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

IDHS Office of the Inspector General
FY22 Annual Report

December 2, 2022

To Governor Pritzker and Members of the Illinois General Assembly:

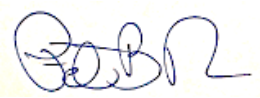
For multiple reasons, the long-term outlook for IDHS OIG is as strong as it has ever been. From a structural perspective, OIG was able to create and fill a Chief Administrative Officer position which will allow OIG to be more efficient regarding the use of its budget and personnel resources. OIG also received a material increase in headcount in Fiscal Year 2022 (from 81 to 89), which will provide OIG with much-needed investigative, analytic and administrative staff. With respect to investigations, over the last three fiscal years, OIG has reduced the number of State facility employees on paid administrative leave due to OIG investigations by more than half. In addition, OIG's primary work-product—its investigative reports—are now more organized and detailed, following a change in formatting and additional training for staff.

However, in the short-term, OIG is experiencing significant challenges related to the slow pace of State hiring. More specifically, OIG, as of the drafting of this letter, has 12 positions that are in various stages of the hiring process—including an investigator position that OIG has been attempting to fill for over a year. Notably, as positions remain open and workloads increase for remaining OIG staff, the number of vacancies often increase, creating a negative cycle that causes material operational difficulties. For example, OIG procured temporary employees to address the administrative staff shortages that were created by positions left unfilled for an extended period of time. As a result, though, supervisory staff, instead of working on investigative matters, have had to spend significant time training workers who may not be with OIG for the long-term, which is not an ideal use of OIG resources. Yet, at the present time, OIG has few alternatives.

With respect to investigations, in a year where OIG experienced a 17 percent increase in investigations opened, having numerous vacant investigative positions quite obviously hurts OIG's ability to complete investigations in a timely manner because, simply put, there are fewer investigators responsible for more cases. It is thus not surprising that OIG's caseload increased 14 percent in FY22.

All this said, once OIG is able to fully utilize its increased headcount, I believe that OIG will be better positioned than ever to conduct timely, impactful investigations. In addition, by devoting additional resources to its analytic efforts, OIG will be able to conduct more in-depth assessments of the root-causes of abuse and neglect to supplement its investigative efforts. Such root-cause analyses could be particularly helpful in addressing systemic issues like those highlighted in the recent reporting on the Choate facility. Accordingly, in spite of the external obstacles that OIG has and will continue to face, there is legitimate reason for optimism about the future of OIG.

Sincerely,



Peter B. Neumer
Inspector General

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Chapter 1: Summary of OIG's FY22

A. Notable FY22 Data

The FY22 data demonstrates that, despite the challenges OIG faced in terms of staffing vacancies, the Office was still able to make modest improvements with respect to the timeliness of its case completions. Most notably, OIG:

- Opened 2,991 cases in FY22, a 17% increase from FY21.
- Processed 12% more hotline calls during FY22 than FY21.
- Experienced a 14% increase in investigator caseload.
- Reduced the average time it took to complete a case from 129 working days in FY21 to 123 working days in FY22.
- Increased the percentage of cases completed within 60 working days from 50 percent in FY21 to 51 percent in FY22.

For a more complete detailing of OIG's FY22 metrics, *see infra* Chapters 2 & 3.

B. Returning to Normal – OIG and COVID-19

In FY22, OIG was able to return to onsite investigative activity and also conduct all of its statutorily-mandated site visits onsite. In FY21, OIG, in response to the COVID-19 pandemic and in accord with public health best practices, conducted the majority of its investigative work remotely and also performed its site visits remotely. OIG initially returned to onsite investigative activity in November 2021, but again moved to remote work following the emergence of the Omicron variant. However, since June 2022, OIG has continually conducted its investigations in a similar manner as it did pre-COVID. OIG sincerely hopes that, going forward, public health emergencies will not have a significant impact on OIG's investigative practices.

With respect to OIG's COVID-19 related investigations, from July 1, 2021 until June 30, 2022, OIG received 15 allegations of neglect related to COVID-19. As of September 2022, OIG completed 9 of those investigations and substantiated neglect in 1 of those investigations. Of the 9 investigations completed, OIG identified other issues that required a written response from the agency or facility in 1 case.

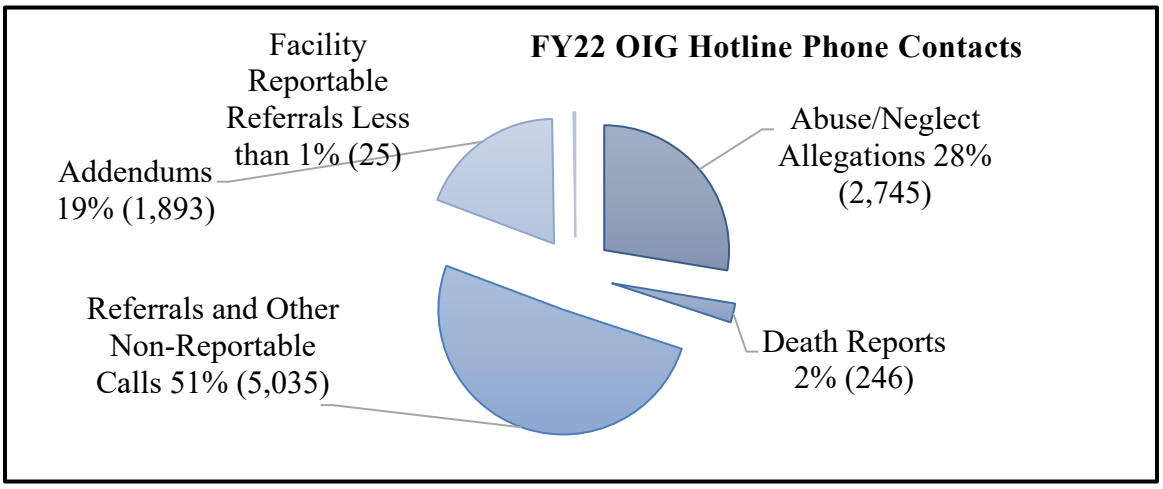
Chapter 2: OIG's FY22 in Numbers

A. OIG Hotline Calls and Referrals

During FY22, the OIG's Intake Bureau processed 9,944 calls, as reflected in the below table. As background, OIG's Intake Bureau is staffed by a Bureau Chief, an Investigative Team Leader, and 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 or calls coming from anonymous sources..

OIG receives and processes complaints alleging abuse (physical abuse, sexual abuse, and mental abuse), neglect and financial exploitation, as well as death reports (reports of death where abuse or

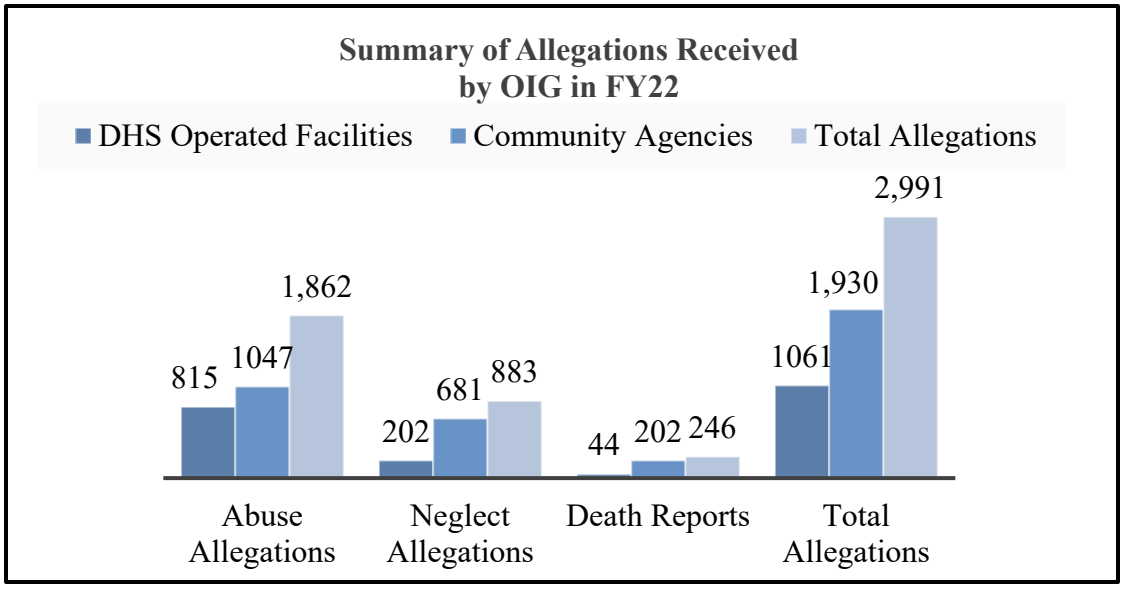
neglect is not suspected) by employees of facilities and community agencies that provide mental health and/or developmental disabilities services and that are operated, licensed, funded or certified by IDHS. OIG's Complaint Intake Bureau also receives thousands of non-reportable calls, which include complaints that do not fall under the definitions set forth in 59 Ill. Admin. Code 50 ("Rule 50"), or other reporting requirements.



