinois Department of Public Health's Healthcare Worker Registry (HCWR) of the employee's name and the nature of OIG's finding. Pursuant to Illinois statute, health care employers are prohibited from employing an individual in any capacity "who is identified by the HCWR as having been subject of a substantiated finding of abuse or neglect of a service recipient." *See* 20 ILCS 1705/7.3. Following OIG's initial report to the HCWR, the employee can request an administrative hearing to determine if their conduct in fact warrants reporting to the Registry. *See* 20 ILCS 1305/1-17(s)(2) and 59 Ill. Admin. Code 50.90.

During FY23, OIG completed 86 substantiated cases which required initial reports to the HCWR of the employee's name and the nature of OIG's finding. During FY23, OIG also made final reports to the HCWR for 81 employees' names and 83 findings, meaning either the employee did not appeal the report or, after a hearing, it was determined that the conduct warranted the reporting.[8][9] Of the 81 employees, 75 of the reported employees were from DDD and 6 reported employees were from DMH. For FY23, OIG's reports to the HCWR placements by finding are reflected in the below chart:

[8] The 81 final reports OIG made to the HCWR encompassed cases that it substantiated during FY20 through FY22.
[9] One employee's name was reported for two separate cases and one employee's name was reported for both egregious neglect and physical abuse.



HCWR Administrative Appeal Hearings

If an employee requests an administrative appeal of OIG's HCWR referral, IDHS has to prove by a preponderance of the evidence that OIG's finding of abuse or neglect warrants the reporting of the employee to the HCWR. During FY23, 18 employees filed appeals challenging their names and findings being reported to the HCWR. Six of those appeals have been resolved. Five employees' names and findings were placed on the HCWR – two of the employees withdrew their HCWR petitions, and three petitions were dismissed for failure to appear. One petition was dismissed, and the person was placed back to work because of resolution prior to arbitration hearing. Twelve of those appeals remain pending at the end of FY23.

The IDHS Bureau of Hearings decided 35 appeals that were filed prior to FY23. The outcomes were as follows.

- Four employees' appeals were denied, and their names were reported to the HCWR;
- Three employees' appeals were granted at hearing, and they were not placed on the HCWR;
- 13 decisions were dismissals - 12 due to failure to appear for the hearing and one because it was filed outside the statutorily allowed time frame;
- Five petitioners withdrew their appeal; and
- Ten appeals were stipulated, and those employees were not reported to the HCWR. Four of those stipulations were because OIG and IDHS agreed that the circumstances surrounding OIG's findings did not warrant the reporting of the employee's name and finding to the HCWR. Six of the cases were stipulated to because the employees were facility employees who had had either filed and won grievances with the facility or had their matters resolved prior to arbitration. An employee's name cannot be reported to the HCWR if their grievance is upheld.

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HCWR Removal Hearings

An employee may petition IDHS to remove their name and OIG's substantiated finding from the HCWR. In that case, the burden is on the petitioner to prove by a preponderance of the evidence that removal of the petitioner's name and OIG finding from the HCWR is in the public interest. The hearing officer is to consider the following criteria when determining whether to remove the petitioner's name and substantiated finding from the HCWR:

- The nature of the abuse or neglect for which the petitioner was placed on the HCWR.
- Evidence that the petitioner is now rehabilitated, trained, or educated and able to perform duties in the public interest.
- Evidence of the petitioner's conduct since his/her name was placed on the HCWR.
- Evidence of the petitioner's candor and forthrightness in presenting information in support of the decision.

During FY23, nine employees requested hearings to have their names and findings removed from the HCWR. All nine cases remain pending at the end of FY23. 11 appeals that were filed prior to FY23 were resolved. Three petitioners withdrew their appeals prior to hearing, one petition was denied after a full hearing, and two were stipulated decisions after OIG conducted an investigation and determined that the petitioner had met all criteria for removal. Five of the 11 appeals were dismissed – four because the petitioner failed to appear and one due to lack of jurisdiction.

Arbitrations

Following the completion and issuance of a substantiated OIG investigative report, AFSCME employees working at IDHS facilities can request labor arbitrations, in which the employees may challenge adverse employment actions based on OIG's cases and findings. During FY23, OIG received the results of eleven labor arbitration requests. Six were resolved prior to arbitration so those six returned to work. Five were decided after a full arbitration hearing. Of the five that went to a full arbitration hearing, the facility prevailed in three cases, so the employee's names and finding were placed on the Health Care Worker Registry. Below are summaries of those three cases.

- Employee Grievance No. 562062 - An OIG investigation established that an STA pushed an individual several times. The arbitrator found that even though no injury occurred to the patient, the employee's repeated shoving of the individual was uncalled for and led to an escalation of events.
- Employee Grievance No. 564604 - An OIG investigation established that on January 2, 2020, a facility MHT slapped an individual on the left side of their face, resulting in redness on their face, and the MHT also told the individual to "shut the fuck up." The arbitrator found the employee's denial [that they slapped the individual] was "contrary to a massive amount of investigative evidence, some of it from eyewitnesses, it ignores physical evidence that unquestionably supports the fact that [the individual] was indeed slapped on the left side of her face…" The arbitrator found the employer had just cause to discharge the employee and the grievance was denied.
- Employee Grievance No. 561648 - An OIG investigation established that a facility STA physically abused an individual when they grabbed an individual by their throat, choked them, and threw them to the ground. Three other individuals present during the contact all

corroborated the individual's account. Although a nurse did not find markings on the individual's neck, the arbitrator found the individual's consistent testimony more credible than the grievant' s inconsistent denials. The arbitrator found the employer had just cause to discharge the employee and the grievance was denied.

Two employees were successful in their grievances, so they also returned to work.

Civil Service Hearings

Following the completion and issuance of a substantiated OIG investigative report, merit compensation employees working at IDHS facilities can request a Civil Service Hearing, in which the employees may challenge adverse employment actions based on OIG's cases and findings. During FY23, OIG received the results of one Civil Service Hearing. In that decision, the employee prevailed.

Stipulations

OIG instituted a process in FY22 whereby a stipulated disposition can be approved without requiring the accused employee to file an appeal. In ten cases, OIG determined that the circumstances surrounding the finding did not warrant reporting to the HCWR and that a stipulated decision not to report the employees' names was appropriate.

I. Site Visits

OIG conducts annual site visits to the 14 IDHS developmental and mental health centers for the purpose of making recommendations regarding systematic issues related to the prevention, reporting, and investigation of abuse and neglect. *See* Department of Human Services Act, 20 ILCS 1305/1-17(i).

In connection with these site visits, OIG identifies systemic issues and concerns and makes recommendations to the facilities with the aim of reducing instances of abuse and neglect. OIG uses the Principals and Standards for Offices of Inspector General promulgated by the Association of Inspectors General as guidance for its site visit methodology. OIG was able to complete the on-site portion of the site visit process at all 14 State-operated facilities for the second time since the COVID-19 pandemic began in 2020.

FY23 Scope

In addition to addressing recommendations from previous fiscal years, the scope of the FY23 site visits was to evaluate each facility's implementation of DHS' Sentinel Events policy and procedures, located in DHS Program Directive, "Sentinel Events/Root Cause Analysis" (02.03.06.030) for the Division of Developmental Disabilities and "Sentinel Events" (02.02.06.010) for the Division of Mental Health. OIG also reviewed and evaluated the quality of each facility's staff training pursuant to the Program Directives relating to Sentinel Events.

The site visit dates were as follows:

Alton Mental Health Center	November 2, 2022 – March 29, 2023
Chester Mental Health Center	November 16, 2022-March 14, 2023

Chicago Read Mental Health Center	September 14, 2022 – February 10, 2023
Choate Developmental Center	April 17, 2023 – June 27, 2023
Choate Mental Health Center	April 17, 2023 – June 16, 2023
Elgin Mental Health Center	September 21, 2022-January 20, 2023
Fox Developmental Center	March 7, 2023-May 17, 2023
Kiley Developmental Center	April 12, 2023-May 19, 2023
Ludeman Developmental Center	February 8, 2023 – May 8, 2023
Mabley Developmental Center	May 2, 2023 – June 15, 2023
Madden Mental Health Center	October 6, 2022 – February 17, 2023
Murray Developmental Center	February 21, 2023 – June 1, 2023
Packard Mental Health Center[10]	October 21, 2022 – January 25, 2023
Shapiro Developmental Center	March 6, 2023 – June 2, 2023

OIG began the site visit process by going to each facility and holding an entrance conference with the facility's administrative staff. OIG staff provided an explanation of the site visit plan, identified the staff to be interviewed, and requested any needed records. The OIG site visit team then reviewed the relevant documentation and interviewed appropriate personnel to discuss the topics of review.

