

# LEGISLATIVE AUDIT COMMISSION



Program Audit  
Office of the Inspector General  
Department of Human Services

December 2008

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Springfield, Illinois 62706  
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**PROGRAM AUDIT  
OFFICE OF THE INSPECTOR GENERAL,  
DEPARTMENT OF HUMAN SERVICES**

**DECEMBER 2008**

**RECOMMENDATIONS - 10**

**IMPLEMENTED – 10**

**Background**

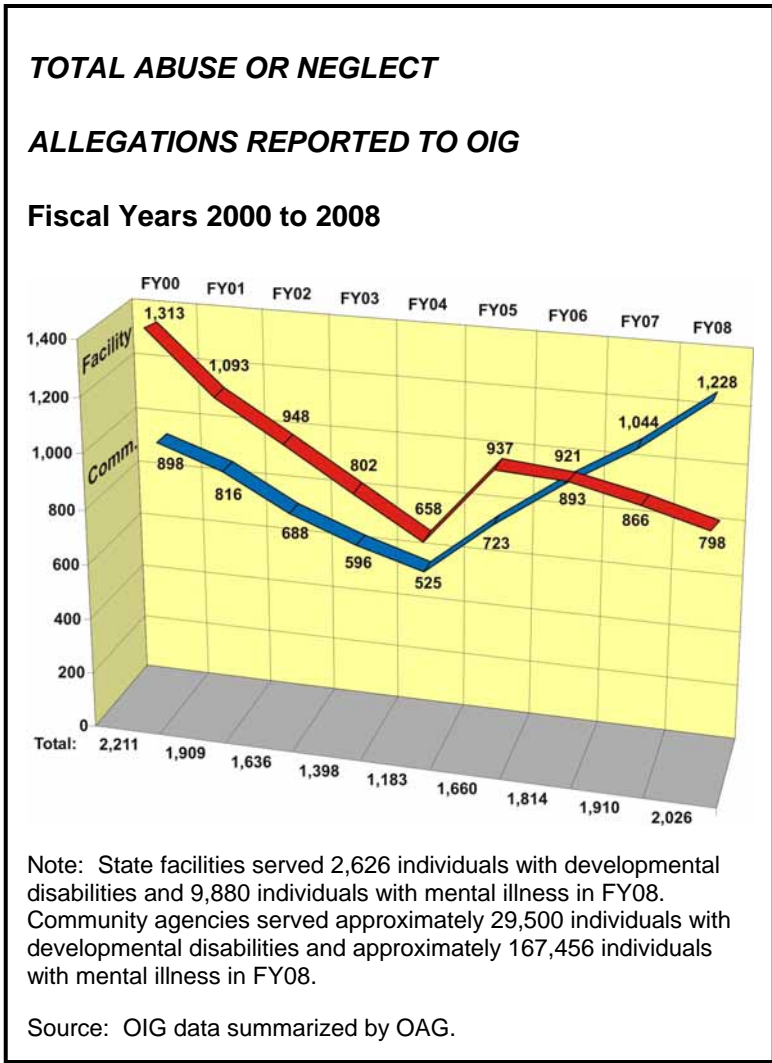
The Program Audit of the Office of the Inspector General, Department of Human Services was conducted by the Office of the Auditor General pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act. The Act states that the audit shall specifically include the Inspector General's effectiveness in investigating reports of alleged neglect or abuse and make recommendations for sanctions to DHS and the Department of Public Health. The Inspector General is appointed by the Governor and confirmed by the Senate for a four-year term. The current Inspector General is Dr. William Davis, and he has served as Inspector General since February 2006.

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

During FY08, the Department of Human Services operated 18 facilities statewide that served 12,506 individuals. Eight facilities served the developmentally disabled only, eight facilities served the mentally ill, and a dual facility which served both (Choate MHC and Choate DC). In addition, DHS licenses, certifies, or provides funding for 346 community agencies operating 3,672 programs providing services to individuals with developmental disabilities or mental illness in community settings within Illinois. These community agency programs provide transportation services, workshops, or community living arrangements. In FY08, approximately 29,500 individuals with developmental disabilities and approximately 167,456 individuals with mental illness were served in community agencies required to report to the OIG.