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. In FY22, OIG had 5,035 referrals and other non-reportable calls. The following table reflects the recipients of these calls:

Referral Location	Total Referred
Local Community Agency or Facility	73% (3,676)
Illinois Department of Public Health	6.4% (320)
IDHS Division of Developmental Disabilities	4.4% (220)
Department on Aging	1.7% (86)
Department of Children and Family Services	Less than 1% (48)
DHS BALC/OCAPS	Less than 1% (43)
Law Enforcement	Less than 1% (35)
IDHS Division of Mental Health	Less than 1% (34)
Department of Healthcare and Family Services	Less than 1% (32)
IDHS Division of Rehabilitation Services	Less than 1% (26)
Department of Alcohol and Substance Abuse	Less than 1% (8)
Other	10.7% (507)
Total Referred	**5,035**

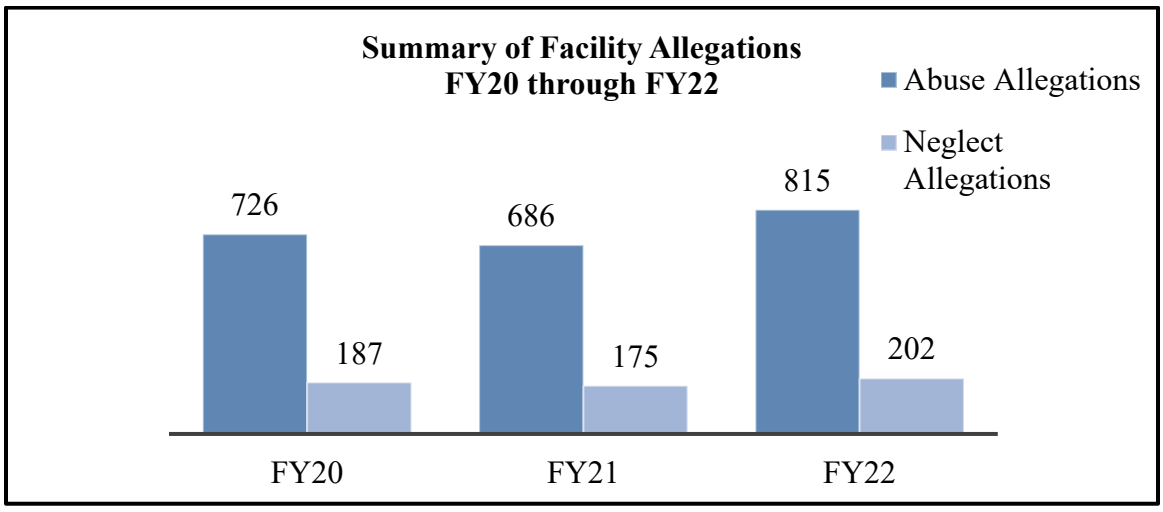
B. Allegations of Abuse and Neglect Received



During FY22, OIG received a total of 2,991 allegations of abuse[1] or neglect (including death reports), 424 more than in FY21. The following tables provide a detailed breakdown of the allegations OIG received in FY22, by type and location. Total abuse allegations in IDHS-operated facilities and community agencies increased from 1,605 in FY21 to 1,862 in FY22, or 16%. Allegations of financial exploitation also increased by 33% from FY21 to FY22. Similarly, neglect allegations in IDHS-operated facilities and community agencies increased by 155 from FY21 to FY22, or 21%.

Facilities

During FY22, OIG received 1,017 allegations of abuse and neglect at the IDHS-operated facilities, an increase of 156 from FY21. 815 of the 1,017 facility allegations were allegations of abuse (which allegations included 32 allegations of financial exploitation). Abuse allegations accounted for 80% of the total allegations at facilities, essentially the same as FY21. 202 of the 1,017 facility allegations OIG received in FY22 were allegations of neglect. The number of FY22 neglect allegations increased by 15% from FY21.

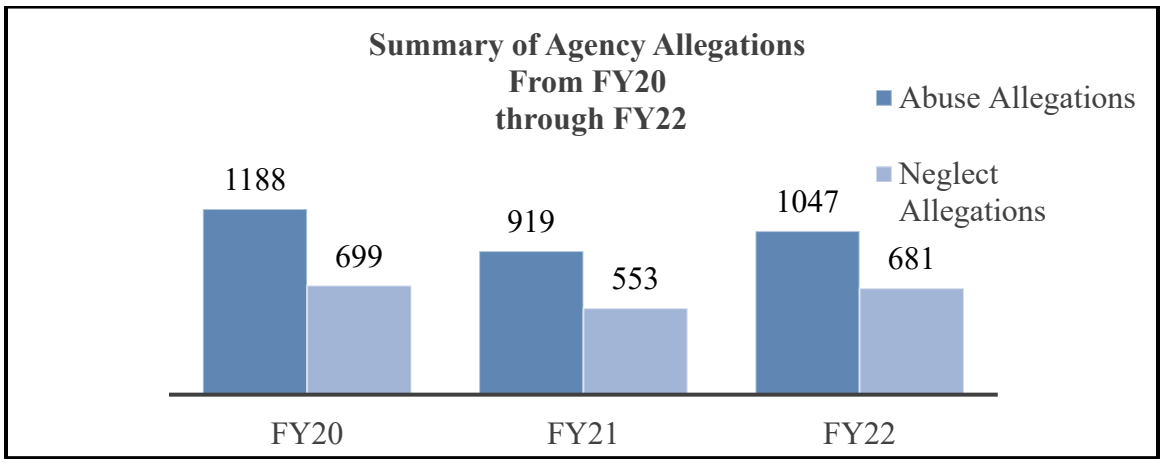


[1] For the purposes of this chart, OIG includes Financial Exploitation allegations within the category of Abuse.

Community Agencies

During FY22, OIG received 1,728 allegations of abuse and neglect at community agencies, a 17% increase from FY21. Of the 1,728 community agency allegations, there were 1,047 allegations of abuse, including 92 allegations of financial exploitation. In FY22, 61% of the community agency allegations OIG received were abuse allegations, compared with 62% in FY21, and 63% in FY20. OIG received 681 allegations of neglect at community agencies in FY22, a 23% increase from the 553 neglect allegations OIG received in FY21.

In FY22, allegations at community agencies accounted for 63% 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.



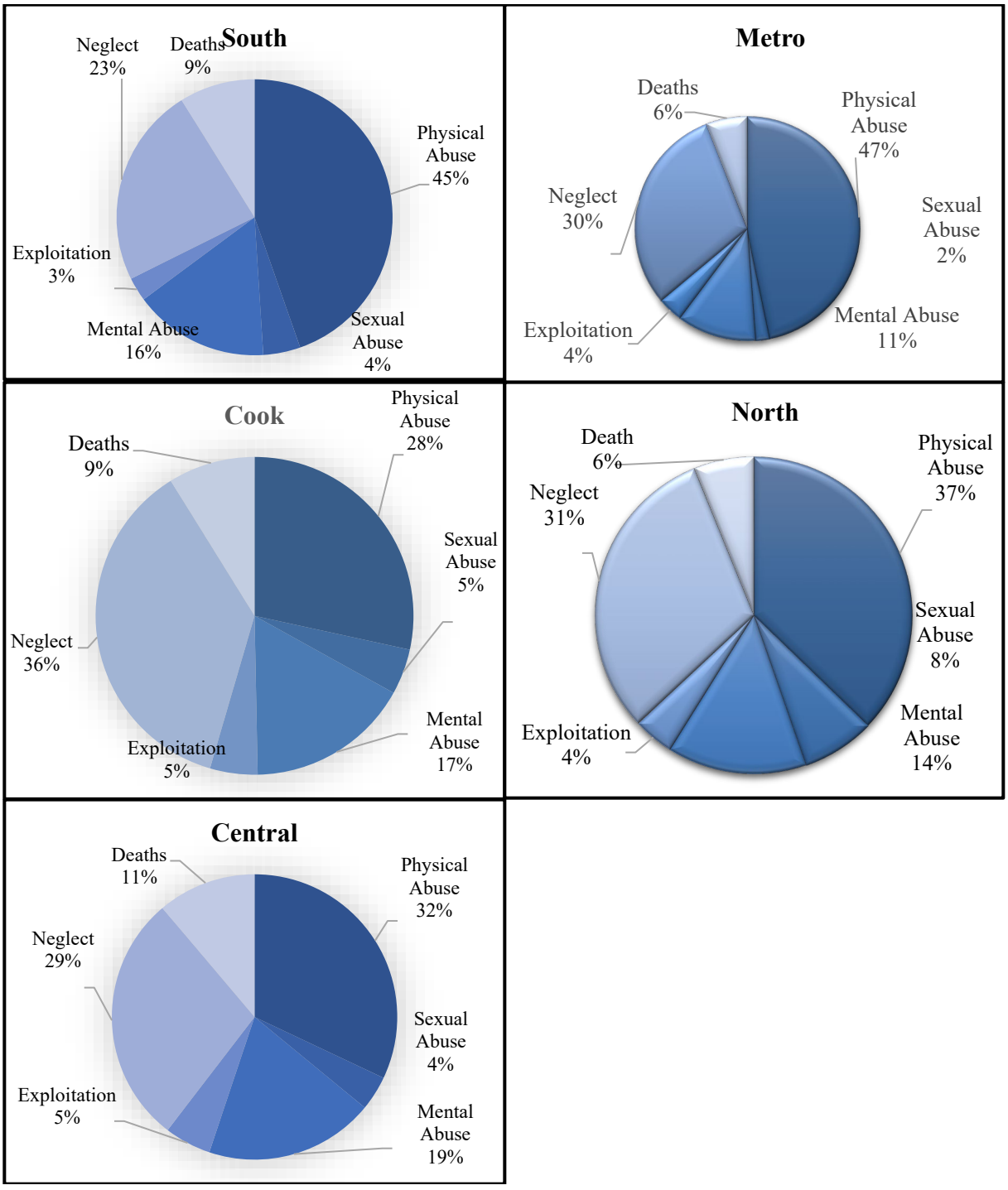
Allegation Type

The following tables show the allegations of abuse and neglect and death reports that OIG receivedduring FY22, categorized by the type of allegation and program location. In addition to the above-described abuse and neglect allegations that OIG received, during FY22, OIG received death reports regarding 246 individuals who were or had been receiving MH/DD services in facility or community agency programs.