Prior to the site visit Exit Conference, OIG provided each facility with a draft site visit report. The draft report contained initial observations and recommendations, and OIG invited the facility to discuss any outstanding questions at the Exit Conference. During the Exit Conference, which was conducted via WebEx, OIG then asked the facility to submit any response or comments in writing within one week of the conclusion of the Exit Conference and included that information in the final report. In several cases, the facility was able to produce additional information that was not available prior to that time, and OIG's reports incorporated that information as appropriate.

OIG provided each facility with a formal report within sixty working days of the Exit Conference. As OIG has done in past years, upon receipt of the final report, OIG asked each facility to submit to OIG a written plan/status update to address the report's recommendations within sixty days of the site visit's completion.

Summary of Recommendations

In FY23, OIG made 43 recommendations (15 for mental health facilities and 28 for developmental facilities). There were 10 follow up recommendations at DD Centers – 9 from FY22 and one from FY19, which could not be resolved (sepsis training). In addition to various documentation issues, OIG found the following:

- At four of the seven Mental Health Centers, OIG recommended that, pursuant to program directive and facility policy, the facility provide proof that it had a process for reviewing Sentinel Events, because they were unable to provide evidence that they had a policy in place.
- At four of the seven Mental Health Centers, OIG recommended that, pursuant to program directive and facility policy, the facility provide proof that Root Cause Analyses and supporting documentation were submitted to the Division of Mental Health within 45 days, because they were unable to provide evidence that they had submitted the documentation timely;
- At all seven Developmental Centers, OIG recommended that they work with the Division of Developmental Disabilities to create and implement a standard Root Cause Analysis form, because a form had not been developed;

[10] Formerly named McFarland Mental Health Center.

- At five of the seven Developmental Centers, OIG recommended that they work with the Division of Developmental Disabilities to create a standardized process for reporting Sentinel Events to the Division, because a standardized process was not in place;
- At four of the Developmental Centers, OIG recommended that the facility ensure that staff is familiar with the Sentinel Event Process, because key staff were not familiar with the process;
- At two of the Developmental Centers, OIG recommended that, pursuant to program directive and facility policy, the facility ensure that Sentinel Event and Root Cause Analysis documentation be kept in a locked and separate file cabinet marked "Confidential: Medical Studies Act," because the documentation was not stored properly;
- At four Developmental Centers and one Mental Health Center, OIG recommended that each facility provide proof that an Action Plan was created in response to findings in a Root Cause Analysis, because there were not able to produce a copy of the plan.

OIG also made four follow-up recommendations – three from FY22 and one from FY21.

Chapter 3: Additional FY23 Data

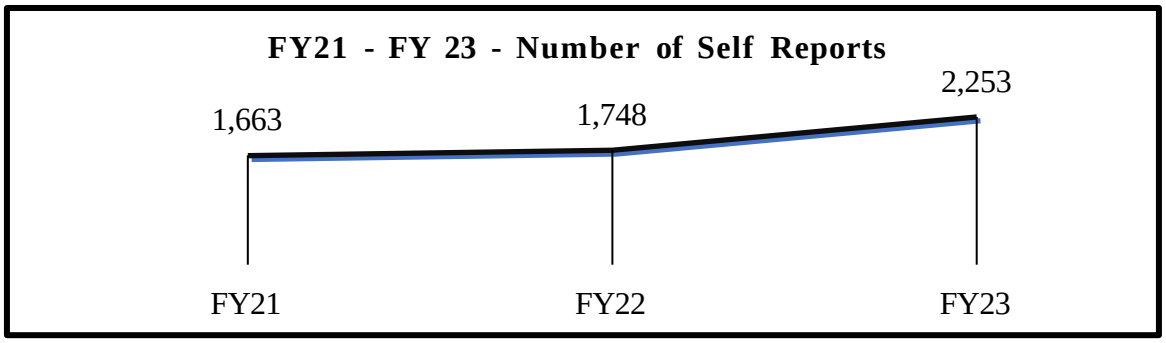
A. Reporting Allegations to OIG in a Timely Manner

Any employee of a State-operated facility or community agency that falls under OIG's jurisdiction is considered to be a required reporter and must report an abuse or neglect allegation to OIG's Hotline within four hours of their initial discovery of the allegation. OIG refers to these types of reports as "self-reports." Allegations reported by anyone who is not a required reporter are called "complaints." Facilities and agencies generally train their staff on the four-hour timeliness reporting requirement.

OIG's Intake Reports indicate if a self-reported allegation was not called into OIG in a timely manner (i.e., more than four hours after it was discovered). As part of the overall investigation, the assigned OIG investigator investigates whether and why the report was not made in a timely fashion. At the conclusion of the investigation, if OIG determines that the agency or facility did not timely report the allegation, OIG makes a recommendation to the agency/facility to address the late reporting and requires the agency or facility to state in writing what corrective action it will take.

Self-Reports

Each month, OIG sends the IDHS program divisions a report of the untimely "self-reports" OIG received in the previous month. The report identifies each late report, states the number of days each report was late, and provides the overall percentage of reports that were late. In FY23, OIG received 2,253 self-reported allegations of abuse and neglect, a 29% increase from FY22.



Late-Reporting

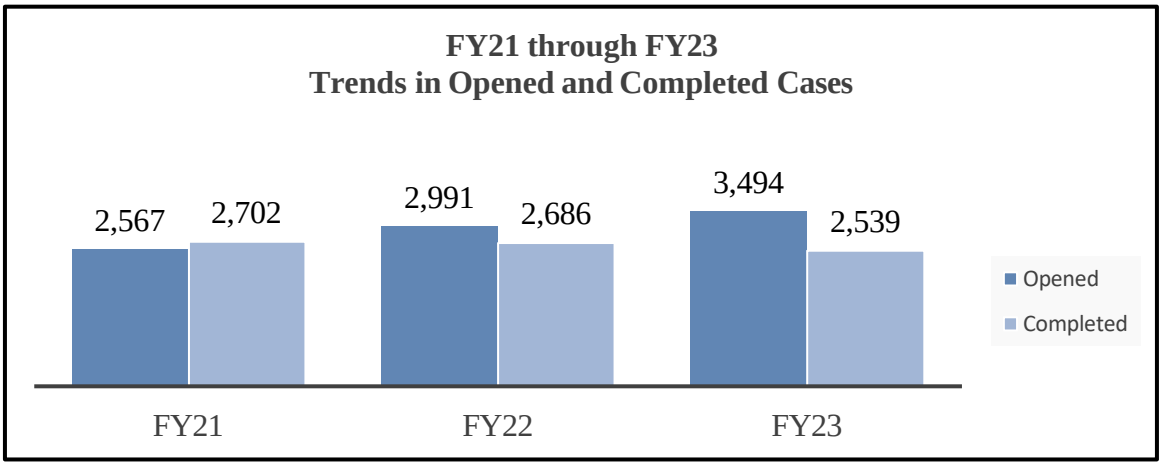
The percentage of late self-reports (i.e., reports of abuse or neglect from facility or community agency employees) increased slightly from 11.10% in FY22 to 12.90% in FY23. OIG continues to send the IDHS program divisions a report of the untimely "self-reports" OIG received in the previous month, which identifies each late report and states the number of days each report was late, and the overall percentage of reports that were late.

FY21-FY23 Late Reporting by Program and Disability Type						
Fiscal Year	**Late from Agencies**		**Late from Facilities**		**Total Late**	**Percent Late**
	DD	**MH**	**DD**	**MH**		
FY21	137	11	25	16	**189**	**11.37%**
FY22	137	16	25	16	**194**	**11.10%**
FY23	195	27	35	35	**292**	**12.90%**

B. OIG Caseloads

During FY23, OIG opened 3,494 cases, a 17% increase from FY22.[11] The below tables reflect the number of cases OIG opened and completed from FY21 through FY23.[12] [13]

[11] The Bureau caseload figures set forth below do not include open death reviews whereas the FY22 and FY23 opened and completed case figures do include completed death reviews.
[12] The June 30, 2023 Caseload figures are, in some cases, slightly different from those reported in OIG's FY22 Annual Report, likely due to database reclassifications or corrections that occurred during FY23.
[13] FY21 data was pulled using open and closed case data while FY22 and FY23 data was pulled using open and completed case data. The date a case is completed is more reflective of the timeliness of OIG's work and does not include the 30 days OIG waits to enter the final date in the OIG database.



FY22 and FY23 Investigator Caseload Comparison By Bureau		
	Caseload as of June 30, 2022	**Caseload as of June 30, 2023**
Central	172	200
Cook	275	448
Metro	458	689
North	235	558
South	250	357
OIG	**1390**	**2252**

C. Timeliness of OIG's Investigations

OIG's directives provide that investigators are to submit investigative case reports within 60 working days of their assignment. However, for a variety of reasons, it is not uncommon for OIG investigations to extend beyond 60 days. Most notably, some cases are complex and require interviews of numerous staff and individuals, the issuance of subpoenas, the review of hundreds of documents or, for cases where medical expertise is necessary, a clinical consultation. To complete these sorts of complex cases thoroughly and professionally within 60 days is not always possible.