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



**REPORT CONCLUSIONS**

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

In this audit the auditors also reported that:

- The OIG made improvements in the timeliness of investigations since the last audit. However, 40% of investigations were not completed within 60 calendar days in FY08. Using the more lenient working days standard established in 2002, the OIG’s timeliness of case completion for FY07 and FY08 was similar to the previous audit.
- Although recommended in prior audits, the OIG has not added serious injuries to its investigative database.
- In response to a prior audit finding, the OIG revised its Checklist for Notification to Illinois State Police/Local Law Enforcement to include the date and time of the

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determination that credible evidence existed that would require reporting. However, in a few cases which were reported to the State Police, this new Checklist was not used.

- In 17 of the 117 (15%) cases sampled where an assignment date could be determined, the case was not assigned to an investigator within the required one working day.
- In FY08, 7% of alleged incidents of abuse or neglect at facilities and 25% at community agencies were not being reported within the four hours required by statute and OIG's administrative rules.
- For some community agency conducted investigations sampled, it was difficult to determine which bureau and investigator was responsible for reviewing the case.
- The Inspector General or his designee is not required to review substantiated cases of mental injury or neglect unless it is deemed "egregious" neglect.
- In 15% (six of 41) of the cases sampled, more than six months passed from the date the case was completed to the date when a written response delineating the corrective actions taken was submitted by the State facility or community agency and approved by DHS.
- DHS could not document that all staff at State-operated facilities received the required training in reporting abuse and neglect.

Even though two State-operated facilities, Tinley Park and Howe, were terminated from participation in federal program for non-compliance with issues related to patient safety and client protection, the OIG did not recommend a sanction against either facility. No Inspector General has recommended a sanction against any State-operated facility in the past 15 years.

In FY08, the OIG substantiated abuse or neglect in 262 of 2,107 closed investigations of incidents reported to the OIG. Six percent of the cases in facilities were substantiated, while 17% of the cases in community agencies were substantiated.

As of July 2008, the OIG had 61 employees, including three on leave. This represents an increase of one position from staffing levels reported in the FY06 audit. Investigative staff for abuse or neglect was 20 in FY08, which is comparable to staffing in FY02, FY04 and FY06.

According to Appendix A, the OIG closed 2,085 cases in FY07 and 2,107 cases in FY08. There are 18 allegation descriptions divided into three categories: abuse, neglect, and death. Almost 50% of all allegations are described as physical abuse without serious harm alleged. The percentage of allegations substantiated was 11% in FY07, and 12% in FY08. The percentage of allegations substantiated in FY08 at the individual DHS facilities varied from 0% at Mabley, Madden and Tinley Park to 43% at Fox for seven cases. Jacksonville had the greatest number of substantiated cases—eight, or 8%. A total of 212, or 17% of cases were substantiated from all the community agencies.

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**Recommendations**

- 1. The Office of the Inspector General should continue to consider adding serious injuries to its investigative database.**

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

However, the OIG continues to consider serious injuries without an allegation of abuse or neglect to be not reportable. Until FY03, these cases were reported and were investigated by the OIG even though there was no allegation of abuse or neglect. Then, the DHS Office of Legal Services determined that mandating agencies to report all serious injuries to OIG would first require a change in statute.

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

**Updated Response:** Implemented. OIG considered adding serious injuries to its database but chose instead to revise the law to clarify that serious injuries are reportable to OIG if abuse or neglect is alleged. HB 3844 was introduced on February 25, 2009, and it passed each house of the General Assembly by a unanimous vote, with final passage on May 19, 2009, and is pending Governor Quinn's signature. The definition of abuse specifies that it must be by (or at the direct instigation of) an employee.