FY22 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	19	6	25	6	12	68	0
Chester	64	5	8	1	23	101	1
Chicago-Read	13	4	12	4	11	44	1
Choate	12	3	6	1	3	25	1
Elgin	74	28	34	12	32	180	4
Madden	9	2	11	0	4	26	1
McFarland	27	10	26	3	3	69	0
Facility Totals	**218**	**58**	**122**	**27**	**88**	**513**	**8**
Community Agencies:							
Residential	12	9	17	11	12	61	12
Non-Residential	10	5	10	14	8	47	5
Agency Totals	**22**	**14**	**27**	**25**	**20**	**108**	**17**
Total Allegations and Reports	**240**	**72**	**149**	**52**	**108**	**621**	**25**

FY22 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	72	6	33	1	22	134	2
Fox	1	0	0	0	2	3	3
Kiley	84	8	8	2	29	131	4
Ludeman	46	0	9	1	31	87	8
Mabley	12	1	0	0	9	22	3
Murray	47	1	4	1	14	67	8
Shapiro	49	1	3	0	7	60	8
Center Totals	**311**	**17**	**57**	**5**	**114**	**504**	**36**
Community Agencies:							
Residential	519	41	237	66	609	1472	177
Non-Residential	64	8	23	1	52	148	8
Agency Totals	**583**	**49**	**260**	**67**	**661**	**1620**	**185**
Total Allegations and Reports	**894**	**66**	**317**	**72**	**775**	**2124**	**221**

Allegations by Bureau



C. Reportable Referrals

During FY22, OIG referred 25 reportable allegations to facilities for an internal investigation. Of those, 17 were self-reported allegations. As background, in FY20, in order to ensure that OIG was

using its limited investigatory resources in the most efficient and effective manner possible, OIG initiated a pilot project—which it developed in conjunction with DDD, DMH, and several advocacy organizations—wherein OIG's Intake Bureau, with Inspector General approval, referred cases to the State-operated facilities to address situations where: (1) the allegation, if true, would likely not result in a report to the Health Care Worker Registry; (2) another entity was better positioned to immediately address the situation; and/or (3) the reporting entity or person had already identified the primary facts relevant to the allegation, meaning additional investigative work would be of minimal value. OIG did not refer allegations if they: (i) presented an emergency situation; (ii) indicated that an individual was in imminent danger; or (iii) would likely result in the reporting of an employee to the Health Care Worker Registry.

Below are the number of cases referred to each Division in FY22 and the average number of days it took to receive the facility response.

FY22 – Number of Referrals Per Division and Average Number of Days to Receive Facility Response[2]		
Disability Type	**# of Cases**	**Average Working Days to Receive Facility Response**
DD	6	11
MH	19	26
Total # of Cases/Average Days	**25**	**22**

Below are additional FY22 metrics regarding the number of reportable referred responses OIG received during FY22 and the results of those referrals. During FY 22, OIG received a response on 37 of its referred cases, with 1 case reporting that two separate employment actions were being taken. Of those, 12 responses were for reportable referrals from FY21 and 26 responses were for reportable referrals from FY22.

[2] The Average Working days to receive the response was based on the date OIG received the Intake. At the present time, OIG's database does not capture the date OIG sent the referral to the facility, but it is attempting to add this capability. Typically, there are 1 or 2 days between the date OIG receives the Intake and the Referral date.

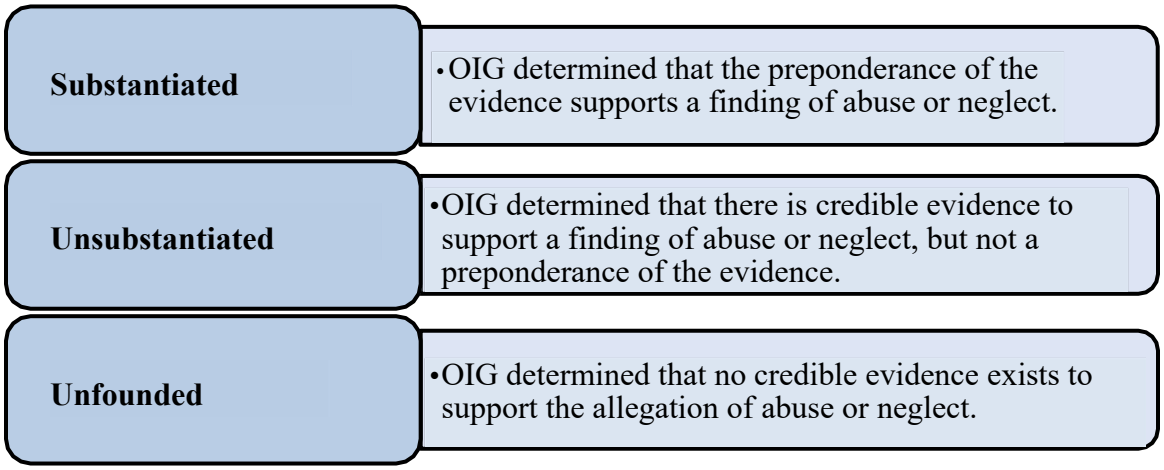
Referral Outcomes	Cases Referred During FY21, Received Outcome During FY22	Cases Referred During FY22, Received Outcome During FY22[3]	Total Number of Outcomes Received During FY22
Administrative Discipline Imposed	0	1	1
No Action Taken	11	20	31
Non-Disciplinary Action – Other	1	1	2
Non-Disciplinary Action - Retraining	0	4	4
Totals	**12**	**26**	**38**

In FY22, OIG conducted compliance reviews of 3 approved facility written responses. OIG did not identify issues with respect to any of those responses.

Going forward, OIG will look to expand the initiative to community agencies as well and will be working with the DD and MH divisions to determine how best to do so.

D. Findings

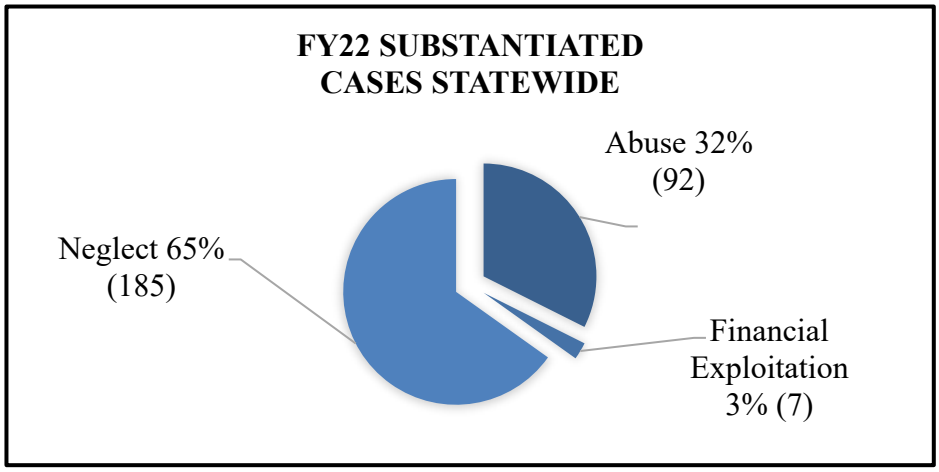
Pursuant to Illinois statute, OIG makes three types of findings in its investigative case reports:



OIG substantiated abuse or neglect in 284 of the 2,467 investigations it completed in FY22, including 185 substantiated neglect cases, 92 substantiated abuse cases, as well as 7 substantiated financial exploitation cases. Of the 284 cases where OIG substantiated abuse or neglect, OIG made a total of 351 findings (in some cases OIG will substantiate abuse or neglect against multiple employees or entities), which includes 283 total findings against accused employees and 68 findings against agencies or facilities.

[3] One case reported in FY22 had two actions received.

The below tables reflect: (1) FY22 Substantiated Cases Statewide by Category; (2) FY22 Substantiated Finding Types by Accused Employee; (3) FY22 Substantiated Findings Against Agencies and Facilities; (4) Substantiation Rates for FY20 through FY22; (5) Substantiated Abuse and Neglect Cases by MH Location; and (6) Substantiated Abuse and Neglect Cases by Developmental Location.



FY22 Substantiated Finding Types Against Accused Employee						
	Physical Abuse	**Sexual Abuse**	**Mental Abuse**	**Financial Exploitation**	**Neglect**	**Egregious Neglect**
Agency Employees						
DD	43	2	34	5	144	0
MH	1	0	2	2	0	0
Total	**44**	**2**	**36**	**7**	**144**	**0**
Facility Employees						
DD	5	2	5	0	19	0
MH	5	1	3	0	9	1
Total	**10**	**3**	**8**	**0**	**28**	**1**
Total	**54**	**5**	**44**	**7**	**172**	**1**

FY22 Substantiated Findings Against Agencies and Facilities	
Agency Substantiated Findings	
DD	
Abuse	5
Neglect	55
Total	**60**
MH	
Abuse	0
Neglect	1
Total	**1**
Total Agency Substantiated Findings	**61**
Facility Substantiated Findings	
DD	
Abuse	0
Neglect	6
Total	**6**
MH	
Abuse	0
Neglect	1
Total	**1**
Total Facility Substantiated Findings	**7**
Total Substantiated Findings Against Agencies and Facilities	**68**

FY20 through FY22 Substantiated Case Trends

OIG's overall substantiation rate stayed steady – in FY21 the substantiation rate was 11.55% and in FY22 it was 11.51%. OIG substantiated 18 fewer abuse, neglect and financial exploitation cases at DD community agencies in FY22 than FY21, but substantiated 3 more abuse, financial exploitation, and neglect cases at State-operated DD facilities.

Substantiation Rate – FY20 through FY22			
Location	**FY20**	**FY21**	**FY22**
MH State Facility	2.9%	4.55%	3.41%
DD State Facility	3.6%	5.65%	7.05%
MH Community Agency	6.1%	8.77%	4.81%
DD Community Agency	12.5%	15.33%	15.79%
Total	**9.4%**	**11.55%**	**11.51%**

FY22 Findings by Mental Health Location					
Location	**Abuse Substantiated**	**Financial Exploitation Substantiated**	**Neglect Substantiated**	**Not Substantiated** [4]	**Findings Total**
Mental Health Centers					
Alton MHC	2	0	2	78	82
Chester MHC	3	0	3	78	84
Chicago-Read MHC	0	0	0	44	44
Choate MHC	0	0	1	17	18
Elgin MH	0	0	0	125	125
Madden MHC	1	0	0	24	25
McFarland MHC	1	0	2	59	62
Center Totals	**7**	**0**	**8**	**425**	**440**
Community Agencies					
Residential	2	0	1	59	62
Non-Residential	0	2	0	40	42
Agency Totals	**2**	**2**	**1**	**99**	**104**
Finding Totals	**9**	**2**	**9**	**524**	**544**

[4] OIG made recommendations in 31 of the 524 MH cases it did not substantiate.

