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Office of the Auditor General

Program Audit of the

Department of Human Services Office of the Inspector General

December 4, 2024

Frank J. Mautino
Auditor General

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OFFICE OF THE AUDITOR GENERAL
FRANK J. MAUTINO

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

This is our report of the program audit of the Office of the Inspector General, Department of Human Services.

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

The audit report is transmitted in conformance with Sections 3-14 and 3-15 of the Illinois State Auditing Act.

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

Springfield, Illinois
December 2024

OFFICE OF THE AUDITOR GENERAL

December 4, 2024
Performance Audit

Report Highlights

Frank J. Mautino *Auditor General*

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Program Audit of the

Department of Human Services Office of the Inspector General

Background:

The Department of Human Services Act (Act) directs the Auditor General to conduct a program audit of the Department of Human Services, Office of the Inspector General on an as-needed basis. Section 1-17(w) of the Act that establishes the authority for this audit can be seen in Appendix A. The Act specifically requires the audit to include the Inspector General's compliance with the Act and effectiveness in investigating reports of allegations occurring in any State-operated facility or community agency (20 ILCS 1305/1-17(w)).

The Office of the Auditor General has previously conducted 13 program audits of DHS OIG. The first audit was released in 1990 and the most recent in 2021, which covered FY18 through FY20. This audit covers FY21 through FY23.

Key Findings:

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

During FY23, there were a total 394 community agencies with 4,217 program sites that were under the investigative jurisdiction of the OIG. In addition, there were also 13 State-operated facilities under the investigative jurisdiction of the OIG. OIG investigators in many cases are responsible for hundreds of program sites covering large areas of the State, as well as State-operated facilities.

- The total number of allegations in FY21 (2,423) was the lowest number of allegations received since FY11 (2,255). However, the total number of allegations increased to 2,772 in FY22 and 3,281 in FY23. For FY11 through FY23, community agency allegations accounted for 59 to 73 percent of all reported allegations of abuse or neglect. For FY21, FY22, and FY23, community agency allegations accounted for 61 percent, 62 percent, and 59 percent of all reported allegations of abuse or neglect, respectively.
- Cases took an average of **205 calendar days** to complete during FY23, or an increase of 25 days, when compared to the FY20 audit.
- For FY23, 22 percent of cases were completed within 60 calendar days, which represents an 8 percent decrease in timeliness from the prior audit and a 14 percent decrease when compared to FY21 (36%) and FY22 (36%).
- The timeliness of case file reviews has worsened since the FY20 audit. During **FY20,** it took the OIG on average **41 days** to complete a supervisory review of substantiated cases. During this audit period, the average number of calendar days to review substantiated cases for **FY21** was **71 days**, for **FY22** was **66 days**, and for **FY23** was **86 days**.
- The Department of Human Services Act and the OIG's administrative rules require that allegations be reported to the OIG Hotline within four hours of initial discovery of the incident of alleged abuse or neglect. For FY21 through FY23, the percentage of allegations not reported within the statutorily required four hours for community agencies was between 15 and 16 percent. For State-operated facilities during the same time period, the number of allegations not reported within the four-hour time frame was between 7 and 10 percent.
- For FY21 through FY23, auditors found that 20 of the 42 (48%) unannounced site visit reports were sent outside of 60 days. No supporting documentation could be provided to show that an OIG employee was on site for the second unannounced site visit date at each State-operated facility for FY22 and FY23.

- During the audit period, FY21 through FY23, the OIG requested to hire for 38 positions. **Of these 38 hiring requests**, 17 positions had been filled as of August 17, 2023, and **21 were still vacant**. Once the position was posted, two positions were filled within three months, **ten positions took between 4 and 6 months to fill, and five positions took between 7 and 12 months to fill after the hiring request was made.**
- For FY23, DHS reported that **5,024** of **7,206 (70%**) State-operated facility employees had overtime. The **5,024** employees accumulated **1,606,962 hours of overtime during FY23**; **793** of these employees accumulated between **501 and 997 hours of overtime**, and **330** employees accumulated over **1,000** hours of overtime during FY23 (**318 of these 330 were employees with a direct care job title**). **These 318 employees accumulated a total of 443,527 hours of overtime during FY23**. Multiple academic studies have found that excessive amounts of overtime can have a detrimental effect on the care provided to residents or patients, as well as the health care workers providing the care.