In addition, investigative caseloads (cases per investigator), on average, remain higher than OIG would like. There is an inverse relationship between the number of cases an investigator has and the

timeliness of their completion of those investigations. In addition, as investigations become older, they become more difficult to complete as witnesses change jobs, video is no longer available, and records are more difficult to locate. Thus, for multiple reasons, as caseloads increase, it becomes increasingly difficult to complete investigations within 60 days. Accordingly, it remains a top priority for OIG to keep investigator caseloads at reasonable levels.

As the below table reflects, for the past three years, OIG's average time to complete an investigation has remained above 60 days.[14] During FY23, the average time it took to complete a case increased to 126.87 from 123.08 days in FY22.

Cases Completed Within and Over 60 Days FY21 through FY23		
Fiscal Year	**Cases Completed Within 60 Days**	**Cases Completed Over 60 Days**
FY21	50%	50%
	(1,367)	(1,372)
FY22	51%	49%
	(1,367)	(1,372)
FY23	39%	61%
	(1,001)	(1,538)

FY23 Cases Completed Within and Over 60 Days – Community Agency Cases vs. Facility Cases			
Timeliness of Community Agency Cases		**Timeliness of Facility Cases**	
Cases Completed within 60 Days	**Cases Completed Over 60 Days**	**Cases Completed within 60 Days**	**Cases Completed Over 60 Days**
32% (480)	68% (1,019)	50% (521)	50% (519)

[14] When the Illinois State Police (ISP) or local law enforcement (LLE) accept a case for criminal investigation, OIG, by agreement, suspends its administrative investigation until ISP/LLE has completed its investigation and the criminal process is complete. Accordingly, when calculating data regarding the timeliness of OIG's investigations, OIG excludes the time during which its investigations are suspended pending the completion of the criminal process. For this reason, OIG counts "average total days" and "average OIG days" separately.

FY21 through FY23 – Average Days for Case Completion		
Fiscal Year	**Average Total Days**	**Average OIG Days**
FY21	130.93	129.24
FY22	129.46	123.08
FY23	139.65	126.87

FY23 Average Days for Case Completion Community Agency Cases vs. Facility Cases			
Community Cases		**Facility Cases**	
Average Total Days	**Average OIG Days**	**Average Total Days**	**Average OIG Days**
162.66	152.91	106.49	88.35

FY23 Average Days for Case Completion by Case Type	
Mental Abuse (COVID)	38.00
Mental Abuse (Psych)	93.34
Mental Abuse - Verbal	98.68
Sexual Abuse	112.30
Physical Abuse	128.17
Death Report	154.33
Neglect	175.03
Financial Exploitation	179.23
Neglect - COVID	231.36
Death Report - COVID	289.83
Suicide	388.00

D. Facility Staffing Ratios

By law, OIG's annual report must include facility census figures which include counts of the number of individuals receiving services in each facility and the ratios of individuals to direct care staff. IDHS calculates those ratios as of June 30, 2023, or the last day of FY23.

Below are the census figures and staffing ratios for each type of facility at the close of FY23. The tables present census figures three ways:

- Counting every individual only once, regardless of the number of times he or she is admitted during the year, which gives an "unduplicated count." This count is presented in the first column.
- The second method is to count every day that individuals are in the facility or on temporary transfer to another location ("person-days" or "on-books bed-days"). This count is presented in the second column.
- The third column reflects the census taken on June 30, 2023, which details the number of individuals in the facility on that day.

IDHS also uses the June 30, 2023, census figure to calculate the direct care staff to patient ratios. The number of direct care staff is counted in Full-Time Equivalents, which counts part-time staff as only a fraction of a FTE. That count, again as of June 30, 2023, is reflected in the fourth column of the tables.

IDHS Budget divides the June 30, 2023 direct care staff figures by the June 30, 2023 census figures to calculate the direct care staff to patient ratios, which are reflected in the fifth column.

DHS State-Operated Facilities[15][16] Census and Staffing Ratios (as of June 30, 2023)					
Facility	**Unduplicated Count of Individuals Served**	**Person-Days (on books annual totals)**	**Inpatient Census on June 30**	**Direct Care Staff (Full-Time Equivalent)**	**Direct Care to Individual Ratio**
Alton MHC	210	39,882	113	141.00	1.25
Chester MHC	536	103,243	287	330.40	1.15
Chicago Read MHC	328	51,753	159	180.90	1.14
Choate MH & DC Total	368	99,667	266	382.70	1.44
Elgin MHC	856	141,339	400	410.10	1.03
Fox DC	79	26,861	70	98.00	1.40
Kiley DC	195	65,892	169	260.30	1.54
Ludeman DC	330	111,203	308	552.50	1.79
Mabley DC	121	42,959	115	141.00	1.23
Madden MHC	1,619	32,719	82	125.10	1.53
Murray DC	288	94,539	266	295.55	1.11
Packard MHC	278	41,908	126	161.75	1.28
Shapiro DC	494	168,285	458	786.20	1.72

[15] Since FY2016, Choate MH and DC provide combined staff totals for MH and DD.
[16] In FY2020 the COVID-19 virus was present beginning Mary 2020. Facilities admissions were halted/slowed from March to June of that year. The virus continued throughout FY22 and FY23 until May 2023, when the disaster proclamation was rescinded.

Total DD Facilities	**1,875**	**609,406**	**1,652**	**2,516.25**	**1.52**
Total MH Facilities	**3,827**	**410,844**	**1,167**	**1,349.25**	**1.16**
Total DD and MH Facilities	**5,702**	**1,020,250**	**2,819**	**3865.50**	**1.37**

E. Quality Care Board

The purpose of the Quality Care Board ("QCB" or the "Board"), which was authorized in 1992, is to "monitor and oversee [OIG's] operations, policies and procedures." *See* Department of Human Services Act, 20 ILCS 1305/1-17(u). The Board is empowered to provide consultation on OIG practices, review regulations, advise on training, and recommend policies to improve intergovernmental relations.

The law provides for the QCB to have seven members, each appointed by the Governor with consent of the State Senate. However, "[f]our members shall constitute a quorum allowing the Board to conduct its business." 20 ILCS 1305/1-17(u). The members must be qualified by professional knowledge or experience in law, investigatory techniques, or the care of people who have mental illness or developmental disabilities. At least two members must either have a disability themselves or have a child with a disability. The members are not paid, but OIG may reimburse them for any costs related to travel.

The QCB members for FY23 were:

Saul Morse, Chairman
Angela Hearts-Glass, Member
Megan Norlin, Member
Shirley Perez, Member
Jae Jin Pak, Member
Nancy Sage, Member

The QCB held six meetings in FY23, all by teleconference. The meeting dates were as follows:

August 16, 2022
October 19, 2022
December 20, 2022
February 21, 2023
April 18, 2023
June 20, 2023

Chapter 4: Areas of Advancement

During FY23 OIG made numerous modifications to its policies and procedures and proposed multiple statutory or regulatory changes, which include the following.

A. Choate Report

In the Spring of 2023, after receiving a September 2022 request from then-Secretary Grace B. Hou, OIG completed an interview-based review of Choate Mental Health and Developmental Center (CMHDC) following a series of criminal indictments of CMHDC staff for abuse of individuals at CMHDC and several OIG investigations that raised concerns about abuse and neglect reporting and prevention at CMHDC.

To conduct its review, OIG identified parties with direct knowledge of CMHDC, including current and former employees of CMHDC, outside monitoring agencies, Illinois State Police's Division of Internal Investigation, which conducts criminal investigations at CMHDC, individuals at CMHDC, and parents and guardians of individuals residing at CMHDC, and sought to learn what factors they believed were contributing to abuse and neglect at the facility and what changes could be made to better prevent and deter abuse and neglect at CMHDC. OIG also utilized its own investigative findings to inform its inquiry.