FY22 Findings by Developmental Location					
Location	**Abuse Substantiated**	**Financial Exploitation Substantiated**	**Neglect Substantiated**	**Not Substantiated[5]**	**Findings Total**
Developmental Centers					
Choate DC	5	0	4	110	119
Fox DC	0	0	0	1	1
Kiley DC	0	0	5	105	110
Ludeman DC	2	0	9	64	75
Mabley DC	0	0	0	15	15
Murray DC	2	0	3	61	66
Shapiro DC	2	0	0	66	68
Center Totals	**11**	**0**	**21**	**422**	**454**
Community Agencies					
Residential	64	5	142	1129	1340
Non-Residential	8	0	13	108	129
Agency Totals	**72**	**5**	**155**	**1237**	**1469**
Finding Totals	**83**	**5**	**176**	**1659**	**1923**

FY22 Substantiated Death Cases

OIG closed 240 death cases during FY22, an increase from the 199 death cases OIG closed during FY21. Of the 240 closed death cases, OIG determined that there was no suspicion of abuse or neglect in 219 of the cases. With respect to the 21 death cases where OIG subsequently opened an abuse or neglect investigation, OIG substantiated 7 cases for neglect. As to the other 14 cases that OIG did not substantiate, OIG identified issues that required a written response from the agency or facility in 4 of those cases.

E. 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

[5] OIG made recommendations in 272 of the 1659 DDD cases it did not substantiate.

dictate that OIG suspend its administration investigation until the criminal investigation and any 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 that 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, in the last quarter of FY22, OIG authorized the return to work of 12 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 FY19 through FY22 (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	
May 2019	108
July 2020	55
June 2021	39
August 2022	46

Although the long-term trend remains positive, there was an increase in employees on paid administrative leave due to ongoing OIG investigations in FY22. OIG will continue to work diligently to reduce the number of facility employees on paid administrative leave due to OIG investigations.

F. Reconsiderations of OIG Findings

In FY22, OIG received and reviewed 99 requests for reconsideration of OIG's investigative findings or recommendations, in connection with 92 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 FY22, OIG received two fewer reconsiderations than in FY21, and granted a lower percentage of those requests. Of the 99 reconsiderations OIG received in FY22, OIG denied 78% and granted 22%, as reflected in the below table. In comparison, of the 101 reconsiderations OIG received in FY21, OIG denied 71% and granted 29%.

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**	

FY21 Reconsideration Outcomes	Number of Cases	Outcomes in Percentages
Denied	66	65%
Denied, with the Issuance of an Amended Report	6	6%
Granted, with the Issuance of an Amended Report	19	19%
Granted, and Reopened Investigation	10	10%
Total Reconsiderations	**101**	

G. 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 FY22, OIG received 137 approved written responses from State-operated facilities and 462 from community agencies for a total of 599 written responses, regarding OIG's findings and recommendations.[6] With respect to the above-described written responses, facilities and agencies detailed the following actions related to OIG's findings and recommendations:

FY22 Actions Taken			
Personnel Action		**Administrative Actions**	
Discharged	161	**Individual Retraining**	268
Resignation	63	**Group Training**	155
Written Reprimand	59	**Policy/Procedural Change**	97
Counseling	38	**Reviewed**	48
Suspension	23	**Treatment Plan Change**	29
Transferred	15	**Administrative Change**	18
Oral Reprimand	11	**No Action**	18
Retirement	2	**Structural Repair/Upgrade**	7
		Supervision	5

H. 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.

[6] These numbers include approved written responses OIG received in FY22 regarding cases it completed in FY21.

The table below reflects the percentage of compliance reviews OIG conducted in FY22 by location and program division:

FY22 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	103	16	15.5%	34	9	26.5%
Community Agencies	427	74	17.3%	35	9	25.7%
Totals	**530**	**90**	**17.0%**	**69**	**18**	**26.1%**

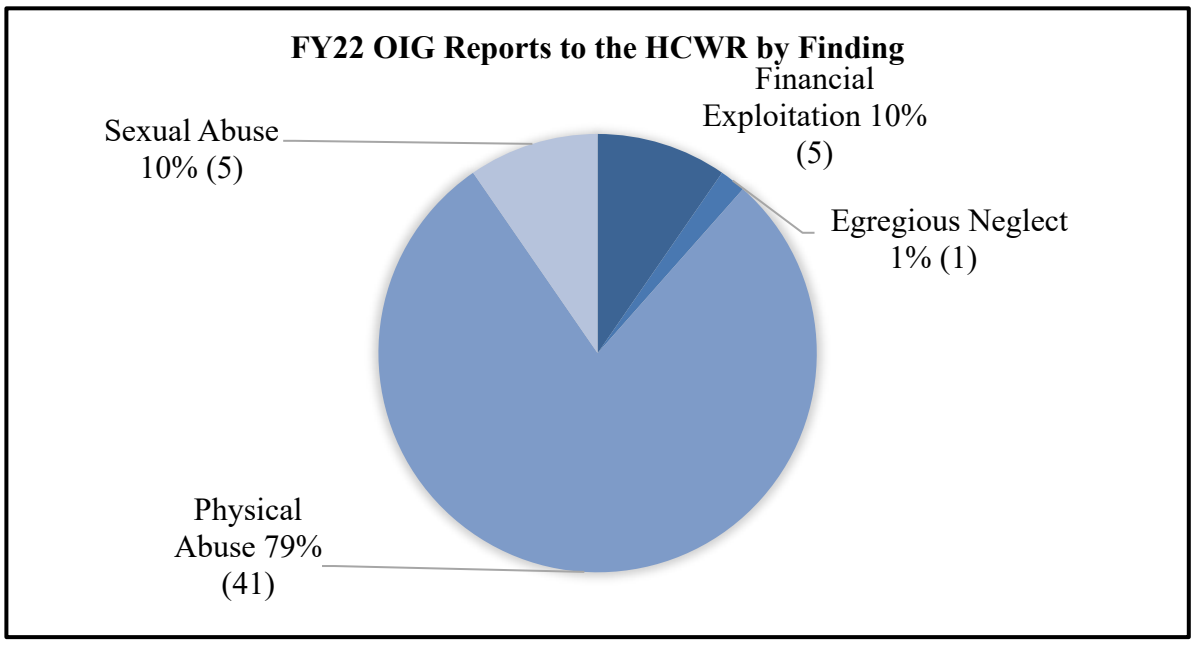
With respect to these compliance reviews, OIG did not issue any "Out of Compliance" letters in FY22.

I. 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 FY22, OIG completed 52 substantiated cases which required initial reports to the HCWR of the employee's name and the nature of OIG's finding. During FY22, OIG also made final reports to the HCWR for 52 employees' names and findings, meaning either the employee did not appeal the report or, after a hearing, it was determined that the conduct warranted the reporting.[7] Of these, 46 of the reported employees were from DDD and 6 reported employees were from DMH. For FY22, OIG's reports to the HCWR placements by finding are reflected in the below table:

[7] The 52 final reports OIG made to the HCWR encompassed cases that it substantiated during FY19 through FY21.



HCWR Administrative 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 FY22, 22 employees filed appeals challenging their names and findings being reported to the HCWR. Although the IDHS Bureau of Administrative Hearings resumed hearings in Spring 2022, 22 of those appeals remain pending.

The IDHS Bureau of Hearings decided 5 appeals that were filed prior to FY22. OIG stipulated to all 5 cases, meaning that 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. Of those, 4 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 or had their matters resolved prior to arbitration. An employee's name cannot be reported to the HCWR if their termination is not upheld. Based on its review of the 5th case, OIG determined that the circumstances surrounding the finding did not warrant reporting to the HCWR and that a stipulation of no reporting was appropriate.[8]

HCWR Removal Hearings

An employee may petition IDHS remove their name and OIG's substantiated finding from the HCWR. In that case, the burden in 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

[8] OIG now has a process where a stipulated disposition can be approved without requiring the accused to file for administrative review. *See infra* Chapter 4(B).

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 FY22, 4 employees requested hearings to have their names and findings removed from the HCWR. Although the Bureau of Administrative Hearings resumed hearings in Spring 2022, those 4 cases remain pending.

Arbitrations

Following the completion and issuance of a substantiated OIG investigative report, certain employees (typically those working at IDHS facilities) have the ability to request labor arbitrations, in which the employees may challenge adverse employment actions based on OIG's cases and findings. During FY22, OIG received the results of three labor arbitration requests. One was decided after a full arbitration hearing and two were resolved prior to arbitration.

With respect to the case that went to a hearing, the facts are as follows: the employee was discharged after OIG's investigation substantiated physical abuse based on its determination that the employee aggressively took down an individual, by placing one arm around the individual's neck and slamming the individual's body down to the floor, causing the individual to land on the individual's back. Following the hearing, the arbitrator ruled that the employee's discharge be converted to a disciplinary suspension, with full reinstatement of seniority and benefits, but without back pay. The arbitrator determined that there was not clear and convincing evidence of physical abuse, even though OIG's statute only requires it to establish physical abuse by a preponderance of the evidence.

J. 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 first time since the COVID-19 pandemic began in 2020.

FY22 Scope

In addition to addressing recommendations from previous fiscal years, the scope of the FY22 site visits was to evaluate each facility's implementation of DHS' restraint policy and procedures, located in DHS Program Directive, "Restraint Use in State Operated Developmental Centers and Programs" (02.03.03.010) for the Division of Developmental Disabilities and "Use of Restraint and Seclusion (Containment) in Mental Health Facilities" (02.02.06.030) 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 restraint use.

The complete site visit dates were as follows:

Alton Mental Health Center	March 3, 2022 – May 20, 2022
Chester Mental Health Center	March 16, 2022 – June 22, 2022
Chicago Read Mental Health Center	November 16, 2021 – April 5, 2022
Choate Developmental Center	May 12, 2022 – June 22, 2022
Choate Mental Health Center	May 10, 2022 – June 15, 2022
Elgin Mental Health Center	April 12, 2022 - June 14, 2022
Fox Developmental Center	March 10, 2022 – May 18, 2022
Kiley Developmental Center	October 14, 2021 – March 2, 2022
Ludeman Developmental Center	November 2, 2021 – April 21, 2022
Mabley Developmental Center	April 19, 2022 – June 10, 2022
Madden Mental Health Center	October 20, 2021 – February 1, 2022
McFarland Mental Health Center	November 30, 2021 – April 22, 2022
Murray Developmental Center	March 31, 2022 – June 23, 2022
Shapiro Developmental Center	December 7, 2021 – June 2, 2022

OIG began the site visit process by requesting pertinent documents from each facility. After a document review, OIG staff then went to each facility and had 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 FY2022, OIG made 52 recommendations (29 for mental health facilities and 23 for developmental facilities). OIG also made 8 follow-up recommendations – 7 from FY2021 and 1 from FY2019. OIG found the following:

- Documentation issues accounted for 34 (65%) of the 52 new recommendations. OIG found multiple instances of missing or inaccurate documentation which were contrary to program directives, including:

- Missing approvals for a physician's rationale to use 5-point versus 4-point restraints or wrist-to-waist restraints;
- No evidence of proper notification to the facility director or guardian/responsible person of a restraint episode;
- No written authorization by the facility director for a second restraint during the 48 hours following a first restraint;
- Missing or outdated physician orders for restraints;
- Inaccurately identified type of restraint; and
- Inconsistent tracking of restraint training.