Key Recommendations:

The audit report contains 12 recommendations including:

- The Office of the Inspector General should work to improve the timeliness of investigative case completion by identifying the barriers that are preventing timely completion and seeking the appropriate remedies for the issues identified.
- The Office of the Inspector General should work to improve the timeliness of OIG conducted interviews, and State-operated facility and community agency liaison conducted statements, including:
  - ensuring initial written statements are taken within 72 hours per OIG directive; and
  - ensuring the complainant and/or required reporter and the victim and/or guardian are interviewed by an OIG investigator within 15 working days of assignment per OIG directive.
- The Office of the Inspector General should ensure that investigations are reviewed by the Investigative Team Leader or Bureau Chief within fifteen working days of receipt absent extenuating circumstances as required by OIG directives.
- The Department of Human Services should ensure that all employees at State-operated facilities receive training in prevention and reporting of abuse, neglect, and exploitation as required by administrative rules, and the Department of Human Services Act (20 ILCS 1305/1-17(h)).
- The Office of the Inspector General should take steps to ensure that unannounced site visit reports are sent to State-operated facilities within 60 days of the site visit being completed as required by OIG Directive.
- The Office of the Inspector General and the Department of Human Services should work together to identify and mitigate the bottlenecks in the hiring process and address pay structure imbalances for management positions.
- The Department of Human Services should conduct a staffing analysis to determine if staffing levels at State-operated facilities are adequate. The staffing analysis should take into consideration the need to reduce excessive amounts of employee overtime, especially for direct care employees.

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

Report Digest

The Department of Human Services Act (Act) directs the Auditor General to conduct a program audit of the Department of Human Services (DHS), Office of the Inspector General (OIG) on an as-needed basis. Section 1-17(w) of the Act that establishes the authority for this audit can be seen in Appendix A. The Act specifically requires the audit to include the Inspector General's compliance with the Act and effectiveness in investigating reports of allegations occurring in any State-operated facility or community agency (20 ILCS 1305/1-17(w)).

The Office of the Auditor General has previously conducted 13 program audits that reviewed the OIG's effectiveness in investigating allegations of abuse and neglect. The first audit was released in 1990 and the most recent in 2021, which covered FY18 through FY20. This audit covers FY21 through FY23. Digest Exhibit 1 shows the current status of the recommendations from the previous audit. (pages 1, 9-11)

Digest Exhibit 1
STATUS OF OIG RECOMMENDATIONS FROM PRIOR AUDIT PERIOD

Rec. #	Subject	Current Status
1	Allegation Reporting	Repeated
2	Investigator Assignment	Repeated
3	Case Completion Timeliness Standards	Partially Implemented
4	Timeliness of Interviews and Statements	Partially Implemented
5	Timeliness of Supervisory Review	Partially Implemented
6	Case Tracking and Closure Forms	Repeated
7	DHS Approval of Written Responses (*Not a recommendation within this audit because of OAG Compliance Examination finding*.)	Repeated
8	Quality Care Board (OIG and DHS) (*Recommendation 7 within this audit*.)	Repeated
9	Investigator Training (*Recommendation 8 within this audit*.)	Repeated
10	Facility Prevention and Reporting Training *(Recommendation 9 within this audit.)*	Partially Implemented
11	Community Agency Prevention and Reporting Training	Implemented
12	Rule 50.30(f) Training	Not Repeated
13	Unannounced Site Visit Reports *(Recommendation 10 within this audit.)*	Partially Implemented
14	Community Agency Site Visits	Not Repeated
15	OIG Annual Reports	Not Repeated
16	OIG Data	Not Repeated

Note: See Exhibit 5 within report (page 9) for full description of Current Status.

Source: OAG summary of updated status of the FY18 through FY20 DHS OIG audit recommendations.

Background

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

State-Operated Facilities

A State-operated facility is a mental health facility or a developmental disabilities center operated by DHS. As of July 2023, there were 13 State-operated facilities, with one being a dual facility. Six of these facilities are mental health facilities, and six are developmental centers. Choate, located in southern Illinois, is both a mental health facility and a developmental disabilities center.

Digest Exhibit 2
UNDUPLICATED INDIVIDUALS SERVED IN STATE-OPERATED FACILITIES
FY10 through FY23

Year	Developmental Centers	Mental Health Centers	Total
FY10	2,485	10,237	12,722
FY11	2,279	9,469	11,748
FY12	2,037	8,960	10,997
FY13	1,918	6,829	8,747
FY14	1,854	6,762	8,616
FY15	1,798	5,709	7,507
FY16	1,897	5,459	7,356
FY17	1,878	5,109	6,987
FY18	1,853	4,587	6,440
FY19	1,881	4,319	6,200
FY20	1,891	3,863	5,754
FY21	1,761	3,397	5,158
FY22	1,859	3,587	5,446
FY23	1,875	3,827	5,702

Source: OIG annual reports.