OIG ultimately interviewed 24 people and, based on those interviews and OIG's investigative findings, OIG made the following recommendations to IDHS:

- CMHDC (and IDHS) should explore all options for the installation of internal security cameras at the facility. Understanding that there may be consent restrictions that create barriers to internal camera installation in certain areas of CMHDC, see infra Section III(A), to the extent they have not done so already, IDHS and CMHDC should consider consulting with external entities (such as Equip for Equality or the Illinois Council on Developmental Disabilities) or entities in other jurisdictions, who may be able to provide guidance about how to navigate the regulatory framework and successfully install cameras at the facility, as there is a widespread consensus that such cameras would have at least some deterrence value with respect to acts of abuse and neglect and would assist OIG and law enforcement in their fact-finding endeavors;
- CMHDC should conduct a top to bottom analysis of all processes related to the reporting of abuse and neglect, including training, because at the present time there appear to be fundamental problems with all aspects of that system, including: (1) repeated instances of CMHDC staff deliberately covering up misconduct—sometimes in coordination with other staff—that they either engaged in or witnessed; (2) repeated instances of CMHDC staff failing to report misconduct, or seeking to report that misconduct anonymously, in fear of possible retaliation from their fellow employees; (3) individuals experiencing retaliation after making reports or being threatened with potential harm for making reports; and (4) a lack of accuracy and thoroughness regarding the allegations that are reported to OIG or documented through CMHDC's incident reporting system;
- Within the context and constraints of the hiring process and the general healthcare workforce shortage, CMHDC (and IDHS) should review the facility's staffing levels for front-line and supervisory staff to ensure that CMHDC's personnel is appropriate and commensurate with the needs of the individuals the facility serves and sufficient to create a culture of professionalism and accountability;

- CMHDC should take action to ensure that it is fully complying with IDHS program directives, which require a root-cause analysis to be conducted with respect to every "unexpected occurrence involving death or serious physical or psychological injury, or the risk of thereof"; and
- CMHDC should seek to make holistic improvements to individual care at the facility, which improvements would include the greater individualization of treatment and activity plans.

IDHS' response to the Choate Report is attached as Addendum III.

B. Obstruction of an Investigation as a HCWR-Reportable Finding

In the Fall of 2022, OIG submitted a legislative proposal seeking to amend 20 ILCS 1305/1-17(a), (m) and (s) to create a new Health Care Worker Registry (HCWR) reportable finding: Material Obstruction of an Investigation. Of great concern was that OIG regularly saw instances where facility or agency staff sought to protect each other from the consequences of their misconduct by remaining silent about what they witnessed or lying to protect their fellow employees. As a result of the legislative proposal, on June 9, 2023, Public Act 103-0076 was signed into law, which made Material Obstruction of an Investigation a HCWR-Reportable finding. Material Obstruction of An Investigation is defined as:

> "the purposeful interference with an investigation of physical abuse, sexual abuse, mental abuse, neglect, or financial exploitation and includes, but is not limited to, the withholding or altering of documentation or recorded evidence; influencing, threatening, or impeding witness testimony; presenting untruthful information during an interview; failing to cooperate with an investigation conducted by the Office of the Inspector General. If an employee, following a criminal investigation of physical abuse, sexual abuse, mental abuse, neglect, or financial exploitation, is convicted of an offense that is factually predicated on the employee presenting untruthful information during the course of the investigation, that offense constitutes obstruction of an investigation. Obstruction of an investigation does not include: an employee's lawful exercising of his or her constitutional right against self-incrimination, an employee invoking his or her lawful rights to union representation as provided by a collective bargaining agreement or the Illinois Public Labor Relations Act, or a union representative's lawful activities providing representation under a collective bargaining agreement or the Illinois Public Labor Relations Act. Obstruction of an investigation is considered material when it could significantly impair an investigator's ability to gather all relevant facts. An employee shall not be placed on the Health Care Worker Registry for presenting untruthful information during an interview conducted by the Office of the Inspector General, unless, prior to the interview, the employee was provided with any previous signed statements he or she made during the course of the investigation."

OIG believes the Material Obstruction of an Investigation finding will deter misconduct as employees will be aware that obstructing an OIG investigation could result in them not being able to work for any Health Care Employer in the state, as provided by the Healthcare Worker Background Check Act, 25 ILCS 46/15. As a result of this amendment, OIG is better positioned to ensure that perpetrators are not able to continue abusing some of the State's most vulnerable individuals.

C. Rule 50 Amendments

During FY23, OIG submitted for consideration proposed amendments to Rule 50, which details the responsibilities of OIG for accepting, investigating, and reporting on allegations of abuse, neglect, and financial exploitation, as well as reporting certain persons to the Registry. On April 4, 2023, the amendments were adopted. The changes include the following:

- Codifying the recent amendment to 405 ILCS 5/3-210, which allows an accused employee to return to work once OIG determines the allegation against them will be unsubstantiated or unfounded in OIG's final investigative report, even if the investigative report is not finalized. The amendment allows for improved staffing at State-Operated facilities.
- Codifying the recent amendment to 20 ILCS 1305/1-17, which provides that an accused employee's name will not be placed on the Registry if OIG requests a stipulated disposition of an investigative report, and the Secretary of the Department of Human Services agrees. Prior to the amendment, a stipulated disposition was not possible unless the employee filed an appeal, which sometimes led to unfair outcomes.
- Each community agency will be required to designate an employee as an OIG Liaison.
- Intake may refer an allegation to a community agency or facility when the primary facts relating to the allegation have been identified, the situation is not emergent and there is no indication the individual is in imminent danger, the agency or facility is better positioned to address the allegation, and the allegation would not result in reporting to the Registry. This amendment codified the Intake Pilot Project OIG implemented during FY21.

D. 2023 Proposed Legislation

1. Budget Floor

In the Fall of 2022 and the Summer of 2023, OIG submitted a legislative proposal seeking to amend 20 ILCS 1305/1-17(d) to create an OIG Budget Floor. This amendment would help ensure that OIG has the independence and resources necessary to prevent and deter the abuse and neglect of the vulnerable communities that OIG serves.

More specifically, the proposed language states.

> Except with the consent of the Inspector General, the Office of the Inspector General's budget shall not be reduced by more than 10 percent (i) within any fiscal year or (ii) over the four-year term of any inspector general. To the extent allowed by law and the Department's policies, the Inspector General shall have sole responsibility for organizing the Office of the Inspector General within its established budget.

A budgetary floor accords with nationally recognized best practices for OIGs and would further ensure that OIG has sufficient resources to fully and effectively perform its watchdog functions for the foreseeable future. *See infra* Chapter 7B. for additional background on the importance of a budget floor for OIGs.

2. OIG Reviews of Facilities and Agencies

In the fall of 2023, OIG submitted a legislative proposal seeking to amend 20 ILCS 1305/1-17 to give OIG authority to initiate reviews of facilities and agencies related to preventing, reporting, and investigating abuse, neglect, financial exploitation, and material obstruction of OIG investigations, in response to complaints or information gathered from investigations. The Inspector General would issue a written report, similar to the Choate Report it produced in FY23, setting forth its conclusion and recommendations, and the report would be distributed to the Secretary and the director of the facility or agency that was subject of the review. The facility or agency would then be required to submit a written response addressing the Inspector General's conclusions and recommendations and, in a concise and reasoned manner, the actions taken to: (i) protect the individual; (ii) prevent recurrences; and (iii) eliminate the problems identified. This amendment would help OIG take a system-focused, proactive approach toward preventing abuse and neglect of individuals.

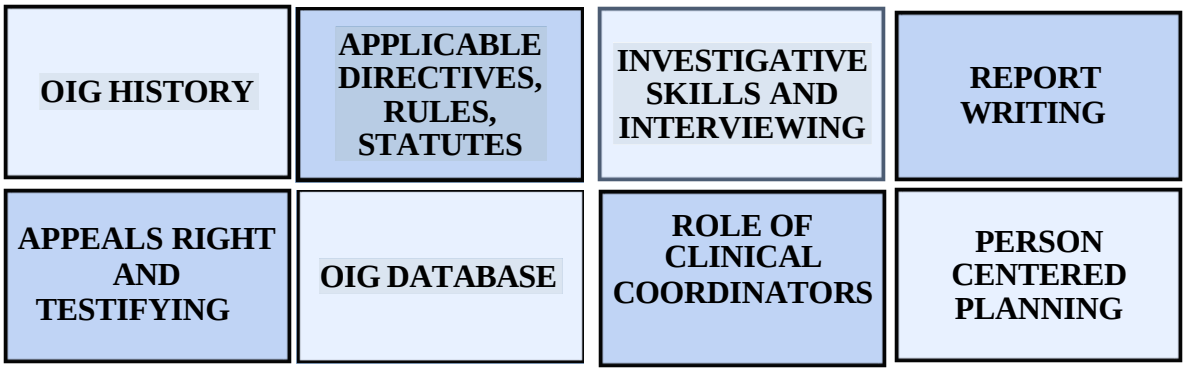
Chapter 5: Training and Certification Updates

A. Staff Training

The State of Illinois, IDHS, and OIG require OIG staff to take certain training courses. The State of Illinois and IDHS have several annual mandatory trainings that cover topics like HIPAA and Ethics. OIG's investigative staff are also to receive ongoing training in Title 59, Chapter I, Parts 50, 115, 116 and 119 of the Illinois Administrative Code, concerning, respectively, OIG's investigations in State-operated facility and community agencies, standards and licensure requirements for community integrated living arrangements (CILAs), administration of medication in community settings, and minimum standards for certification of developmental training programs, all of which areas are directly related to OIG's work and mission. OIG's directives also require that staff take a minimum of three training courses in investigative skills, computer skills and personal/professional growth.