- 2. The Office of the Inspector General should continue to work to improve the timeliness of investigations of abuse and neglect.**

**Findings:** The effectiveness of an investigation is diminished if it is not conducted in a timely manner. The OIG changed the definition of days in its administrative rules in January 2002 to be **working** rather than **calendar** days. Sixty working days generally works out to over 80 calendar days.

Timeliness of investigations has been an issue in all of the nine previous OIG audits. During this audit period, the OIG made improvements in its timeliness for completing investigations. In FY06, 52% of OIG investigations were completed in 60 calendar days. Timeliness improved in FY07 with 56% and in FY08 with 60% completed in 60 calendar days.

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In FY06, the average was 69 days and the median was 57 days. In FY07, the average was 67 days and the median was 50 days. In FY08, the average was 63 days and the median was 43 days.

<i>Exhibit 2-1</i>						
<b>CALENDAR DAYS TO COMPLETE ABUSE OR NEGLECT INVESTIGATIONS</b>						
<b>Fiscal Years 2003 to 2008</b>						
Days to Complete Cases	FY03 % of Cases	FY04 % of Cases	FY05 % of Cases	FY06 % of Cases	FY07 % of Cases	FY08 % of Cases
<b>0-60</b>	<b>30%</b>	<b>39%</b>	<b>55%</b>	<b>52%</b>	<b>56%</b>	<b>60%</b>
61-90	16%	11%	22%	19%	15%	13%
91-120	17%	10%	11%	14%	13%	13%
121-180	23%	20%	6%	11%	11%	11%
181-200	5%	5%	1%	2%	1%	0%
>200	9%	14%	5%	2%	3%	2%
<b>Total &gt; 60 days</b>	<b>70%</b>	<b>61%</b>	<b>45%</b>	<b>48%</b>	<b>44%</b>	<b>40%</b>
Total Cases	1,248	1,472	1,659	1,597	1,936	1,929
<p>Note: Analysis excludes cases investigated by the Illinois State Police. "Completed cases" shown in this Exhibit are cases where the OIG issued a Preliminary Report to the State facility or community agency in the fiscal year. "Closed cases," referred to later in this report, are cases where the OIG sent the final report to the Secretary of DHS in the fiscal year. Totals may not add due to rounding.</p> <p>Source: OAG analysis of OIG data.</p>						

With the more lenient working day standard, the OIG completed 76% of its FY05 cases and 71% of its FY06 cases within 60 working days. For FY07 and FY08, this remained steady as the OIG completed 71% and 72% of cases, respectively, when using the 60 working day standard.

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

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

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The OIG has also filled existing investigator vacancies and obtained more computers. For the 1,929 cases closed in FY08, 219 cases were completed by other bureaus. This represents a large increase over the 19 cases that were conducted by other bureaus during the previous audit in FY06.

<b>Exhibit 2-2 CASES WITH INVESTIGATIONS GREATER THAN 60 WORKING DAYS Cases Closed During FY08</b>			
<b>OIG Bureaus</b>	<b>Number of Cases Greater Than 60 Working Days</b>	<b>Total Cases Closed</b>	<b>Percent Greater Than 60 Working Days</b>
North	102	401	25%
Metro	327	508	64%
Central	25	493	5%
South	17	308	6%
Other <sup>1</sup>	69	219	32%
<b>Total</b>	<b>540</b>	<b>1,929</b>	<b>28%</b>
Note: <sup>1</sup> Other includes cases assigned to the Bureau of Domestic Abuse, Bureau of Hotline and Intake, or Clinical Coordinators. Source: OIG data summarized by OAG.			

**Cases Over 200 Days**

The number of OIG investigations taking more than 200 calendar days to complete between FY06 and FY08 has varied from 38 in FY06 to 66 in FY07 to 40 in FY08.