- Restraint Training for FY22 across facilities was mostly consistent. OIG made three recommendations that facilities ensure training requirements were completed. However, OIG also acknowledged that Covid restrictions made it difficult for facilities to conduct hands-on training.

- At five facilities (two mental health facilities and three developmental centers), OIG found that restraint episodes were not reviewed in a timely manner.

- Three facilities needed restraint policy updates and were working with appropriate entities to ensure that their policies met requirements.

- Three facilities did not follow restraint release procedures and individuals were either released before criteria were met or after the one-hour release requirement.

- At one facility, an individual's Behavior Intervention Plan, which indicated that certain measures were to be attempted prior to restraint, was not followed.

- At two facilities, restraint data which was entered into the centralized BlueZone CICS system was inaccurate or different from that recorded on other documentation.

- At one facility, in three of eight restraint episodes documented, OIG could not determine from the information provided whether the restraints were warranted or used for the convenience of staff.

Chapter 3: Additional FY22 Data

A. Reporting Allegations to OIG in a Timely Manner

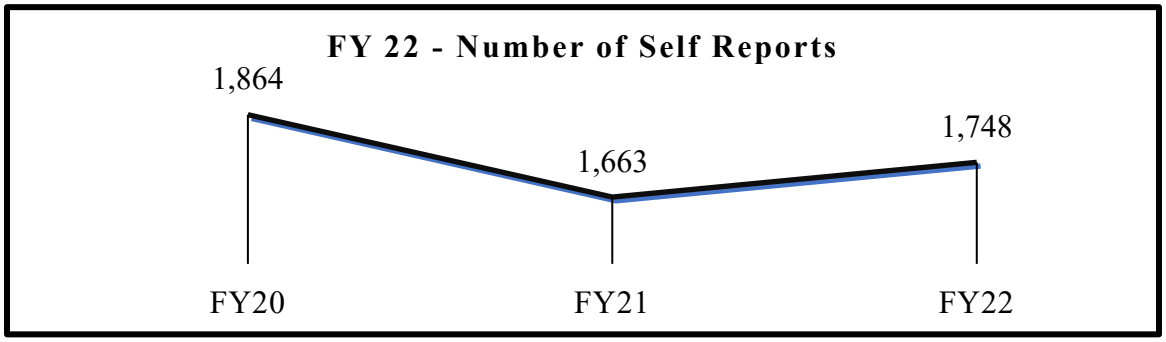
Any employee of a State-operated facility or community agency that falls under OIG's jurisdiction is considered to be a required reporter and must report an abuse or neglect allegation to OIG's Hotline within four hours of their initial discovery of the allegation. OIG refers to these types of reports 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 hours 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 and states the number of days each report was late, and the overall percentage of reports that were late.

In FY22, OIG received 1748 self-reported allegations of abuse and neglect, a 5% increase from FY21.



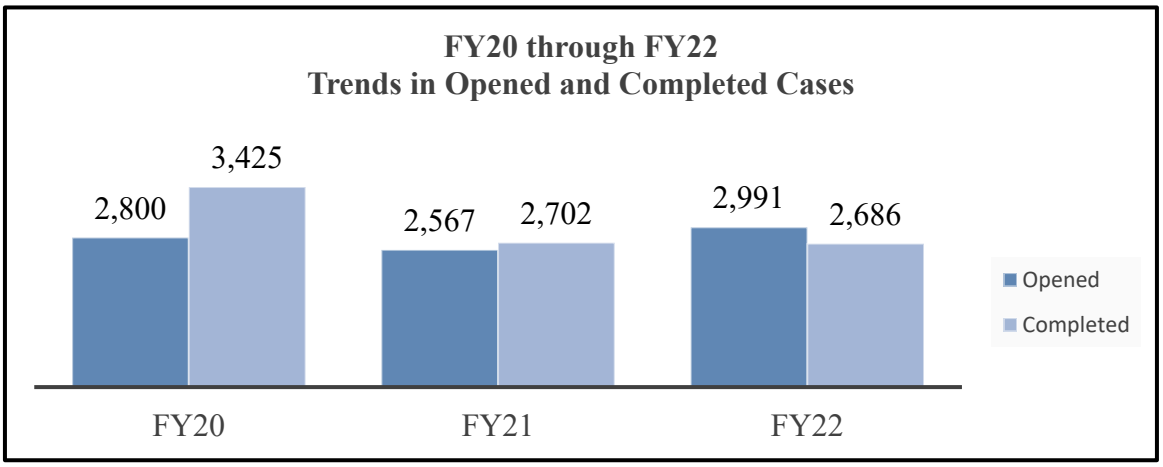
Late-Reporting

The percentage of late self-reports (i.e., reports of abuse or neglect from facility or community agency employees) increased slightly from 189 in FY 21 to 194 in FY22. 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.

FY20-FY22 Late Reporting by Program and Disability Type						
Fiscal Year	Late from Agencies		Late from Facilities		Total Late	Percent Late
	DD	MH	DD	MH		
FY20	163	14	17	12	**206**	**11.1 %**
FY21	137	11	25	16	**189**	**11.37 %**
FY22	137	16	25	16	**194**	**11.10%**

B. OIG Caseloads

During FY22, OIG opened 2991 cases, a 17% increase from FY21.[9] The below tables reflects the number of cases OIG opened and completed from FY20 through FY22.[10][11]



FY21 and FY22 Investigator Caseload Comparison By Bureau		
	Caseload as of June 30, 2021	**Caseload as of June 30, 2022**
Central	208	174
Cook	235	262
Metro	387	408
North	139	264
South	223	246
OIG	**1192**	**1354**

[9] The Bureau caseload figures set forth below do not include open death reviews whereas the FY21 and FY22 opened and closed case figures do include completed death reviews.

[10] The June 30, 2022 Caseload figures are, in some cases, slightly different from those reported in OIG's FY21 Annual Report, likely due to database reclassifications or corrections that occurred during FY22.

[11] FY20 and FY21 data was pulled using open and closed case data while FY22 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.

With respect to OIG's North Bureau, the Bureau experienced a 90 percent increase in allegations in FY22. To counteract this significant increase, OIG has sought to hire an additional investigator and an additional investigative supervisor for the Bureau. However, with the slow pace of hiring, OIG does not expect to have these positions filled until after the end of FY23. This is another example of how the State's hiring woes negatively impact OIG. That said, OIG does expect that bringing on the additional personnel will ultimately help reduce North Bureau's caseload.

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, though, for the past three years, OIG's average time to complete an investigation has remained above 60 days.[12] However, in FY22, for the first time in recent years, OIG completed over half of its cases within 60 days. OIG further notes that the average time it took to complete a case decreased from 129.24 days to 123.08.

[12] 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.

Cases Completed Within and Over 60 Days FY20 through FY22		
Fiscal Year	**Cases Completed Within 60 Days**	**Cases Completed Over 60 Days**
FY20	47%	53%
	(1,618)	(1,847)
FY21	50%	50%
	(1367)	(1372)
FY22	51%	49%
	(1379)	(1307)

FY22 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**
43% (760)	57% (993)	66% (619)	34% (314)

FY20 through FY22 – Average Days for Case Completion		
Fiscal Year	**Average Total Days**	**Average OIG Days**
FY20	119.4	118.7
FY21	130.93	129.24
FY22	129.46	123.08

FY22 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**
152.79	149.72	85.63	73.02

FY22 Average Days for Case Completion by Case Type	
Mental Abuse (Verbal)	75.61
Mental Abuse (Psych)	85.87
Physical Abuse	106.10
Sexual Abuse	108.75
Death Report	118.00
Financial Exploitation	146.95
Neglect	188.99
Neglect - COVID	195.39
Death Report - COVID	240.47

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 carestaff. IDHS calculates those ratios as of June 30, 2022, or the last day of FY22.

Below are the census figures and staffing ratios for each type of facility at the close of FY22. 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, 2022, which details the number of individuals in the facility on that day.

IDHS also uses the June 30, 2022 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, 2022, is reflected in the fourth column of the tables.

IDHS Budget divides the June 30, 2022 direct care staff figures by the June 30, 2022 census figures to calculate the direct care staff to patient ratios, which are reflected in the fifth column.

DHS State-Operated Facilities[13] Census and Staffing Ratios (as of June 30, 2022)					
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	197	36,649	101	149.00	1.48
Chester MHC	518	100,592	279	342.40	1.23
Chicago Read MHC	274	49,219	138	166.90	1.21
Choate MH & DC Total	353	98,070	268	379.70	1.42
Elgin MHC	799	127,510	367	397.00	1.08
Fox DC	77	26,253	71	91.00	1.28
Kiley DC	210	72,744	195	261.60	1.34
Ludeman DC	326	115,647	313	579.50	1.85
Mabley DC	121	41,392	115	139.75	1.22
Madden MHC	1,544	33,167	88	112.10	1.27
McFarland MHC	255	43,710	121	157.75	1.30
Murray DC	275	91,619	256	304.82	1.19
Shapiro DC	497	167,941	460	728.60	1.58
Total DD Facilities	**1,859**	**613,666**	**1,678**	**2,484.97**	**1.48**
Total MH Facilities	**3,587**	**390,847**	**1,094**	**1,325.15**	**1.21**
Total DD and MH Facilities	**5,446**	**1,004,513**	**2,772**	**3,810.12**	**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.

[13] Since FY2016, Choate MH and DC provide combined staff totals for MH and DD.

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 FY22 were:

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

In September 2022, a sixth member, Nancy Sage, was added to the QCB.