In FY23, OIG staff completed all necessary courses to meet these requirements, OIG used IDHS' OneNet system to initiate, implement and document OIG staff trainings. In FY23, OIG also started the process to convert new employee staff training from the OIG database to the DHS OneNet Training system, which should be completed by the end of FY24.

OIG notes that OIG's classroom training for new hires includes instruction in the following areas:



More senior and experienced ISIs, under close supervision of their Bureau Chief and Investigative Team Leader, also participate in mentoring newly hired ISIs.

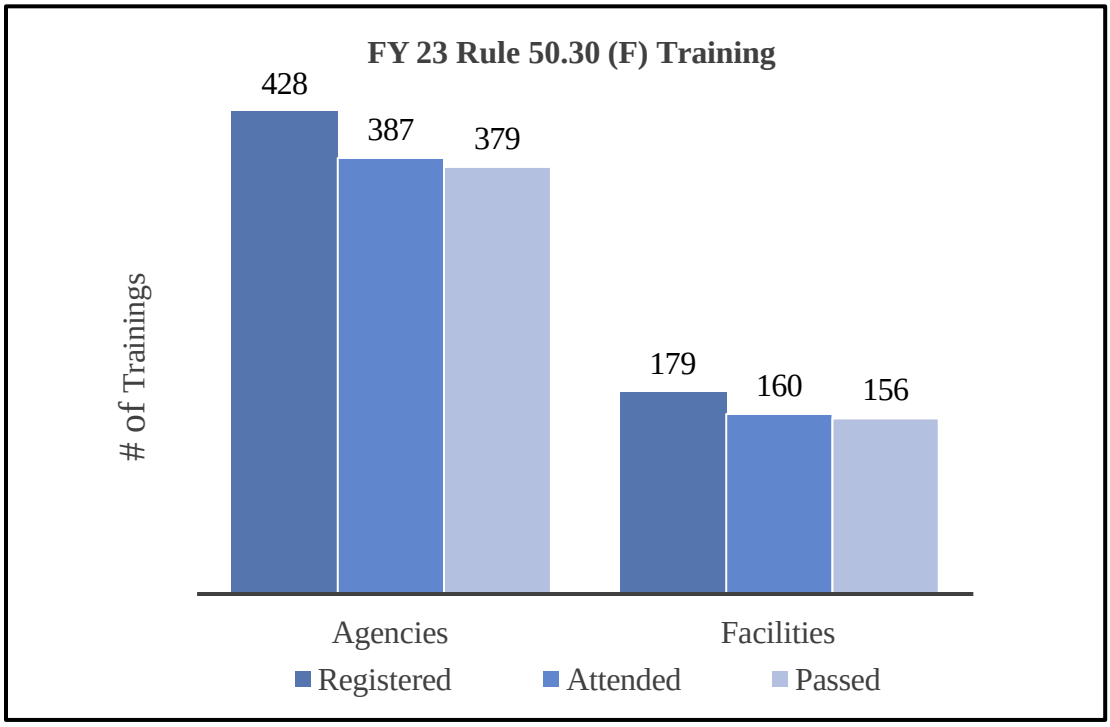
OIG conducts weekly evaluations and assessments to ensure the new probationary ISIs obtain all necessary investigative skills. During FY23, 14 staff were hired, which included one Bureau Chief, two Investigative Team Leaders, nine Investigators, and two administrative staff. Of the 14 staff hired, nine were certified, one left for a promotion, and three returned to their prior positions.

B. Training for Agencies and Facilities

50.30(f) Initial Incident Response

Section 50.30(f) of Rule 50 requires agencies and facilities to take initial steps to respond to an allegation of abuse or neglect. These steps include 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.

OIG provides online training to help agencies and facilities carry out this important function. In FY23, 607 agency and facility staff registered for OIG's online 50.30(f) training, 547 attended the training and of those, 535 passed. To pass the training, the staff have to score 70% or better on a test. Roughly 98% of agency staff and 98% of facility staff who took the training passed the test. The numbers of agency and facility staff that registered, attended, and passed the training are reflected in the table below.



OIG Investigative Steps

OIG also provides an online "Investigative Steps" training for employees at IDHS' Developmental and Mental Health Centers that provides instruction on interviewing and document/evidence collection. For a Facility employee to become a Facility Investigator (which allows them to play a more significant role in the initial response to an allegation, including conducting interviews instead of gathering statements), they must take the Investigative Steps training. During FY23, 47 facility staff registered for the training, 36 facility staff attended, and 100% who attended passed the test.

Special Trainings

OIG conducted an in-person training at Ludeman Developmental Center on September 29, 2022, covering Rule 50.30(f) and Investigative Steps. DDD requested these trainings to improve the abuse and neglect reporting and investigative processes at Ludeman.

Rule 50 Training

During the fourth quarter of FY23, OIG began collecting the number of persons who were recorded as having been Rule 50 trained at their facility or agency. The purpose was to ensure staff who were registering for 50.30(f) or Investigative Steps had the required Rule 50 training prior to taking the other classes. 416 distinct persons were recorded as having been Rule 50 trained at their facility or agency.

Chapter 6: Notable OIG Investigations

OIG's work often results in significant criminal or administrative consequences for employees who engage in abuse, neglect, or financial exploitation. Below are deidentified, narrative summaries of a small sample of the 307 cases OIG substantiated in FY23.[17]

9522-0042 - OIG substantiated a finding of neglect where its investigation established that two facility supervisors failed to ensure an individual received medically prescribed, 24-hour one-to-one supervision when the facility was short staffed. The individual was found unresponsive and died the next day. Although there was insufficient evidence to establish that the individual would have survived had he received 1:1 supervision, the individual would have received more timely medical attention and likely would have had a better chance of surviving. In response to the investigation, the facility indicated both employees were discharged.

1122-0206 - OIG substantiated a finding of neglect where its investigation established that a CILA employee intentionally placed an incense stick into a gap of a padded wall in an individual's bedroom, because the individual was gaseous. This caused a small fire requiring the apartment to be evacuated. Also, the individual required 2:1 direct support at all times; however, at the time of the incident, 1:1 supervision was in place. OIG recommended that the agency ensure the individual received appropriate supervision as required by the individual's Behavior Support Plan. The agency's response

[17] Several of the summaries do not address what the agency or facility did in response to a finding or recommendation. This is due to OIG not receiving the written responses at the time of completion of this report.

to the investigation was that the CILA employee was terminated, and the individual was discharged from the agency.

1123-0241 – OIG substantiated a finding of neglect where its investigation established that a CILA employee fed multiple individuals' dinners late (at 10:00 p.m.) while they were unsupervised in their bedrooms. One of the individuals required monitoring while eating for safety. The employee also failed to change their Depends in a timely manner and left them wet/soiled until the end of the employee's shift. OIG recommended that the agency address another employee's failure to report similar incidents that occurred approximately two months earlier than the allegation at issue in the case. The agency's response to the investigation was that the first employee was terminated due to an issue unrelated to this case, and the second employee was retrained on Rule 50, with an emphasis on reporting requirements and responsibilities.

2920-0098 – OIG substantiated a finding of physical abuse and mental abuse where its investigation established that a facility employee struck an individual in the face, bloodying his lip, and then forced the individual to stand with his hands above his head for an extended period as a form of punishment. The employee, who was subsequently criminally investigated, pleaded guilty to battery in connection with the incident and was sentenced to 12 months of court supervision. The facility's response to the investigation was that the employee resigned with no reinstatement rights. OIG subsequently reported the employee's name and OIG's finding to the HCWR, rendering the employee ineligible to be employed by an Illinois health care employer.

OIG also substantiated neglect against the facility for a systemic failure on the part of staff to report the abuse they witnessed. OIG determined that the facility was ultimately responsible for the lack of timely reporting, as the facility failed to create an environment where employees believed they could report abuse without experiencing significant negative consequences. OIG recommended that the facility (1) review its training programs with respect to the reporting of misconduct to ensure that incoming facility staff understand the importance of reporting misconduct, and, more importantly, understand that reporting misconduct will not cause them to lose employment; and (2) review its policies and procedures related to retaliation to ensure that new staff do not immediately become fearful of reporting misconduct because of implicit or explicit threats of retribution from current facility staff. The facility's response was that current employees were trained on OIG Rule 50 and the code of silence, and these trainings would be ongoing for new employees.