In FY08, the Metro Bureau continued to have the largest percent of investigations taking longer than 200 days with 53%. The other three bureaus ranged from 17.5% in the Central Bureau and 15% in the North Bureau to 2.5% in the South Bureau. For five of the 40 cases, a Clinical Coordinator was assigned primary investigative responsibility.

Of the 40 cases that took more than 200 days to complete, five of 40 (12.5%) were State operated facilities, while 35 (87.5%) were investigations of allegations at community agencies.

**OIG Response:** OIG agrees and will work to continue to improve. However, OIG is gratified that, as the audit report recognizes, we have significantly reduced

our time for completing abuse/neglect investigations, from an average of 53 days/case in FY06 to an average of 44 days/case in FY08, despite the ongoing increase in allegations and decrease in investigators.

**Updated Response:** Implemented. Despite the continuing fiscal constraints facing the State that limit OIG's ability both to hire investigators and to travel for conducting investigations, OIG again has an average in FY09 through eleven months of 44 days/case for Rule 50.

OIG further hired another registered nurse on contract beginning October 20, 2008, to help reduce the time required for completing death cases and investigations involving clinical issues.

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- 3. The Office of the Inspector General should maintain the necessary documentation to monitor referrals to the Illinois State Police. Monitoring should be in place to ensure that the referrals are timely as required by State law.**

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

**OIG Response:** OIG agrees. The investigative bureaus have been reminded to use the current version of the form. The bureau chiefs will continue to be responsible to monitor this form.

**Updated Response:** Implemented. OIG also created a database version of the law enforcement reporting form, implementing it on December 19, 2008. The form allows OIG investigative staff to complete the form faster since it automatically enters some information from the database, and it saves other information back to the database.

Further, OIG reiterated the importance of the OIG directive and form at a Leadership Team meeting on January 14, 2009, and also redistributed the relevant OIG directive and form to all OIG investigative staff on that date.

- 4. The Department of Human Services should comply with CMS rules and DHS policy by not renewing emergency appointments.**

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

The time to conduct investigations assigned to a Clinical Coordinator increased significantly from FY06 to FY08. In FY06, the average completion time for cases referred to the Clinical Coordinator was 66 days. For FY08, the average completion time for

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cases referred to the Coordinators was 119 days. In the review of cases that took more than 200 days to complete, five of 40 were assigned to Clinical Coordinators.

The OIG hired an additional Clinical Coordinator on a 60 day emergency basis in December 2007 and again in February 2008. In April 2008, a full-time Clinical Coordinator was finally hired.

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

**Updated Response:** Implemented. The Department of Human Services needed emergency assistance in the title PSA, particularly 37015-10-14-930-11-01 & Internal Security Investigator 2, 21732-101-14-700-21-01.

Once the initial (60) calendar day emergency appointment expired, emergency assistance was still required. The Illinois Central Management Services agreed to allow the agency to emergency appoint the two individuals to the same title a second time.

The agency has now ceased all consecutive emergency appointments.

The Department of Human Services is required to and will comply with Section 302.150 of the Personnel Rules regarding emergency and temporary appointments.

DHS will seek approval from the CMS for back-to-back appointments in unique or extenuating situations. Approval for back-to-back appointments will be reflected by the CMS signature/approval on the CMS-2.

**5. The Office of the Inspector General should assign all allegations to an investigator within one working day and complete all investigative plans within three working days as is required by OIG directives.**

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

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

**Updated Response:** Implemented. OIG sent an email reminder to all investigative leadership on November 30, 2008, reiterating the importance of meeting the OIG directives requirement for case assignment within one working day and investigative plans within three working days. During the January 14, 2009, Leadership Team meeting, OIG also reinforced the importance of timely case assignment and timely completion of the investigative plan.