The number of individuals served in State-operated facilities has decreased slightly since our last audit. In FY20, there were 5,754 individuals at State-operated facilities compared to 5,702 in FY23. However, since FY10, the total number of unduplicated residents at all facilities has declined by 55 percent. The number served at State mental health centers has decreased by 63 percent, and the number served at State developmental centers has decreased by 25 percent. Digest Exhibit 2 shows the number of unduplicated residents served at State-operated facilities for the period FY10 through FY23.

Community Agencies

A community agency is an agency that is licensed, funded, or certified by DHS to provide mental health services or developmental disabilities services, such as a CILA. Also falling under this category are programs licensed, funded, or certified by DHS to provide mental health services or developmental disabilities services, such as a day training program. (page 2)

OIG Organization

The headcount provided by the OIG shows the number of employees increased since our previous audit. As of June 30, 2023, the OIG had 85 employees, 11 of

these employees were contractual (7 of the 11 were part-time contractual employees). In the FY18 through FY20 OIG audit, auditors reported the OIG had 78 employees and 2 were contractual.

The five OIG investigative bureaus are organized by region. According to information provided by the OIG, as of June 2023:

- The **North Bureau** is responsible for three facilities (Elgin Mental Health Center, Kiley Developmental Center, and Mabley Developmental Center) and 860 program sites operated by 56 community agencies in 20 counties in northern and northwestern Illinois.
- The **Cook County Bureau** is responsible for two facilities (Chicago-Read Mental Health Center and Madden Mental Health Center) and 1,460 program sites operated by 172 community agencies in Cook County.
- The **Chicago Metro Bureau** is responsible for two facilities (Shapiro Developmental Center and Ludeman Developmental Center) and 395 program sites operated by 22 community agencies in five counties in the northeastern part of the State.
- The **Central Bureau** is responsible for three facilities (Fox Developmental Center, Packard Mental Health Center, and Alton Mental Health Center) and 964 program sites operated by 83 community agencies in 47 counties in the central part of the State.
- The **South Bureau** is responsible for three facilities (Chester Mental Health Center, Choate Mental Health Center/Developmental Center, and Murray Developmental Center) and 538 program sites operated by 61 community agencies in 29 counties in the southern part of the State.

Digest Exhibit 3 summarizes the five OIG investigative bureaus and the number of counties, facilities, agencies, program sites, and square mileage each is responsible for investigating.

Digest Exhibit 3
SUMMARY OF OIG INVESTIGATIVE BUREAUS AND RESPONSIBILITIES
As of June 30, 2023

OIG Bureau	Number of Investigators	Counties	Sq. Mileage by Bureau	State Facilities	Community Agencies	Program Sites
North	5	20	10,628	3	56	860
Cook County	7	1	946	2	172	1,460
Chicago Metro	7	5	3,391	2	22	395
Central	8	47	28,588	3	83	964
South	9	29	12,040	3[1]	61	538
Total	**36[2]**	**102**	**55,593**	**13**	**394**	**4,217**

[1] Includes Choate, which is a dual facility located in the South Bureau.

[2] Does not include three investigative staff who were on leave of absence as of June 30, 2023.

Source: OAG analysis and OIG data.

As of June 30, 2023, there were a total of 394 community agencies with 4,217 program sites under the investigative jurisdiction of the OIG. In the previous audit, auditors reported that there were 518 community agencies operating 4,401 programs. As is shown in Exhibit 3, OIG investigators in many cases are responsible for hundreds of program sites covering large areas of the State. For instance, the Cook County Bureau has seven investigators who are responsible for allegations reported for two State-operated facilities and 1,460 community agency program sites (**an average of 209 sites per investigator**). In the Central Bureau, eight investigators are responsible for three State-operated facilities and 964 community agency program sites across 47 counties, covering **28,588 square miles, which is 3,574 square miles per investigator**. (pages 4-7)

Trends in Reported Allegations of Abuse and Neglect

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

Digest Exhibit 4
ALLEGATIONS OF ABUSE AND NEGLECT REPORTED
FY11 through FY23

Year	Facility Allegations	Community Agency Allegations	Total
FY11	712	1,543	2,255
FY12	746	1,753	2,499
FY13	797	2,120	2,917
FY14	987	2,357	3,344
FY15	888	2,455	3,343
FY16	932	2,373	3,305
FY17	984	2,713	3,697
FY18	1,172	2,700	3,872
FY19	1,152	2,423	3,575
FY20	915	1,886	2,801
FY21	948	1,475	2,423
FY22	1,044	1,728	2,772
FY23	1,335	1,946	3,281

Note: Beginning in FY21, OIG included death reports as part of total allegations received in the annual reports. Death reports are not included in this exhibit in order to remain consistent with prior OIG audits.