2915-0057 - OIG substantiated a finding of physical abuse where its investigation established that a facility employee punched an individual multiple times in the face and placed the individual in a choke hold, which caused abrasions to the individual's face, neck, and chest, and a laceration to the individual's upper lip, among other injuries. The employee was charged with aggravated battery and ultimately pleaded guilty to obstructing justice, a felony. The facility's response to the investigation was that the employee resigned. After OIG completed its investigation, OIG subsequently reported the employee's name and OIG's finding to the HCWR, rendering the employee ineligible to be employed by an Illinois health care employer.

OIG further substantiated a finding of neglect against five other employees who were present during the altercation but failed to intervene and failed to subsequently report the cause and full extent of the injuries, even though, as one employee stated, it looked like the individual had "gone three rounds with Mike Tyson." Three of these employees pleaded guilty to failure to comply with reporting

requirements, a misdemeanor. The facility's response to the investigation was that four of these employees were discharged and one retired.

OIG also substantiated a finding of neglect against the facility as staff systemically failed to comply with facility policies and DHS Directives. In addition, the evidence suggested that the facility had not taken sufficient steps to combat the "code of silence"—wherein employees witnessed misconduct by another employee but concealed what they saw. OIG recommended that the facility take action to ensure that security cameras were installed at the facility in an effort to combat the culture of deception that appeared to have taken hold among at least eight facility staff. The facility's response was that cameras were ordered.

2918-0064 – OIG substantiated a finding of physical abuse where its investigation established that a facility employee caused an individual to drink a cup of hot sauce. The individual, who was not aware of the contents of the cup, choked and had difficulty breathing after drinking the hot sauce. Following the Illinois State Police's criminal investigation of the incident, the employee was indicted and ultimately pleaded guilty to one count of obstructing justice. The employee was sentenced to 24 months of probation and further agreed to refrain from having employment in any DHS facility, nursing home, or home for those with a disability or a mental illness. The facility's response to this portion of the investigation was that employee was terminated non-certified. After OIG completed its investigation, OIG subsequently reported the employee's name and OIG's finding to the HCWR, rendering the employee ineligible to be employed by an Illinois health care employer.

OIG recommended that the facility take action to ensure that staff understood the confidential nature of investigatory information and that the facility ensure any sort of retaliatory threat or behavior was met with consequences. The facility's response was that the employee who shared confidential information was voluntarily transferred to another agency prior to the release of the investigative report, and all staff were retrained on the reporting abuse directive.

2918-0065 - OIG substantiated findings of physical abuse where its investigation established that two facility employees caused an individual to suffer a fractured shoulder. The employees initially denied any involvement with the injury, but the subsequent criminal investigation uncovered evidence that the employees conspired to cover-up their involvement with the individual's injury. Accordingly, the employees were both charged with obstructing justice in connection with this incident. One employee ultimately pleaded guilty to one count of obstructing justice, a felony, was sentenced to 24 months of probation, and further agreed to refrain from having employment in any DHS facility, nursing home, or home for those with a disability or a mental illness. The facility's response to the investigation that one employee was terminated non-certified, and the other employee was discharged. After OIG completed its investigation, OIG subsequently reported both employees' names and OIG's findings to the HCWR, rendering the employees' ineligible to be employed by an Illinois health care employer.

OIG also recommended the facility take steps to counteract the cover-up culture that appeared to have taken hold amongst at least certain of its staff, wherein staff conspired to conceal misconduct instead of reporting it, and explore all legal options for installing cameras within the facility. The facility's response was that it would review its injury reporting policy and procedures and to make changes as necessary, to retrain all staff on reporting and abuse and anti-harassment, and indicated cameras were ordered.

2922-0098 - OIG substantiated a finding of neglect against a facility where its investigation established that the facility failed to provide adequate medical care for four individuals as it was ongoing nursing practice to require the individuals to collect and search their own feces for previously ingested foreign objects. This practice resulted in the individuals suffering emotional distress, placed their health and safety at risk, and violated facility policy and procedure. The facility's response to the investigation was that staff would be retrained on dignity and respect of individuals and the pica monitoring plan.

6621-0099 - OIG substantiated a finding of neglect where its investigation established that two facility employees failed to complete required 15-minute individual observation checks during their nighttime shift, which was from 11 p.m. to 7 a.m. Those checks were intended to ensure the safety of an individual and other individuals on the unit. At some point during that nighttime shift, the individual hung themself in their room, and the individual was not found until after 8 a.m. Although OIG could not establish that the employees' completion of these required routine checks would have prevented the individual's death, OIG determined that their failure to follow established protocols placed the individual's health and safety at substantial risk. OIG recommended the facility address the falsification of observation sheets by the two employees, address a nurse's statement that they were not trained to physically make rounds every two hours, and address staff's documentation that showed a check was completed by one person when it was actually completed by a different person. The facility's response to the investigation was that pre-disciplinary hearings were held with three staff; the observation check sheets were revised by the facility and training occurred; audits of the observation sheets will be conducted on every shift for 6 months; and an onboarding training checklist was developed for all contractual nurses**.**

6622-0075 - OIG substantiated a finding of sexual abuse where its investigation established that a facility employee showed an individual sexually explicit pictures of the employee which the employee kept on their cell phone. The employee also gave the individual their personal cell phone number so they could contact the employee, which the individual did on multiple occasions. Further, the employee allowed the individual to braid their hair while in the individual's bedroom, and the employee pinched the individual's buttocks. After OIG completed its investigation, the employee filed an arbitration, and a resolution was reached that the employee would resign. The employee did not request a HCWR hearing so their name and the finding was reported to the HCWR. OIG further recommended that the facility address the actions of another employee who obstructed OIG's investigation by inappropriately providing the employee with information related to the allegations. That employee was suspended and returned to work.

1320-0169 - OIG substantiated a finding of sexual abuse and mental abuse where its investigation established that a CILA employee gave an individual a full back massage on multiple occasions, asked the individual for sex, and discussed sex with the individual. The individual consistently stated that they were fearful of the employee. Following a criminal investigation, the employee was indicted and ultimately pleaded guilty to one count of abuse of a long-term care facility resident, a felony, and was sentenced to 15 days in jail and placed on probation for 30 months. The agency's response to the investigation was that the employee was immediately placed on suspension and did not return to the agency. After OIG completed its investigation, OIG subsequently reported the employee's name and OIG's finding to the HCWR, rendering the employee ineligible to be employed by an Illinois health care employer.

1321-0031 - OIG substantiated a finding of physical abuse and mental abuse where its investigation established that a CILA employee grabbed an individual's face and stated, "I'm not going to deal with your shit, and you are going to shower." After the individual responded by engaging in maladaptive behavior, the employee put the individual in a headlock. OIG's investigation further established that the employee took a television remote away from the individual without reason, then prevented the individual from going to their room. When the individual responded to these actions by engaging in maladaptive behaviors, the employee pulled the individual from their wheelchair, dragged the individual across the floor, and laid on top of them, which caused bruising to the individual's forearm. The employee was criminally investigated for his actions and pleaded guilty to aggravated battery, a felony. The agency's response to this portion of the investigation was that the employee was suspended due to the incident and never returned to the agency. After OIG completed its investigation, OIG subsequently reported the employee's name and OIG's finding to the HCWR, rendering the employee ineligible to be employed by an Illinois health care employer. OIG recommended the agency train staff who worked with the individual on the use of CPI physical holds. The agency's response was that all staff who worked with an individual who may require holds would be trained in CPI.

1321-0266 - OIG substantiated a finding of neglect against an agency where its investigation established that there was a systematic failure to provide adequate care to two individuals. The two individuals were removed from the agency by the IDHS under imminent risk and admitted to a facility. Upon admission to the facility, both individuals were in poor physical condition as a result of the agency's failures. One individual appeared emaciated, had very thin arms and torso, and their ribs were discernable. Records showed that the individual lost 7-pounds from April to May 2021 under the agency's care. The individual also had a significant bruise in their left/mid chest area in a late stage of healing. Moreover, when the other individual was admitted, he weighed well below their average ideal body weight, and their lab results indicated kidney failure, most likely due to severe dehydration. This individual also had numerous wounds and pressure ulcers that were in various stages of healing and were noted to have purulent drainage and a foul odor. The agency's response to the investigation was that they denied the allegation of neglect, but acknowledged the agency was no longer in operation.

1221-0330 - OIG substantiated a finding of physical abuse where its investigation established that an agency employee straddled an individual on a bed, held the individual down on the bed, restricted the individual with a blanket, pushed various parts of the individual's body, and threw a blanket onto the individual's head/face. The employee pled guilty to one count of battery and was sentenced to 160 days in jail. OIG recommended that the agency ensure staff were trained on service documentation of the individuals they served and that the records were appropriately retained. After OIG completed its investigation, OIG subsequently reported the employee's name and OIG's finding to the HCWR, rendering the employee ineligible to be employed by an Illinois health care employer.