**6. The Office of the Inspector General should continue to work with State facilities and community agencies to ensure that allegations of abuse or neglect are reported within the time frame specified in Department of Human Services Act and OIG’s administrative rules.**

**Findings:** Alleged incidents of abuse and neglect are not being reported by facilities and community agencies in the time frames required by statutes and the OIG’s administrative rules. The Department of Human Services Act requires that allegations be reported to the OIG hotline within four hours of initial discovery of the incident of alleged abuse or neglect. Community agencies continue to have a larger percentage of untimely reports in comparison to facilities. Exhibit 2-10 shows allegations of abuse and neglect not reported within four hours of discovery for State facilities and community agencies from FY05 through FY08.

- **Facility** – 7% of facility incidents were not reported within the four-hour time requirement in FY08 compared to 6% in FY06.
- **Community Agency** – 25% of community agency incidents were not reported within the four-hour time requirement in FY08 compared to 29% in FY06.

<b>Exhibit 2-10</b>		
<b>ALLEGATIONS OF ABUSE AND NEGLECT NOT REPORTED WITHIN FOUR HOURS OF DISCOVERY</b>		
<b>Fiscal Year</b>	<b>Facility</b>	<b>Community Agency</b>
FY05	6%	34%
FY06	6%	29%
FY07	5%	21%
FY08	7%	25%
Source: OAG analysis of OIG data.		

Several steps have been taken since the previous audit in order to improve the timeliness of reporting allegations of abuse and neglect. Effective June 13, 2006, Public Act 94-853 added a provision that states that a required reporter who willfully fails to comply with the

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reporting requirements is guilty of a Class A misdemeanor. According to OIG officials, the OIG is also citing late reporting more often when it does happen. OIG officials cited late reporting in 34 cases in FY06, 68 cases in FY07, and 175 cases in FY08.

**OIG Response:** OIG agrees. OIG has taken the following steps to reinforce timeliness of reporting:

- Notified the facilities and community agencies of the new law (P.A. 94-853) making intentional late reporting or failure to report a Class A misdemeanor;
- Re-issued to all facilities and community agencies a handbook, "Reporting and Investigating Abuse and Neglect of Adults with Disabilities," which emphasizes timely reporting;
- Ensured the DHS contracts with community providers includes the requirement for reporting and a mandate for at least biennial training of all staff in Rule 50;
- Reviewed all community agency internal policies on reporting to ensure that every one includes the time requirements in Rule 50;
- Maintained the database-generated "flags" on all new intakes, so investigators are notified of identified or potential late reporting when it occurs;
- Routinely cites late reporting in investigative reports, which requires the facility or community agency to submit a Written Response listing actions that will be taken to prevent recurrence and address problems identified;
- On a monthly basis, notifies the DHS divisions of facilities and community agencies that reported late; and
- Continues to conduct trainings of community agency staff, conducting 26 trainings with a total of 681 participants in Rule 50 during FY 2008 alone.

**Updated Response:** Implemented. In addition, during FY09, OIG conducted 27 trainings in Rule 50 with a total of 581 participants.

**7. The Office of the Inspector General should:**

- **ensure that review responsibility for all cases is clearly assigned and that all forms are completed and contained in the case file; and**
- **consider requiring that the Inspector General or his designee review all substantiated cases of abuse or neglect.**

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

### **Documentation of Case Monitoring and Review**

The OIG requires that case files contain case monitoring and review documentation. These are the Case Tracking Form and the Case Routing/Approval Form.

- **Case Tracking Form** - All case files sampled contained a Case Tracking Form as required by investigative directives. However, for two cases, although the tracking form was in the file, it had not been completed. The Case Tracking Form identifies information such as the case number, investigative agency, bureau, and allegation. Dates for when the investigative report was received, when it was reviewed, and when it was closed are all tracked on this form. It is also used to document the case finding and recommendations for action.
- **Case Routing/Approval Form** - After a case is submitted for review, the review progress is documented through the Case Routing/Approval Form. After each level of review, the reviewer signs and dates the form to indicate that the review has taken place and sends the case to the next level of review. On these forms, the reviewer can note when the case was sent to special review, clinical, legal, a consultant, or another office. Two of the 127 cases tested did not contain a Case Routing/Approval Form. Both of these cases were conducted by a community agency and the OIG Bureau of Hotline and Intake was responsible for the case review. In two other cases sampled the person assigned as the primary investigator to conduct the investigation also reviewed and approved the investigation on the Case Routing/Approval Form as the team leader and because these cases were not substantiated, there was no review or approval by the Bureau Chief.