Source: OIG annual reports and OIG data.

Digest Exhibit 4 shows the total number of allegations decreased in FY20 and FY21 before increasing again in FY22 and FY23. The total number of allegations in FY21 (2,423) was the lowest number of allegations received since FY11 (2,255). For FY11 through FY23, community agency allegations accounted for 59 to 73 percent of all reported allegations of abuse or neglect. For FY21, FY22, and FY23, community agency allegations accounted for 61 percent, 62 percent, and 59 percent of all reported allegations of abuse or neglect, respectively.

In March 2020, the Governor issued a Gubernatorial Disaster Proclamation for the COVID-19 public health emergency. The Disaster Proclamation ended on May 11, 2023. The COVID-19 public health emergency was in effect during the majority of the audit period and affected how the OIG conducted investigations due to the Stay-At-Home Order, and as reported in the FY20 audit, impacted allegation reporting as well. (page 15)

Timeliness of Reporting Allegations

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

Digest Exhibit 5
ALLEGATIONS OF ABUSE AND NEGLECT NOT REPORTED WITHIN FOUR HOURS OF DISCOVERY
FY21 through FY23

Fiscal Year	Facility	Community Agency
FY21	7%	16%
FY22	10%	15%
FY23	9%	16%

Source: OAG analysis of OIG data.

As shown in Digest Exhibit 5, for FY21 through FY23, the percentage of allegations not reported within the statutorily required four hours for **community agencies** was between 15 and 16 percent. For **State-operated facilities** during the same time period, the number of allegations not reported within the four-hour time frame was 7 percent during FY21, 10 percent during FY22, and 9 percent during FY23. There was a significant percentage of allegations for which auditors could not determine if the incident was reported within the required four hours. For **State-operated facilities**, the number of cases where timeliness could not be determined ranged from 18 percent in FY22 to 23 percent in FY23. For **community agencies** the number of cases where timeliness could not be determined ranged from 19 percent in FY21 to 25 percent in FY23. (pages 22-23)

Investigation Timeliness

The timeliness of OIG investigations is critical because victims may forget what happened or not be able to recount what happened consistently, physical evidence may become lost over time, and employees or alleged perpetrators may no longer be available for interviews because of either a change in jobs or termination. This includes timeliness of the assignment of the investigation, timeliness in conducting interviews, and timeliness of supervisory review. (page 25)

Timeliness of Assignment

For investigations closed and not referred to the Illinois State Police, local law enforcement, or initially determined to be non-reportable, 91 percent of FY21 cases (2,433 of 2,662) were assigned within three working days, 92 percent of FY22 cases (2,367 of 2,573) were assigned within three working days, and 93 percent of FY23 cases (2,519 of 2,704) were assigned within three working days. (page 25)

Timeliness of Investigations

OIG directives state that the OIG **strives to complete investigations in 60 workdays**; however, the directive on conducting investigations requires the Investigative Bureau Chief to ensure investigations are completed within 60 days from assignment absent extenuating circumstances. Generally, 60 working days works out to over 80 calendar days. For consistency with prior audits, auditors will continue to report timeliness in both calendar and working days so that comparisons can be made over time.

Digest Exhibit 6
CALENDAR DAYS TO COMPLETE ABUSE AND NEGLECT INVESTIGATIONS
FY21 through FY23

Days to Complete Cases	Percentage of Cases Completed FY21	FY22	FY23
0-60 Days	**36%**	**36%**	**22%**
61-90 Days	14%	17%	20%
91-120 Days	9%	10%	14%
121-180 Days	10%	11%	14%
181-200 Days	2%	3%	3%
>200 Days	28%	24%	27%
Percent > 60 Days	**64%**	**64%**	**78%**
Total Cases Completed	**2,496**	**2,350**	**2,551**

Note: Totals may not add due to rounding.

Source: OAG analysis of OIG data.