The QCB held five meetings in FY22, all by teleconference. The meeting dates were as follows:

August 17, 2021
October 19, 2021
December 21, 2021
February 15, 2022
April 19, 2022
June 21, 2022

Chapter 4: Areas of Advancement

During FY22, OIG made numerous modifications to its policies and procedures and proposed multiple statutory or regulatory changes, which include the following.

A. Proposed Rule 50 Amendments

During FY22, OIG submitted for consideration proposed amendments to Rule 50 (59 Ill. Adm. Code 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. OIG's proposed rulemaking includes the following changes:

- 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 for 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 results.

- Each community agency would 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 would codify the Intake Pilot Project OIG implemented during FY21.

B. HCWR Amendments

As background regarding the below-detailed legislative initiatives, OIG is required to report to the HCWR the names of any DHS State-Operated Facility (SOF) or community agency employee who OIG has found to have engaged in physical abuse, sexual abuse, financial exploitation, or egregious neglect of an individual. *See* 20 ILCS 1305/1-17(s). Illinois statutory law prohibits health care employers from subsequently hiring or employing such people for "position[s] with duties involving direct care of clients, patients, or residents," effectively barring them from working in the Illinois health care industry. 225 ILCS 46/25(e). *See supra* Chapter 2(I) for additional background regarding the HCWR.

1. Public Act 102-0883 – HCWR Stipulation Amendment

In FY22, an OIG-drafted amendment to 20 ILCS 1305/1-17(s), which was designed to make the HCWR reporting process fairer and more efficient, was subsequently enacted into law as Public Act 102-0883.

Notably, 20 ILCS 1305/1-17(s)'s mandatory reporting requirement does not allow for any exceptions, which means an employee who takes a stick of gum from an individual and an employee who takes $10,000 from an individual are to be treated identically: OIG must report them both to the HCWR, which could result in them being banned from working in the health care industry in Illinois indefinitely.

Pursuant to the Illinois Administrative Code, OIG and the IDHS Secretary can agree to a stipulated disposition of an OIG substantiated report, meaning that the employee's name will not be sent to the HCWR, as it would have been absent the stipulation. This stipulation process can help prevent unjust results, as suggested by the above example.

Prior to the passage of Public Act 102-0883, however, the OIG and the Secretary could only reach a stipulated disposition if OIG first substantiated the allegations and informed the employee that their name was being forwarded to the HCWR. If the employee requested a hearing before OIG reported, the matter could be resolved by stipulation. Absent a request for hearing, there could be no stipulated disposition. Now, OIG can recommend the stipulation of an HCWR case in its Final Investigative Report. This allows for greater equity and fairness with respect to the employees whose names are sent to the HWCR and also make the HWCR reporting process more efficient.

2. 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.

The present version of the statute does not allow OIG to report employees to the HCWR who obstruct its investigations. Of great concern is that OIG regularly sees instances where facility or agency staff seek to protect each other from the consequences of their misconduct by remaining silent about what they witnessed or lying to protect their fellow employees. Most notably, as part of a recently concluded OIG investigation of physical abuse at Choate, OIG determined at least 8 Choate staff actively colluded to obstruct criminal and administrative investigations of the abuse, including by lying to law enforcement officials, to cover up the beating of an individual. In addition, multiple staff failed to report the abuse they witnessed, although the individual's injuries were what multiple witnesses described as the worst injuries they had seen. However, even with respect to the employees who pleaded guilty to felony obstruction of justice, OIG could not report them to the HCWR.

Troublingly, such collusion to obstruct investigations can, on occasion, allow for those who engaged in misconduct to avoid discipline. Therefore, it is necessary to deter this type of behavior, or else it becomes more difficult for OIG to root out abuse and neglect. One way to deter such conduct would be to make Material Obstruction of an Investigation a HCWR-reportable finding. Employees would be less likely to engage in this type of cover-up behavior because they would be aware that they risked losing their employment if they were placed on the Registry and would not be able work for any Health Care Employer in the state, as provided by the Healthcare Worker Background Check Act, 25 ILCS 46/15.

Accordingly, as a result of this amendment, OIG would be better able to identify the perpetrators of abuse and neglect and also poised to ensure that those perpetrators were not able to continue abusing some of the State's most vulnerable individuals.

C. Budget Floor Legislation

In the Fall of 2022, 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.

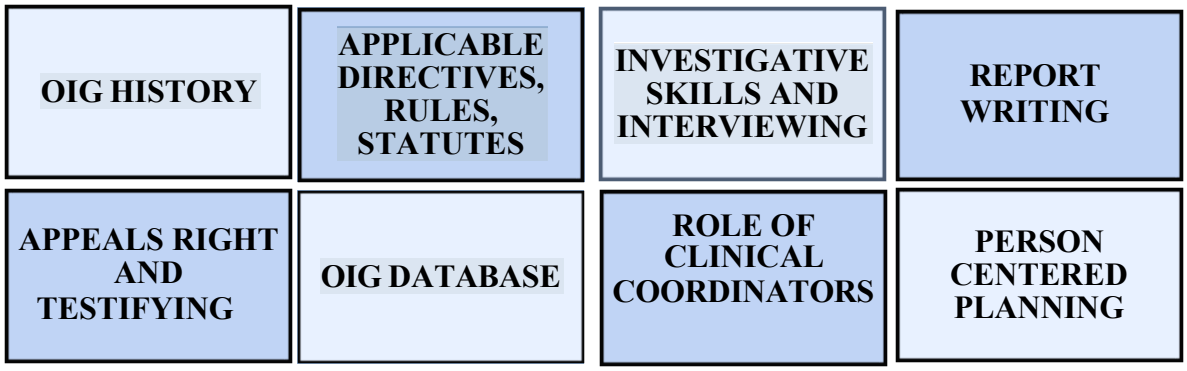
Chapter 5: Training and Certification Updates

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 FY22, OIG staff completed all necessary courses to meet these requirements. In FY22, OIG also started the process to convert documenting staff training from the OIG database to the DHS OneNet Training system, which should be completed by the end of FY23.

OIG notes that each of the new 6 OIG staff hired in FY22 (1 Chief Administrative Officer, 2 Internal Security Investigators (ISIs), 1 RN Clinical Coordinator, and 2 Office Associates) received OIG's classroom training, which 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.

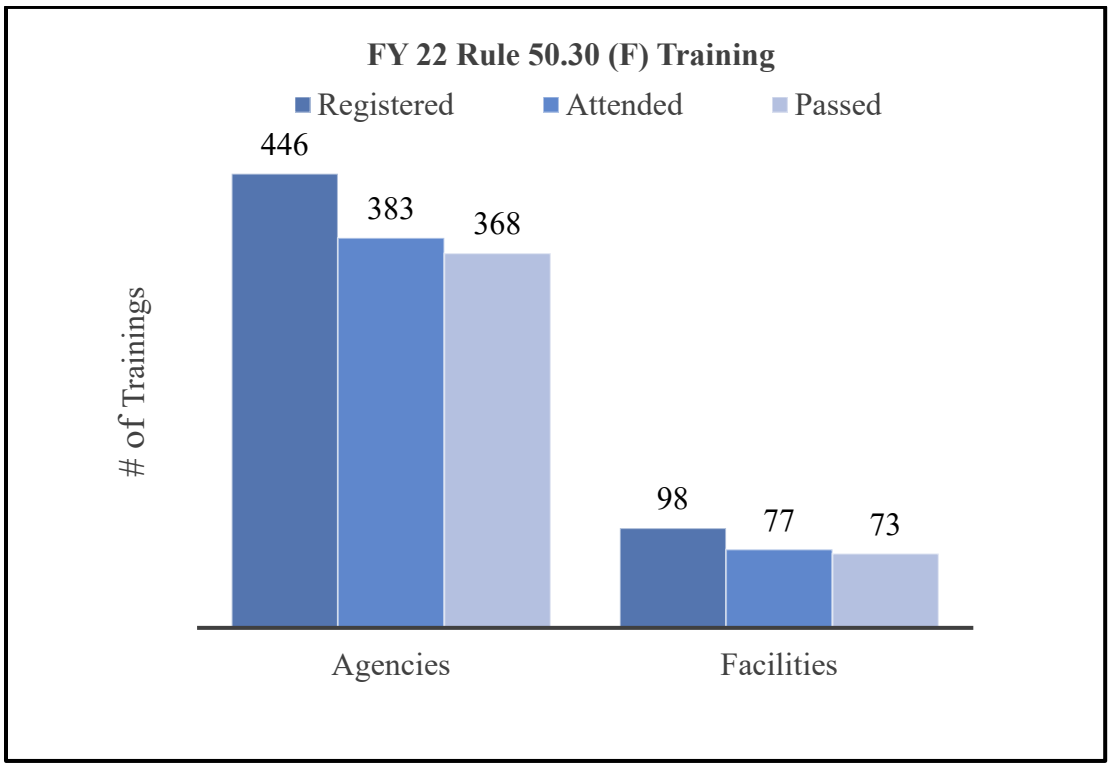
OIG conducts weekly evaluations and written assessments to ensure the new probationary ISIs obtain all necessary investigative skills. Of the 2 ISIs OIG hired in FY22, both completed their classroom and field training to become certified ISIs.

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 FY22, 544 agency and facility staff registered for OIG's online 50.30(f) training, 460 attended the training and of those, 441 passed. To pass the training, the staff have to score 70% or better on a test. Roughly 96% of agency staff and 95% 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 FY22, 45 facility staff registered for the training and 41 staff completed the training.

Special Trainings

OIG conducted an in-person training at Choate Developmental and Mental Health Center on May 11, 2022 and May 12, 2022, covering Rule 50.30(f) and Investigative Steps. OIG conducted a similar online training via WebEx for Kiley Developmental Center on June 23, 2022. DDD requested these trainings to improve the abuse and neglect reporting and investigative processes at both facilities.

Rule 50 Training

During the fourth quarter of FY22, OIG began collecting the number of persons who were recorded as having Rule 50 training 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. 212 distinct persons were recorded as having Rule 50 training at their facility or agency.