### **Investigative Reports**

The OIG investigative reports tested from FY08 were generally thorough, comprehensive, and addressed the allegation. Once the investigator completes the investigative report, it is reviewed by management who must "sign off" on the case before a recommendation is sent to the facility or community agency. All of the cases we reviewed contained an investigative report.

### **Case Review**

The case file review process can vary depending on the type of case (facility or agency), whether the allegation is substantiated, and even what type of abuse or neglect was

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

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

**OIG Response:** OIG agrees. OIG has required all reviewing staff to ensure that the database reflects all receipt and completion dates for reviews. OIG is also developing new and more detailed database reports to monitor and evaluate review time. In addition, OIG will consider requiring that the Inspector General or his/her designee review all substantiated cases of abuse or neglect.

**Updated Response:** Implemented. The Deputy Inspector General's quarterly reviews, which examine cases that the OIG directive does not require his routine review, have identified no substantial issues. Thus, OIG considered but, on July 8, 2009, decided not to revise the directive. On that same date, OIG also implemented the case review monitoring reports.

OIG also recently completed a database report that will monitor case review time, which accounted for a significant portion of OIG's total investigative time during FY 2009.

### **8. The Office of the Inspector General should:**

- **continue to work to ensure consistency of investigations and recommendations; and**
- **consider clearly defining what constitutes physical injury and physical harm.**

**Findings:** During the previous audit, auditors concluded that there were inconsistencies between investigative bureaus related to how the bureaus classify findings. In addition, auditors found inconsistencies between what is and is not accepted by the Bureau of Hotline and Intake as an allegation of abuse or neglect. Additionally, OIG's four investigative bureaus (South, Central, Metro, and North) are decentralized. While substantiated cases of physical abuse, sexual abuse, or egregious neglect are reviewed by the Inspector General or his designee to ensure consistency, cases closed as substantiated mental injury, substantiated neglect, unfounded, or unsubstantiated are closed by the Investigative Team Leader (ITL) or Bureau Chief from each bureau and are not reviewed centrally.

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The OIG has taken steps to try to improve consistency in what constitutes a reportable allegation, and the classification of the outcome of cases as substantiated, unsubstantiated, and unfounded continues to be an area of concern at the OIG. During testing, the auditors identified cases that involved clients that were left unsupervised that had different outcomes. Below is a discussion of three of these cases.

Case #1 involves an individual served at a community agency, in which the individual was left alone at a day outing. Staff did not discover that the individual was missing until they had returned to the residence approximately 30 minutes later. The employee at the location of the day outing called the police upon discovering that the individual was separated from the group. The individual was taken to the police station, where she was picked up by agency staff. According to the intake narrative it was non reportable because “this incident did not rise to the level of neglect as described in Rule 50 (client suffered no harm or injury), and can be handled internally by the agency.” There was no information in the incident narrative regarding the individual’s level of functioning. The final outcome of the case was **Non Reportable**.

Case #2 involves an individual served at a community agency that was left alone for approximately three hours. The individual was at a day work program location for approximately two hours waiting for either a staff member to pick him up, or for a staff member to let him know that they had called a cab. Staff never picked him up or called a cab. The manager of his workplace called a cab after the individual had been waiting for approximately two hours. When the cab took the individual to his residence no one was there because the residents had all been moved to a different location due to staffing issues that day. The individual waited for an additional hour outside of his residence until another resident asked where he was. Then a staff member picked him up and took him to where the residents in his house were located. According to the intake narrative “due to the length of time [the individual] was left alone... and his inability to comprehend that he could have gone to the neighbors for help,” this was an acceptable allegation of abuse. According to documentation found in the case file, this individual functioned at a severely mentally retarded level. The final outcome of the case was **Unfounded with issues**.