Digest Exhibit 6 shows the percentage of cases completed in terms of ranges of the number of **calendar days** to completion for FY21, FY22 and FY23. Case completion is measured from the date the allegation of abuse or neglect is reported to the OIG to the date the investigative report is sent to the State-operated facility or community agency notifying them of the investigative outcome. For FY23, 22 percent of cases were completed within 60 calendar days, which represents an 8 percent decrease in timeliness from FY20 and a 14 percent decrease when compared to FY21 (36%) and FY22 (36%), as shown in Digest Exhibit 6. **Cases took an average of 205 calendar days to complete during FY23, or an increase of 25 days, when compared to FY20.** (pages 27-28)

Timeliness of Investigative Statements and Interviews

During fieldwork, a random sample of 50 investigations was selected for testing. As part of testing, the timeliness of statements taken and investigative interviews was reviewed.

OIG directives requires written statements to be taken by the **State-operated facility or community agency liaison immediately**, but no later than **72 hours** from the time the allegation was reported. However, during fieldwork testing, auditors found that for the 39 investigations where a victim could give a statement, 18 (46%) took over 72 hours. For the 41 investigations where an alleged perpetrator was available for a statement to be taken, 28 (68%) took over 72 hours to be completed.

The OIG updated their investigative directive on February 18, 2022, to include time frames for OIG investigators interviewing the complainant and/or required reporter and the victim and/or guardian. An OIG directive requires the OIG to interview the complainant and/or required reporter and the victim and/or guardian within 15 working days of case assignment. All other necessary interviews are to be conducted in a timely manner. Of the 39 investigations within our sample which had a victim who was verbal, 5 (13%) were not interviewed within 15 working days. The length of time for the interview to occur for these five cases ranged from 24 to 536 working days. Of the 33 investigations within our sample where a complainant was able to be interviewed, 5 (15%) were not interviewed within 15 working days. The interviews took place between 49 and 573 working days for these five cases.

There is no requirement in the OIG's directives for the time frame to interview the alleged perpetrator. However, OIG's directives do require the case to be completed within 60 working days unless there are extenuating circumstances.

Within the sample, auditors identified 10 investigations, which took the OIG over 60 working days to interview the alleged perpetrator. For these 10 cases, it took between 61 and 859 working days to interview the alleged perpetrator.

Conducting interviews quickly is essential in conducting effective investigations. As time passes, victims who have a developmental disability or mental illness may be more likely to forget what happened or be unable to recount what happened accurately. It may be more difficult to contact the complainant or required reporter, victims or their guardians, as well as witnesses, or perpetrators due to moving or a change in employment. (pages 32-33)

Timeliness of Supervisory Review and Approval

The timeliness of case file reviews has worsened since our last audit in FY20. During **FY20,** it took the OIG on average **41 days** to complete a supervisory review of substantiated cases. During this audit period, the average number of calendar days to review substantiated cases for **FY21** was **71 days**, for **FY22** it was **66 days**, and for **FY23** it was **86 days**.

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

OIG's database does not track cases that were sent back for additional investigation. Therefore, our analysis only shows the total calendar days from the date submitted for review until the Bureau Chief signed the case as reviewed. Improvements in the time it takes to review substantiated cases could have a substantial effect on the overall timeliness of case completion at the OIG. (page 34)

Thoroughness of Abuse and Neglect Investigations

Auditors randomly selected a sample of 50 closed investigations from FY23. The sample was weighted and stratified by OIG investigative bureau and by the number of closed community agency investigations and closed State-operated facility investigations. The results of testing are not projectable to the population.

OIG case reports auditors reviewed were generally thorough, comprehensive, and addressed the allegations. Case files contained interviews and witness statements, injury reports, pertinent medical records, and treatment plans, as well as photographs. (page 37)

Documentation of Case Monitoring and Review

In 5 of the 50 (10%) investigations sampled, the Case Tracking Form was not completely filled out. The section, which identified the accused party and the finding, was left blank. For 26 of the 50 (52%) investigations sampled, according to the Case Closure Checklist, it appeared that the Investigative Team Leader or Bureau Chief did not review the case file as required. Instead the initial reviewer either signed or initialed for the Bureau Chief, which circumvents the purpose of

the second review. For three investigations (6%), there was no signature or initials for the Investigative Team Leader or Bureau Chief, and for one investigation (2%), the Case Closure Checklist was not filled out. (page 39)

Quality Care Board

The Act establishes a Quality Care Board (Board) within the Office of the Inspector General. The Board is required to monitor and oversee the operations, policies, and procedures of the Inspector General to ensure the prompt and thorough investigation of allegations of neglect and abuse. The Act requires the Board to be composed of seven members appointed by the Governor with the advice and consent of the Senate. Two members are required to be a person with a disability or a parent of a person with a disability.