OIG Training Updates

In FY22, OIG began a review of its internal training processes, as well as its trainings for agencies and facilities. OIG's ultimate goal is to use IDHS' OneNet system to initiate, implement and document such trainings. OIG's new Chief Administrative Officer will be generally responsible for seeing this project to completion.

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 284 cases OIG substantiated in FY22.

9520-0058 - OIG substantiated an allegation of neglect where its investigation established that a facility failed to provide medical monitoring for a known COVID-19 positive individual as the individual's health declined over a 9-day period, failed to notify staff on the unit of the individual's COVID-19 status, and failed to isolate the individual. The resident subsequently died from COVID-19. OIG further recommended that the facility address: 1) its procedures for maintaining continuity of medical care when an individual's physician is on leave status; and 2) its procedures for ensuring that physician's orders are implemented.

9522-0038 - OIG substantiated an allegation of neglect where its investigation established that the facility failed to provide an individual with a consistent level of food and liquid through the individual's gastrostomy tube as ordered by his physician, which contributed to the individual's decline and numerous hospitalizations. In response to the finding, the facility provided an in-service training on G-tube feeding and documentation.

9522-0049 - OIG substantiated an allegation of neglect where its investigation established that a Lead Worker failed to assign a one-to-one staff for more than ten minutes for an individual and that the Mental Health Technician (MHT) who was eventually assigned failed to supervise the individual for approximately 50 minutes. As a result of these failures, the individual was found with a laceration, which required sutures to close. OIG recommended that the facility address staffs' failure to fill out house logs and other accountability documents which record the care and supervision of individuals at the facility. In response to the finding, the facility provided an in-service training on the facility

policy covering client protection and supervisions of persons served, and on the daily house report log and the residential accountability sheet.

7419-0082 – OIG substantiated an allegation of sexual abuse where its investigation established that an MHT had a physical relationship with an individual, which included sexual contact, while the individual was a patient at the facility. Following a criminal investigation, the employee pleaded guilty to Official Misconduct and Unlawful Restraint in relation to the employee's conduct toward the individual. In the response to the finding, the facility reported that the MHT resigned from employment. After OIG completed its investigation, OIG subsequently reported the employee's name and OIG's finding to the Health Care Worker Registry (HCWR), rendering the employee ineligible to be employed by an Illinois health care employer.

7421-0014 – OIG made a finding of egregious neglect where its investigation established that a physician failed to have a COVID-19 positive individual transported to the hospital when the individual experienced severe medical decompensation, and the physician failed to perform physical examinations of the individual over a 6-day period when the individual was a high-risk patient and medically compromised. The physician's neglect resulted in a serious deterioration of the individual's physical condition and contributed to the individual's death. Further, OIG substantiated neglect against two facility staff for knowingly violating facility policies by not wearing a face mask to prevent the spread of COVID-19. OIG concluded their willful failure to follow COVID-19 mitigation policies placed the health and safety of the individuals at the facility at substantial risk. OIG further recommended that the facility take action sufficient to ensure that all staff comply with the COVID-19 protocols in place at the facility as the evidence suggested a systemic compliance issue. In response to the finding, the facility reported that the physician retired before discipline could be administered, two facility staff were disciplined, and one staff resigned due to the staff's failure to wear any PPE. The facility further advised managers that they must monitor and discipline any known incidences of non-compliance and staff received regular emails advising them of COVID-19 protocols.

1120-0360 - OIG substantiated a finding of physical abuse where its investigation established that a Direct Service Provider (DSP) pushed an individual when the individual tried to elope from the home. The OIG recommended that the agency address its failure to ensure its staff were appropriately trained in the requirements of Rule 50 upon being hired and at least biennially thereafter, as one accused had not received Rule 50 training since 2017, and therefore was out of compliance. In response to the recommendation, the Agency retrained program supervisors to ensure their employees would be in compliance with Rule 50 training requirements. 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 reporting would render the employee ineligible to be employed by an Illinois health care employer—and that appeal is pending.

1622-0039 - OIG substantiated a finding of neglect where its investigation established that a van driver failed to check the vehicle they were driving after dropping off individuals at a day program, which resulted in an individual being left on a bus in dangerously high temperatures for approximately six hours. In response to the finding, the agency reported that the van driver quit in lieu of discharge.

4521-0041 - OIG substantiated two findings of neglect where its investigation established that a MHT inappropriately strapped the individual into a wheelchair for non-ambulatory reasons and a MHT Trainee (MHTT) saw the individual inappropriately strapped into a wheelchair but left the individual alone with the door closed. The individual subsequently slid down her wheelchair and was asphyxiated

by the seat belt around her neck. The individual was found unresponsive and required Cardiopulmonary Resuscitation to be resuscitated. In response to the finding, the facility reported the MHT received a 30-day suspension and the MHTT separated from the facility.

1022-0005 - OIG substantiated findings of neglect where its investigation established that two DSPs failed to provide line of sight supervision to an individual who went outside, unnoticed, through the hallway door and out to the patio area. While the individual was outside unsupervised, it is believed the individual had a fall after suffering a seizure. Secondary to the fall, the individual incurred a hematoma to the back of the individual's head and an abrasion to the individual's right elbow. Subsequently, the individual suffered heat stroke and incurred a large second degree burn to the left side of the individual's back due to being outside for over 50 minutes. OIG also recommended the agency address the employee's failure to report the allegation in a timely manner. In response to the finding, the two DSPs were terminated from the agency.

1022-0044 - OIG substantiated a finding of financial exploitation where its investigation established that for over a year, an employee repeatedly and inappropriately used funds from an individual's checking account to make unauthorized purchases for the employee's personal use, totaling over $500. OIG identified aggravating circumstances in the case as the employee failed to take responsibility for their actions and implausibly claimed that they made the unauthorized purchases unknowingly. Given the number of unauthorized purchases and the method of payment—a check signed by both the individual and the accused— OIG found that the DSP's acts were intentional and that the DSP was not fully forthcoming about their actions during their OIG interview. OIG recommended that the agency consider reviewing its policies and procedures regarding the use of individual's funds to ensure it had sufficient fraud controls in place given that the DSP was able to make unauthorized purchases, albeit in relatively small amounts, for over a year without being detected. In response to the recommendation, the agency agreed to review policies and procedures related to individual's funds to ensure fraud protection. The employee involved was terminated. 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 reporting would render the employee ineligible to be employed by an Illinois health care employer—and that appeal is pending.

2922-0011 - OIG substantiated a finding of sexual abuse where its investigation established that an MHT received foot massages from an individual on approximately 10 occasions and received shoulder massages from a second individual on approximately 10 occasions and a second MHT received neck and shoulder massages from two individuals on approximately three occasions. The back, neck and shoulder massages constituted acts of intimate physical contact, which is listed as a prohibited action under OIG regulations, separate from sexual contact, under the sexual abuse element**.** After OIG completed its investigation, one of the two employees filed an appeal regarding OIG's potential reporting of their name and the finding to the HCWR—which reporting would render the employee ineligible to be employed by an Illinois health care employer—and that appeal is pending.

1322-0025 - OIG substantiated a finding of neglect where its investigation established that a COVID-19-exposed DSP worked in a 24-hour CILA, overnight, contrary to agency, State and CDC guidelines. In addition, OIG substantiated a finding of neglect against the supervisor for knowingly allowing the DSP to work and for knowingly requesting a second employee to work in the CILA when the employee had possible exposure and subsequent symptoms of hand, foot and mouth disease, a highly contagious viral disease. OIG recommended that the agency take action sufficient to ensure all staff were appropriately trained in COVID-19 protocols, and that training records were maintained to document

these trainings as the agency was unable to provide training documents as requested by OIG. OIG noted that staff should have a complete understanding of relevant COVID-19 protocols, because absent such an understanding, the health and wellbeing of individuals and staff could be placed in jeopardy, as occurred in this case. The agency responded that it would retrain the DSP on COVID protocol, and the supervisor stepped down to a DSP and was to be retrained on COVID protocol. The agency further responded that it would modify DSP training expectations to include COVID protocols and that staff would be retrained on Covid-19 protocols once each quarter.

2917-0099 - OIG substantiated a finding of physical abuse where its investigation established an employee intentionally punched an individual in the ribs with his fist, fracturing two ribs. OIG referred this allegation to the Illinois State Police. After an investigation, the employee was criminally charged for his conduct. The employee pleaded guilty to misdemeanor Battery and received 12 months of probation, 50 hours of public/community service and one day of jail time. The employee resigned from the facility. After OIG completed its investigation, OIG 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.

6619-0018 - OIG substantiated a finding of neglect where its investigation established a facility physician placed an individual on a drug combination that caused increased risk of cardiac arrhythmias and the physician failed to conduct proper monitoring of the individual's health. OIG also substantiated neglect against the facility as the evidence reflected that it failed to convene a Treatment Review Panel to review the suitability of the individual's medications and failed to perform adequate 15-minute visual observations, that resulted in a delay in the individual's receipt of medical treatment. Although there was not a preponderance of evidence that these failures caused the individual's death, the physician and facility failures placed the individual's health and safety at substantial risk**.** In response to the report, the facility notified OIG that the doctor was no longer on contract at the facility; their policies were updated to require additional monitoring of an individual's health to ensure staff check for "signs of life" during rounding and the facility established a leadership staff role to ensure rounds are completed.

2920-0057 - OIG substantiated an allegation of physical abuse and mental abuse against a MHT based on its determination that the MHT slapped an individual on the side of their face, resulting in redness, and also told the individual to "shut the f--- up." 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 reporting would render the employee ineligible to be employed by an Illinois health care employer—and that appeal is pending.

1320-0297 - OIG substantiated a finding of neglect where its investigation established that a House Manager and DSP failed to provide adequate supervision to an individual when they failed to ensure that the individual had required 1:1 supervision during eating. As a result, the individual choked on food, which led to the individual's death. OIG's investigation further established that the agency failed to ensure that the individual received safe-eating coaching from staff and failed to ensure the individual received swallow studies that were physician ordered. OIG recommended that the agency ensure that Individual Service Plans (ISP) were current to address individuals' medical needs and ensure agency staff knew who was responsible for implementing those plans. In response to the findings and recommendations, the agency reported that it reviewed its policy to ensure clarity as to who is responsible for making sure that the ISP addresses all needs and that staff responsible understand. The

HM no longer works at the agency (unrelated to the incident) and the DSP was retrained on relevant policy.