Case #3 occurred at a State facility, and involved an individual who was found sleeping in her bed when she was supposed to be at her day training center. Upon medical examination she was found to have no signs of visible injury. The person reporting the allegation stated that the individual is assigned to same room supervision during bathing, toileting, and meals, and should not be left unsupervised because of her profoundly mentally retarded functioning level. The final outcome of the case was **Substantiated Neglect** because according to the case file report “it could have resulted in an injury.”

### **Definition of Physical Harm**

In the previous audit, the auditors found that there may have been different interpretations for the definition of physical harm. The OIG’s definition of abuse and

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neglect in its administrative rules include the term “physical injury.” Physical harm is not defined in the Department of Human Services Act or in Rule 50.

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

Effective August 28, 2007, Public Act 95-545 amended the Department of Human Services Act and the Abused and Neglected Long Term Care Facility Residents Reporting Act

transferring all provisions concerning the Office of the Inspector General within the Department of Human Services from the Abused and Neglected Long Term Care Facility Residents Reporting Act to the Department of Human Services Act. According to OIG officials, since the law was not substantially altered, Rule 50 was not revised.

**OIG Response:** OIG agrees in part. OIG will continue efforts to ensure consistency of investigative findings. OIG has defined physical injury in Rule 50 but maintains that the issue of defining physical harm would be resolved by revisions to the statute. Until the statute is revised, however, any change to Rule 50 would be premature. In the meantime, OIG will continue to reinforce that physical “harm” is a physical “wrong or injustice.”

**Updated Response:** Implemented. On February 25, 2009, a bill was proposed to include significant risk in the definition of neglect; this bill passed the General Assembly on May 19, 2009, and is awaiting the Governor’s signature.

OIG also has drafted a revision to Rule 50 that defines significant risk and bodily harm; the revision is pending approvals. Still, OIG has conducted two internal trainings with its investigators to ensure consistent understanding and application of the definitions.

<p>Exhibit 3-1 <b>DEFINITION OF PHYSICAL INJURY AND PHYSICAL HARM</b></p>
<p><u>Physical Injury</u> <b>Defined as physical harm to an individual caused by any non-accidental act or omission.</b></p>
<p><u>Physical Harm</u></p> <ul style="list-style-type: none"><li>• <b>Not defined in the Department of Human Services Act (20 ILCS 1305/1-17)</b></li><li>• <b>Not defined in 59 Ill. Adm. Code 50.10</b></li><li>• <b>Only defined in OIG Training Manual as a <u>WRONG OR INJUSTICE</u></b></li></ul>
<p>Source: OAG analysis of statutes, administrative rules, and training manual.</p>

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- 9. The Department of Human Services should ensure that written responses from facilities and community agencies are received and approved in a timely manner.**

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

It is the policy of the OIG to obtain, track, review, and monitor written responses for substantiated cases and for unsubstantiated or unfounded cases with recommendations. The Act requires that the OIG monitor any written response that takes more than 120 days to implement. However, this can only begin after the respective DHS division has approved the written response.

In a review of 127 case files, auditors identified 15 files that did not contain the required written response; however, auditors were able to obtain a copy of the written response from the OIG for all 15 files. For one case, the written response from the agency was dated November 9, 2007 but was not approved by DHS for over nine months on August 29, 2008. In another case, the agency date on the written response was September 9, 2008 and the DHS approved date was also September 9, 2008. However, the case was completed in August 2007.

Overall there were 43 cases in the sample that required a written response. Of the 41 cases in the sample for which auditors could determine an investigative completion date and a response date, six of 41 (15%) took more than six months from the date the case was completed until the written response was approved by DHS. Two of these cases took more than a year. For two cases, auditors could not determine the date the case was completed.