The Board did not meet the statutory requirement of having seven members during the audit period, and two members had been serving on expired terms. Statutory requirements regarding Board membership state that upon the expiration of each member's term, a successor shall be appointed; in the case of a vacancy in the office of any member, the Governor shall appoint a successor for the remainder of the unexpired term. The Board cannot fully function as directed by statute to "monitor and oversee the operations, policies, and procedures of the Inspector General" with vacancies and neglected membership requirements (20 ILCS 1305/1-17(u)). (pages 49-51)

Training

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

- *Establish a comprehensive program to ensure every person authorized to conduct investigations receives ongoing training relative to investigation techniques, communication skills, and the appropriate means of interacting with persons receiving treatment for mental illness, developmental disability, or both mental illness and developmental disability; and*
- *Establish and conduct periodic training programs for facility and agency employees concerning the prevention and reporting of any one or more of the following: mental abuse, physical abuse, sexual abuse, neglect, egregious neglect, or financial exploitation…Nothing in this section shall be deemed to prevent the Office of Inspector General from conducting any other training as determined by the Inspector General to be necessary or helpful.* (page 52)

Investigator Training

Auditors received training data for OIG employees, including hire date for new employees, the trainings completed, the date of each training, and each employee's job title for FY21, FY22, and FY23. Auditors found 6 of 9 (67%) newly hired investigative employees did not have documentation to support completion of the required new hire trainings.

Auditors also reconciled the training information provided for OIG employees required to have continuing training. During FY21, 7 of 61 (11%) OIG employees were missing between 1 and 7 trainings. During the prior audit, 5 of the 61 (8%) employees who were required to have continuing training in FY20 did not complete it, which is comparable to FY21. However, for FY22 and FY23, compliance with the required trainings was significantly worse. During FY22, 34 of 56 (61%) OIG employees did not meet the training requirements. These 34 employees were missing between 2 and 6 trainings. During FY23, 27 of 53 (51%) OIG employees did not meet the training requirements. These 27 employees were missing between 1 and 7 trainings. (pages 52-53)

Rule 50 Training

The OIG's administrative rules outline the training requirements for State-operated facility and community agency employees. This training is commonly referred to as "Rule 50 training." The OIG provides State-operated facilities and community agencies with Rule 50 training materials through PowerPoint presentations on the DHS website, and the community agency or State-operated facility provides the training for its employees. All employees at community agencies and State-operated facilities are required to have Rule 50 training upon being hired, and then at least biennially thereafter (59 Ill. Adm. Code 50.20(d)(2)).

The Act does not require the OIG to monitor compliance with training; it only requires that the OIG establish and conduct training concerning prevention and reporting of abuse and neglect. (pages 53-54)

Documentation provided by DHS showed that employees at State-operated facilities did not always receive the statutorily required Rule 50 training. The Division of Mental Health could not provide calendar year 2021 Rule 50 training at facilities; they could only provide an aggregate total for calendar years 2016 through 2021. **For that time period the overall percentage for compliance with Rule 50 training was 87 percent**. Compliance with Rule 50 training was provided for calendar years 2022 and 2023.

The information provided shows that none of the State-operated facilities reached 100 percent compliance with the Rule 50 training requirement for all three calendar years 2021 through 2023. Shapiro had the lowest completion percentage of the Developmental Centers (83% during CY22), and Madden had the lowest completion percentage of the Mental Health Centers (94% during CY23). Auditors could not determine the completion percentages for the Mental Health Centers for calendar year 2021 for reasons explained previously.

In the prior audit, DHS officials stated that training on Rule 50 is required annually as a proactive measure to ensure that employees are well versed regarding Rule 50 and the expectations regarding treatment of and for residents/patients. Although the data provided shows that there was an improvement when compared to the prior audit period, employees at State-operated facilities are still not always receiving Rule 50 training annually, as required by DHS. Not ensuring that all State-operated facility employees receive

Rule 50 training on the prevention and reporting of abuse and neglect may put the health and safety of residents and patients at risk. (pages 53-55)

Unannounced Site Visits

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

The Inspector General reviews and approves the unannounced site visit report, and the approved report is sent to the State-operated facility. