HOUSE RESOLUTION

WHEREAS, The Department of Human Services (DHS), through its Office of the Inspector General (OIG), is responsible for investigating allegations of abuse and neglect that occur in mental health and developmental disability facilities and community agencies licensed, certified, or funded by DHS to provide mental health and developmental disability services operated by DHS; and

WHEREAS, The OIG is essential in assisting agencies and facilities in prevention efforts by investigating all reports of abuse, neglect, and mistreatment in a timely manner to foster humane, competent, respectful, and caring treatment of persons with mental and developmental disabilities; and

WHEREAS, In December 2024, the Office of the Auditor General released a report of the program audit of the OIG and DHS that covered FY21 through FY23; and

WHEREAS, The audit found significant problems with the quality of investigations being conducted by the OIG, causing misconduct allegations within DHS to increase and OIG to become slower to investigate complaints; this audit resulted in 12 recommendations, including improving the timeliness of investigation completion, involving interview procedure and

1 supervisory review, determining the OIG must fulfill statutory
2 requirements to appoint members to the Quality Care Board, and
3 declaring the OIG and DHS should work together to identify and
4 mitigate the bottlenecks in the hiring process and address pay
5 structure imbalances; and

6 WHEREAS, The timeliness of case file reviews has worsened
7 since the FY20 audit; during FY20, it took the OIG on average
8 41 days to complete a supervisory review of substantiated
9 cases; during this audit period, the average number of
10 calendar days to review substantiated cases for FY21 was 71
11 days, for FY22 was 66 days, and for FY23 was 86 days; case
12 investigations took an average of 205 calendar days to
13 complete during FY23 compared to an average of 180 calendar
14 days during FY20; and

15 WHEREAS, The Quality Care Board (the Board) is required to
16 monitor and oversee the operations, policies, and procedures
17 of OIG to ensure the prompt and thorough investigation of
18 allegations of neglect and abuse; the Department of Human
19 Services Act requires the Board to be composed of seven
20 members appointed by the Governor, with the advice and consent
21 of the Senate, and two members are required to be a person with
22 a disability or a parent of a person with a disability; and

23 WHEREAS, The OIG continues to show improvement in meeting

1 the statutorily required Board membership; for example, in
2 FY20, the Board had five members compared to having four
3 members in FY17; as of September 10, 2024, the Board's website
4 showed that there were seven members on the Board, meeting
5 statutory requirements, but three members were serving on
6 expired terms; and

7 WHEREAS, During the audit period of FY21 through FY23, the
8 OIG requested to hire for 38 positions; 17 positions had been
9 filled as of August 17, 2023, and 21 were still vacant; once
10 position requests were posted, two positions were filled
11 within three months, ten positions took between four and six
12 months to fill, and five positions took between seven and 12
13 months to fill after the hiring request was made; and

14 WHEREAS, The OIG has struggled to retain and recruit
15 employees to improve their efficiency as employees are
16 overloaded with work and vacancies require employees to take
17 on additional responsibilities; employees are so overwhelmed
18 with responsibilities that the DHS State-operated facilities'
19 5,024 employees accumulated 1,606,962 hours of overtime during
20 FY23; and

21 WHEREAS, The OIG officials stated that a lack of
22 investigators worsens timeliness, increases caseloads, and
23 creates detrimental effects on residents and employees; the

1 requirement for completing cases per OIG directives is 60
2 working days; during the audit period, the OIG completed 42%
3 of cases within 60 working day during FY23; however, there
4 were also 858 cases during the audit period that took 500 or
5 more days to complete; and

6 WHEREAS, The OIG cannot effectively carry out its
7 statutory mandate of investigating allegations of abuse and
8 neglect as these issues persist; the lower quality and longer
9 time an investigation is conducted, the more its usefulness is
10 diminished; all of the underlying issues must be effectively
11 addressed to allow the OIG to perform investigations of abuse
12 and neglect and fulfill their obligation which is imperative
13 to ensuring the safety of residents living within
14 State-operated facilities; therefore, be it

15 RESOLVED, BY THE HOUSE OF REPRESENTATIVES OF THE ONE
16 HUNDRED FOURTH GENERAL ASSEMBLY OF THE STATE OF ILLINOIS, that
17 we urge the Office of the Inspector General (OIG) and the
18 Department of Human Services (DHS) to review the audit
19 findings and implement the recommendations listed in a timely
20 and satisfactory manner; and be it further

21 RESOLVED, That we urge the OIG to work to improve the
22 timeliness of investigative case completion by identifying the
23 barriers that are preventing timely completion and seeking the

1 appropriate remedies for the issues identified and recommended
2 in the audit; and be it further

3 RESOLVED, That we urge the OIG to work with the necessary
4 entities relevant to strengthen its investigation process,
5 including State agencies such as the Illinois State Police,
6 the Department of Children and Family Services (DCFS), and the
7 Department of Public Health (DPH); and be it further

8 RESOLVED, That suitable copies of this resolution be
9 delivered to DHS and the OIG.