6619-0082 - OIG substantiated a finding of physical abuse where its investigation established that a STA pushed an individual and slapped the individual's face and hand. OIG referred this allegation to the Illinois State Police. After the ISP investigation, the STA was criminally charged and convicted of misdemeanor Battery. OIG, upon completion of its administrative investigation, also recommended that the facility address the inaction of multiple employees to report the clear physical abuse that occurred in their presence; address the two employees who implausibly claimed they did not witness the physical abuse, which claim was contradicted by video evidence, and address one employee who failed to appropriately document the use of force, which OIG determined constituted an obstruction of OIG's investigation. In response to the findings, the facility informed OIG that one employee separated from the facility and disciplinary action was recommended against three employees. 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 reporting would render the employee ineligible to be employed by an Illinois health care employer—and that appeal is pending.

1620-0278 – OIG substantiated a finding of financial exploitation where its investigation established that a Qualified Mental Health Professional (QMHP) made 24 unauthorized cash withdrawals totaling $4,600 from an individual's account. OIG also recommended that the agency address a DSP's failure to report the allegation in a timely manner and further recommended that the agency take action to ensure funds are protected through the creation of policies and procedures. In response to the finding and recommendation, the agency reported that (1) the QMHP was terminated, (2) the DSP received a verbal reprimand for failure to report and was relieved of duties related to management of the program and no longer had authority regarding member financial accounts, and (3) policies and procedures regarding disbursement of member funds were revised to ensure individual funds are properly received and to prevent future financial exploitation. After OIG completed its investigation, OIG subsequently reported the QMHP to the HCWR, rendering the employee ineligible to be employed by an Illinois health care employer.

1620-0213 - OIG substantiated a finding of neglect where its investigation established that the agency failed to maintain required 1:1 supervision of an individual with PICA, which likely would have prevented the individual's ingestion of a latex surgical glove, which caused injury. OIG also recommended that the agency take action against three current employees who failed to respond to multiple OIG requests for an interview. In response, the agency noted that: (1) one employee left full time employment with the agency; and (2) two employees received counseling for failure to follow OIG rules and regulations and received additional training regarding abuse and neglect as well as other trainings.

1621-0254 - OIG substantiated a finding of physical abuse and mental abuse where its investigation established that a DSP hit an individual in the arm and yelled, "Shut the f--- up." OIG also recommended that the agency address a DSP's failure to timely report the allegation to OIG and address a DSP's failure to properly fill out an incident and injury report. In response to OIG's findings, the agency reported that the DSP was terminated and that the DSP who failed to timely report was retrained on Rule 50 and received a counseling memo to ensure the employee was aware of agency expectations with respect to completing forms. After OIG completed its investigation, OIG subsequently reported the DSP to the HCWR, rendering the employee ineligible to be employed by an Illinois health care employer.

1619-0030 - OIG substantiated a finding of neglect where its investigation established that an agency failed to properly secure a steak knife and an individual accessed the knife and stabbed multiple other individuals. More specifically, the evidence reflected that the agency failed to have a policy in place regarding securing sharp objects and hazardous items prior to this incident. In response to the finding, the agency reported that it had established precautions to prevent such an incident from happening again and further reported that the Behavior and Human Rights Committee approved locking up all knives and sharp objects.

1618-0512 - OIG substantiated a finding of neglect where its investigation established that a DSP failed to provide adequate 1:1 supervision, which allowed the unsupervised individual to seriously injure another individual, who required surgery for sustained injuries. OIG recommended the agency address its failure to timely report the allegation to OIG. In response to the finding and recommendations, the agency reported that the accused was terminated from employment and that the agency would ensure that internal investigations are conducted within the 4-hour time window to meet reporting requirements.

Chapter 7: Closing Remarks

A. IDHS OIG Chief Administrative Officer Jesse Escarpita

Upon becoming IDHS OIG's first Chief Administrative Officer in February 2022, one of my primary goals was to assess OIG's administrative and budgetary operations and to identify improvements that could be made in those operations. To make those assessments, I drew on my previous experience as a performance auditor at the City of Chicago OIG, where I evaluated the performance of City operations, as well as my private sector experience, where I managed the operations and budgets of large-scale commercial construction projects.

As I familiarized myself with IDHS OIG's processes and learned how those processes interacted with IDHS and State of Illinois procedures, I determined that OIG's biggest challenge was budget management. Historically, OIG has had minimal involvement in the creation or tracking of its budget, in part because OIG lacked a position that was specifically devoted to budgetary oversight. Rather, IDHS was primarily responsible for setting and adjusting OIG's budget on a year-to-year basis. In addition, for specific spending requests (e.g., travel, contracting, among others), OIG would rely on IDHS' budget team to determine whether OIG had sufficient funds to fulfill the request.

To address these budgetary challenges, I have begun to review, approve, and track all OIG expenditures. This includes tracking all OIG costs on a separate file and reconciling the costs with the monthly expenditure report OIG receives from Budget. Taking these steps will allow OIG to have a more accurate account of its expenditures and proactively identify which line items are at risk of going over budget and which line items are projected to come under budget. I have also begun to conduct periodic analysis of OIG's current and past budgets to determine whether OIG's budget has kept up with its operating needs and maintenance costs. For example, I identified that OIG's computer/IT budget has remained the same for the last 3 years, but IT equipment costs and headcount have increased significantly, meaning OIG would need additional resources just to maintain its existing levels of technology. In addition, I have started to reorganize and reallocate some budget line-item costs based on FY23 needs.

Perhaps most importantly, OIG has established consistent communication with the IDHS Budget personnel in order to gain insight into the budget-making process, to provide input as to how best to allocate OIG's existing financial resources, and, where appropriate, to advocate for additional resources. I am optimistic that through continual and open communication, OIG will be able to achieve its goals of increasing fiscal responsibility, using OIG's financial resources more efficiently and effectively, and moving toward the independent management of OIG's budget.

B. Inspector General Peter Neumer

A theme I have returned to repeatedly in IDHS OIG's recent annual reports is the necessity of independence. To ensure the long-term success of any Office of Inspector General, the Office must be free from external pressures as it engages in fact-finding and makes investigative determinations and programmatic recommendations.

It is important to note that in my three years as IG, I have never once felt the slightest pressure to modify a finding or alter the scope of an investigation or do anything other than root out abuse and neglect to the best of the Office's ability. That is a true testament to IDHS leadership, whose support is further evidenced by the 10 percent increase in headcount OIG received in FY22. That increase will not address all of OIG's resource challenges, but it is a notable step in the right direction.

However, the unfortunate truth is that there are ways that OIG could have pressure exerted upon it. Most notably, unlike certain other OIGs in Illinois, such as the City of Chicago OIG and the Tollway OIG, IDHS OIG does not have a budget floor in place. Thus, there is nothing in IDHS OIG's present statute that would prevent OIG from experiencing a significant budget reduction. It is for this reason that OIG proposed a legislative amendment in FY22 that would provide that OIG's budget could not be reduced by more than 10 percent (i) within any fiscal year or (ii) over the four-year term of any inspector general. The amendment further proposes that OIG's budget "be adequate to support an independent and effective office."

A passage from a 2013 report produced by Business and Professional People for the Public Interest, titled "Inspectors General and Government Corruption: A Guide to Best Practices and an Assessment of Five Illinois Offices," illustrates why a budgetary floor is important for OIG:

> Control over resources such as budget and staff is a critical aspect of independence, for whoever controls the budget and staff of an OIG can thwart not only individual investigations but an OIG's basic ability to perform its mission . . . . In addition to protecting an OIG from interference, such measures also ensure adequate funding. The concern that the OIG budget should be flexibly responsive to current needs can be addressed by other means, for example, by empowering the legislature to raise or lower the OIG budget in emergencies.

Being protected from interference is more important than ever for IDHS OIG because, as evidenced by the recent reporting on abuse and neglect at Choate Mental Health and Development Center, OIG's findings and recommendations are increasingly being cited in the media. This is generally a positive sign, as it demonstrates that OIG is being recognized as a credible source of information on matters of abuse and neglect. However, the fact that OIG's work-product is now receiving significant attention also means that initiatives like the budget-floor initiative are necessary so that OIG can be better insulated from any attempts to curtail the impact of its work.

With respect to the other above-identified pillar of independence—control over personnel decisions—OIG is also not ideally positioned. The general public may be surprised to learn that OIG only has complete hiring authority for 1 of its 89 positions. For all other positions, external, non-investigative entities play a material role in determining both who should be interviewed and who should be hired. Such outside involvement can slow down the pace of reform within OIG.

As an example, soon after I became IG in November 2019, I recognized that it was important for OIG to have a position devoted specifically to personnel and budget with program review responsibilities as well. I, therefore, sought to create a Chief Administrative Officer (CAO) position, which I was ultimately successful in doing. However, that position was not ultimately filled until February 2022, more than two years after I joined OIG, and more than a year after the position was first posted. In comparison, the Deputy Inspector General position, which is exempt from the standard hiring process, was posted and filled within 3 months.

During the short time that CAO Jesse Escarpita has been on staff, he has already identified budgetary resources we were not previously aware of and, drawing on his background conducting audits and program reviews, has made improvements to our site visit processes. I am thrilled about these advances but have to acknowledge my frustration that it has taken so long to begin this process in earnest.

Having been able to address a glaring need in terms of the CAO position, I next hope to advance OIG with respect to its root-cause analysis—namely, using the data and information collected in our site visits and thousands of investigations each year to make programmatic recommendations with the intent of not just rooting out bad apples, but changing existing systems that may contribute to abuse and neglect. OIG already makes recommendations arising out of its individual investigations, but the next step in that process is to identify trends that are occurring throughout the state and conduct a more holistic analysis that is applicable to more than just one facility or agency.

To advance in that direction, we are in the process of modifying and posting analyst positions. Given the current pace of State hiring, where positions can often take up to a year to fill, OIG has to temper expectations about how soon these changes will come about. However, when it comes to analytic progress for OIG, it is a matter of when, not if. And I am very excited about how OIG will be able to utilize these additional resources to better prevent and deter abuse and neglect.

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 DisabilitiesAdministrative 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 supportagency licensed or certified by a State agency other than the Department, unless operated by theDepartment 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."