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

**DHS Response:** Agree. Beginning July 2008, an improved process was established which has significantly reduced the number of past due written responses and will continue to result in more timely receipt and review of written responses from community agencies. The receipt of written responses is being tracked and monitored, weekly review meetings are held and bi-monthly reports are used to ensure prompt review of all responses received. Reminder notices are being sent to developmental disabilities service providers to remind them of the written response development and submission expectations.

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**Updated Response:** Implemented. A written protocol was implemented May 8, 2009 outlining the process to track compliance regarding written responses for:

- a). Reporting and addressing incidents of alleged neglect,
- b). Deaths and certain other incidents to the DHS Office of the Inspector General in accordance with DHS Rule 59, Illinois Administrative Code 50.

DHS is tracking the substantiated cases of abuse and neglect via an excel spreadsheet to ensure written responses are received and approved in a timely manner.

**10. The Department of Human Service should ensure that all staff are consistently trained in abuse and neglect and at least once biennially and should maintain adequate documentation to show that the training has been conducted.**

**Findings:** DHS could not document that all staff at State-operated facilities received the required Rule 50 training. Employees at community agencies and State facilities are required to have Rule 50 training biennially.

Auditors requested information from DHS regarding whether all staff at State-operated facilities had received Rule 50 Training and received information from DHS that showed only management staff was being trained at three facilities (Jacksonville Developmental Center, Murray Developmental Center, and Shapiro Developmental Center). During the audit exit process, DHS provided additional information for these three facilities regarding abuse and neglect training that had been conducted. While the information provided showed that additional staff was trained, auditors were unable to determine whether all staff were being trained in abuse and neglect.

The OIG site visit for Howe Developmental Center reported that only 504 of the facility's 835 (60%) employees had been trained in OIG Rule 50 during the last year. For the third year, the OIG site visit for Tinley Park Mental Health Center reported that only 172 of the facility's 207 (83%) employees had been trained in OIG Rule 50.

The statute does not require the OIG to monitor compliance with training; it only requires that they establish and conduct training concerning prevention and reporting of abuse and neglect. According to OIG officials, the amount of resources that it would take to monitor compliance with Rule 50 training at the more than 350 community agencies would be prohibitive. However, beginning in FY09, training is now mandated through agency contractual agreements with DHS; the DHS divisions of Mental Health and Developmental Disabilities along with the Bureau of Accreditation, Licensure, and Certification are responsible for ensuring compliance with contractual agreements. For the State-operated facilities, the DHS DD division and the DHS MH division monitor training.

**DHS Response:** Agree. Developmental Disabilities staff are trained in abuse and neglect at least once biennially; however, at the time of this audit there was no system in

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place to track compliance from a central location. A new tracking system will be established by State Operated Developmental Center (SODC) Operations to ensure compliance with the OAG recommendation. The Bureau of Quality Management will also issue a notice to all community developmental disabilities providers reminding them of their responsibility to conduct training at least biennially. The Bureau of Quality Management will sample providers, in person and via paper audits, to verify that training in the reporting of abuse and neglect has been completed.

**Updated Response:** Implemented. The Bureau of Quality Management (BQM) has prepared a memo to remind all community agencies of the responsibility to conduct abuse and neglect report training at least once every two years.

DHS has implemented a process to sample community agencies adherence to the contractual training requirement through on-site review as they occur and documentation will be obtained. A sample of 20 community agencies that are not currently subjected to on-site reviews will receive a desk audit to check for adherence to the abuse and neglect training requirement.

The DHS Divisions of Mental Health and Developmental Disabilities are monitoring state operated facility compliance with the required abuse and neglect training standard.

The results will be reviewed on a quarterly basis and reported to management. Any facilities not meeting the 100% compliance biennially will have follow-up conducted.