1923-0043- OIG substantiated a finding of neglect where its investigation established that a facility employee maintained an inappropriate relationship with an individual, which started on the date of the individual's discharge from the facility and continued while the individual lived at an agency. The inappropriate relationship caused the individual emotional distress after the inappropriate relationship ended. The facility's response to the investigation was that the employee was discharged.

1220-0182 - OIG substantiated a finding of neglect where its investigation established that over a period of approximately two years, an employee stole a total of $14,948.91 from twenty-two individuals. The employee pleaded guilty to ten counts of Financial Exploitation of a Disabled Person. The employee was sentenced to probation for 30 months and was ordered to pay the balance of

$15,624.11. The agency's response to the investigation was that policies and procedures were added so clients' transactions would be approved by the Program Director or Executive Director and funds would be tracked and logged and reviewed monthly to show revenues and expenses.

1622-0378 and **1622-0384** - OIG substantiated a finding of financial exploitation where its investigation established that an agency employee used two individuals' debit cards to make unauthorized purchases for the employee in an amount which exceeded $1500. After OIG completed its investigation, OIG subsequently reported the employee's name and OIG's finding to the HCWR, rendering the employee ineligible to be employed by an Illinois health care employer.

OIG recommended that the agency review its system for tracking individuals' debit card purchases to ensure appropriate controls were in place to identify unauthorized transactions in a timely manner. The agency's response to the investigation was that it updated internal controls for handling individuals' debit cards and that it would update the agency's custodial accounts policy to be consistent with the changes.

1620-0426 – OIG substantiated a finding of neglect where its investigation established that an agency employee transported 5 individuals in an agency van for an outing and used the van to commit a criminal act. The employee drove by their residence and witnessed a romantic interest and another person engaged in conversation with another person sitting in a car. The employee drove the van into the vehicle and the other two persons. As a result of the collision, one individual in the van suffered a cut to one of his arms from broken glass. The employee was arrested and charged with First Degree Attempted Murder and Aggravated Battery/Use Deadly Weapon. The employee was terminated for reasons related to the allegation.

5423-0016 – OIG substantiated a finding of physical abuse where its investigation established that a facility employee took a fighting stance and made a fist with their right hand during a verbal confrontation with an individual. The employee then reached out and pushed the individual's right shoulder. The facility's response to the investigation was that the employee retired. OIG has begun the process to report the name and the finding to the HCWR—which would render the employee ineligible to be employed by an Illinois health care employer.

1620-0448 – OIG substantiated a finding of neglect where its investigation established that a CILA employee served an individual a hotdog, but failed to cut the hotdog into small pieces and failed to monitor the individual while they ate. The individual required supervision during meals as the individual was at risk for choking based on their history of stuffing their mouth and eating too fast during meals. After the individual choked on a piece of the hotdog, the individual was transported to the hospital via ambulance and died three days later.

1620-0462 – OIG substantiated a finding of neglect where its investigation established that a CILA employee failed to supervise an individual who left an individual outside on the back porch in the direct sun, when the temperature was approximately 90-degrees Fahrenheit, for at least one hour. The individual was treated for heat stroke, dehydration, syncope, hypotension, and multiple 1st degree burns. The agency's response to the investigation was that the employee no longer works for the agency for a reason unrelated to this investigation.

3922-0004 – OIG substantiated a finding of sexual abuse where its investigation established that a facility employee attempted to have sex with an individual three or four times in the facility laundry room, and, when off duty, the facility employee had numerous conversations with the individual and

sent sexually explicit pictures to the individual's cell phone, which they had on the unit. The facility's response to the investigation was that the employee was discharged. After OIG completed its investigation, OIG subsequently reported the employee's name and OIG's finding to the HCWR, rendering the employee ineligible to be employed by an Illinois health care employer.

4521-0026 - OIG substantiated a finding of physical abuse where its investigation established that a facility employee struck an individual in the head while the individual was having a behavior, and the individual had a bloody nose after the incident. The facility's response to the investigation was that the employee separated from the facility. After OIG completed its investigation, the employee filed an appeal regarding OIG's potential reporting of their name and the finding to the HCWR—which would render the employee ineligible to be employed by an Illinois health care employer—and that appeal is pending.

Chapter 7: Closing Remarks

A. IDHS OIG Chief Administrative Officer Jesse Escarpita

FY23 was an important year for me at the State of Illinois, because it marked my first full year as Chief Administrative Officer (CAO) for IDHS OIG. As background, I was hired as CAO in February 2022, and I am the first to hold the CAO position full-time. With the support of the OIG and IDHS communities, I was able to fully immerse myself in the administrative processes and operations of OIG and to understand how those processes interacted with IDHS and State of Illinois procedures. In FY23, I was able to begin addressing some of the administrative challenges of OIG that I identified in the FY22 annual report, and I identified additional challenges to address in FY24. Overall, FY23 included some positives, negatives, and reasons for optimism for the future of OIG administrative operations.

In FY23, OIG was able to identify funds that were not being used optimally from its personnel fund that resulted from vacant OIG positions. With these funds, OIG immediately began to replace aging and malfunctioning computer equipment for OIG staff. We were also able to send all six of OIG's investigative bureau chiefs to a week-long training to become Association of Inspectors General (AIG) Certified Inspector General Investigators[18] in an effort to provide our investigative leadership with high-quality certification and training.

In FY23, OIG also obtained a much-needed increase of funds for OIG's budget for FY24 operating needs and maintenance costs due to cost increases from inflation and costs related to onboarding new staff. In addition, the budget approval included additional funds for OIG to extend its database project. Finally, OIG successfully completed its FY23 site visits on sentinel events. During the site visits, OIG found that multiple DD and MH facilities were failing to properly identify or rectify sentinel events as required by their division's program directive.

While OIG did make progress in terms of our budget and equipment, OIG continued to be affected by the slow pace of hiring in FY23. Most notably, OIG lost both of its Administrative Assistant IIs, who had important responsibilities such as timekeeping, HR duties, and procurement. As a result of the slow pace of hiring, OIG had to shift these responsibilities to other staff, which caused much strain to

[18] The AIG provides certified programs where participants receive instruction from highly qualified instructors in core competency areas. See the AIG website as of December 5, 2023, The Association of Inspectors General – Advancing Professionalism, Accountability & Integrity

OIG operations. Although both positions were filled in early FY24, one position took 10 months to fill and the other took 5 months.

Despite OIG's operational challenges, I am very optimistic about what FY24 holds for our agency. OIG plans to move forward with strategic administrative hires to help alleviate and distribute the administrative workload more evenly throughout OIG. The office is hopeful that it will finish its new database project by the end of FY24. OIG's new database will be a web-based system that will allow OIG to be more efficient in managing its investigative and administrative data. Finally, OIG is in the process of working with IDHS Business Services to identify a new office space for our staff housed at Madden Mental Health Center, which would allow OIG to continue to attract and retain high-quality staff.

B. Acting Inspector General Charles Wright

Looking forward, OIG has begun to rebuild. Although higher caseloads and the slow pace of hiring had a substantial impact on productivity and timeliness in FY23, some of the positions OIG posted in FY23 were finally filled in FY24. For example, in OIG's North Bureau, which only had two full-time investigators for much of FY23, four new investigators started in November and December of 2023. OIG also recently hired a Deputy Inspector General, Megan Carlson, who has significant experience from her roles with the City of Chicago Office of Inspector General, Cook County Office of the Independent Inspector General, and as a former Assistant State's Attorney with the Cook County State's Attorney's Office.

That said, as of November 30, 2023, OIG had 31 unfilled positions. Accordingly, it will take time for OIG to be in a sustainable position, especially since onboarding and training takes time and resources. My hope is that the vast majority of the OIG's 31 unfilled positions will be filled during FY24. As OIG's staffing levels improve, OIG will be able to doubly focus on addressing case backlogs and improving timeliness.

I am grateful for the dedicated OIG staff who work tirelessly toward our cause, even in difficult circumstances, and I look forward to continuing to support them as we fight to protect our society's most vulnerable.

APPENDIX A – Relevant Illinois Statutes

Healthcare Worker Background Check Act

225 ILCS 46/15

"Health care employer" means:

(1) the owner or licensee of any of the following:

(i) a community living facility, as defined in the Community Living Facilities

(ii) a life care facility, as defined in the Life Care Facilities Act;

(iii) a long-term care facility;

(iv) a home health agency, home services agency, or home nursing agency as defined in the Home Health, Home Services, and Home Nursing Agency Licensing Act;

(v) a hospice care program or volunteer hospice program, as defined in the Hospice Program Licensing Act;

(vi) a hospital, as defined in the Hospital Licensing Act;

(vii) (blank);

(viii) a nurse agency, as defined in the Nurse Agency Licensing Act;

(ix) a respite care provider, as defined in the Respite Program Act;

(ix-a) an establishment licensed under the Assisted Living and Shared Housing Act;

(x) a supportive living program, as defined in the Illinois Public Aid Code;

(xi) early childhood intervention programs as described in 59 Ill. Adm. Code 121;

(xii) the University of Illinois Hospital, Chicago;

(xiii) programs funded by the Department on Aging through the Community Care Program;

(xiv) programs certified to participate in the Supportive Living Program authorized pursuant to Section 5-5.01a of the Illinois Public Aid Code;

(xv) programs listed by the Emergency Medical Services (EMS) Systems Act as Freestanding Emergency Centers;

(xvi) locations licensed under the Alternative Health Care Delivery Act;

(2) a day training program certified by the Department of Human Services;

(3) a community integrated living arrangement operated by a community mental health and developmental service agency, as defined in the Community-Integrated Living Arrangements Licensing and Certification Act; or

(4) the State Long Term Care Ombudsman Program, including any regional long term care ombudsman programs under Section 4.04 of the Illinois Act on the Aging, only for the purpose of securing background checks.

Mental Health and Developmental Disabilities Administrative Act

20 ILCS 1705/7.3

Sec. 7.3. Health Care Worker Registry; finding of abuse or neglect. The Department shall require that no facility, service agency, or support agency providing mental health or developmental disability services that is licensed, certified, operated, or funded by the Department shall employ a person, in any capacity, who is identified by the Health Care WorkerRegistry as having been subject of a substantiated finding of abuse or neglect of a service recipient. Any owner or operator of a community agency who is identified by the Health Care Worker Registry as having been the subject of a substantiated finding of abuse or neglect of a service recipient is prohibited from any involvement in any capacity with the provision of Department funded mental health or developmental disability services. The Department shall establish and maintain the rules that are necessary or appropriate to effectuate the intent of this Section. The provisions of this Section shall not apply to any facility, service agency, or support agency licensed or certified by a State agency other than the Department, unless operated by the Department of Human Services.

(Source: P.A. 100-432, eff. 8-25-17.)

APPENDIX B – Rule 50 Definitions of Abuse and Neglect

Chapter I, Part 50, Section 50.10 of the Illinois Administrative Code provides the following OIG Definitions:

Abuse

Physical Abuse"[a]n employee's non-accidental and inappropriate contact with an individual that causes bodily harm." Section 50.10 further defines "bodily harm" as "[a]ny injury, damage or impairment to anindividual's physical condition, or making physical contact of an insulting or provoking nature with an individual."

Sexual Abuse
"[a]ny sexual contact or intimate physical contact between an employee and an individual, including an employee's coercion or encouragement of an individual to engage in sexual behavior that results in sexual contact, intimate physical contact, sexual behavior, or intimate physical behavior." Sexual abuse also includes "employee's actions that result in the sending or showing of sexually explicit images to an individual via computer, cellular phone, electronic mail, portable electronic device, or other media, with or without contact with the individual."

Sexually Explicit Images
"any material that depicts nudity, sexual conduct, or sadomasochistic abuse, or that contains explicit and detailed verbal descriptions or narrative accounts of sexual excitement, sexualconduct, or sadomasochistic abuse." Images contained in sex education materials used by employees to educate individuals are not considered sexually explicit images."

Financial Exploitation
"[t]aking unjust advantage of an individual's assets, property or financial resources through deception, intimidation or conversion for the employee's, facility's, or agency's own advantage or benefit."

Mental Abuse
"[t]he use of demeaning, intimidating or threatening words, signs, gestures or other actions by an employee about an individual and in the presence of an individual or individuals that results in emotional distress or maladaptive behavior, or could have resulted in emotional distress or maladaptive behavior, for any individual present."

Neglect

Neglect
"[a]n employee's, agency's or facility's failure to provide adequate medical care, personal care or maintenance," which "causes an individual pain, injury or emotional distress, results in eitheran individual's maladaptive behavior or the deterioration of an individual's physical condition or

mental condition or places an individual's health or safety at substantial risk of possible injury, harm or death."

Egregious Neglect

"A finding of neglect as determined by the Inspector General that represents a gross failure to adequately provide for, or a callous indifference to, the health, safety or medical needs of an individual and results in an individual's death or other serious deterioration of an individual's physical condition or mental condition."

Appendix C – IDHS' Response to the Choate Report

June 9, 2023

Peter Neumer
Illinois Department of Human Services (IDHS) Inspector General

Re: Response to Requested OIG Report

Dear Inspector General Neumer,

Thank you for accepting my request to conduct a special review of the Choate Mental Health and Developmental Center (Choate) resident safety reporting practices and for the submission of your report. We both share the goal of ensuring the health and safety of all residents at the State Operated Developmental Centers (SODCs). Your and your team's work is vitally important, and we respect and value our important relationship. Since I made this request of your Office, IDHS announced and began implementation of a Choate transformation plan and has continued to diligently address and mitigate challenges at the Center and across the system.

Your independent and expert views and recommendations strengthen our system of care. We are well into the implementation for the recommendations you have made. Your work confirms the importance and urgency of our work to transform Choate, and to carry out best practices for quality and safety across the I/DD residential system in Illinois.

IDHS continues to diligently respond to any and all allegations of misconduct, in partnership with your Office, the State Police, and the Illinois Department of Public Health. I also want to note the outstanding, compassionate, and life-supporting work that the vast majority of the more than 600 dedicated employees at Choate do on behalf of residents and patients every day.

The system-wide transformation that is underway is well aligned with your recommendations and is aimed at providing better care and resources for individuals with intellectual and developmental disabilities in this State including:

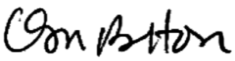
- **Appointed New Leaders.** Tonya Piephoff was appointed Director of the Department of Developmental Disabilities and Ryan Thomas was appointed as Chief Resident Safety Officer. Ms. Piephoff brings more than 20 years of experience serving individuals with intellectual and developmental disabilities which includes extensive experience in SODC operations. Ms. Thomas brings over 16 years of regulatory compliance, patient safety, and change management experience to her position.
- **Installed Cameras.** 18 outdoor security cameras have been installed and activated at Choate and, based on recent guidance from the federal Centers for Medicare and Medicaid Services, cameras in common indoor areas where there is a low, or no reasonable expectation of personal privacy (as opposed to resident bedrooms, restrooms, etc.) are being installed. IDHS plans to install cameras at all SODCs.

- **Developed and Implemented New Trainings.** In partnership with the Illinois State Police, IDHS implemented training at Choate in March 2023 designed to improve reporting, safety, and care, including training for frontline and direct care staff on abuse reporting, investigations, retaliation, and code of silence. Prior to the transformation, Choate employees received training from the Illinois Crisis Prevention Network on de-escalation techniques.
- **Supported Enhanced Penalties.** SB 855 (Fine/LaPointe), a passed bill championed by your Office and supported by IDHS, removes employees who materially obstruct investigations into abuse or neglect from the being able to work at our SODCs or in any other healthcare setting. We believe that this measure will deter additional misconduct and encourage full and appropriate cooperation in reviews into abuse or neglect at State facilities.
- **Employed New Staffing Strategies.** Sufficient staff is key to providing quality services to residents and to ensuring that residents are safe and supported. While IDHS is contending with a nationwide shortage of healthcare staff, the department has been filling existing vacancies through continuous postings of jobs, broadly advertising available jobs, hosting on-campus job fairs to allow potential employees to apply in real time, speeding up the hiring process to onboard employees as quickly as possible, and increasing the starting wages for new employees.
- **Planning and Implementing Resident Transitions.** Some Choate residents have already transitioned out of the facility, and significant investments are being made to ensure that, over a 3-year period, over 100 Choate residents can successfully transition to the living arrangement of their choice, including waiver-funded settings such as Community Integrated Living Arrangements (CILAs), Home Based Support Services (HBS), and Community Living Facilities (CLFs), as well as long-term care facilities such as Intermediate Care Facilities (ICF-DDs) and other SODCs.

IDHS believes these changes will bring Illinois in closer alignment with nationwide, research-informed best practices, advance the State's commitment to equity and the civil rights of people with disabilities, and meet the State's legal duty to ensure that residents with disabilities have a full opportunity to live in the least restrictive environment of their choosing.

Thank you again for your work and effort on this report. IDHS takes your findings and recommendations very seriously and will continue to work in good faith with your staff, along with our employees, and other crucial stakeholders, including parents, guardians, and disability civil rights advocates, to address them. The ongoing care, health, and welfare of our residents remains our top priority and we will continue to work diligently to provide the highest quality care.

Sincerely,



Grace B. Hou
Secretary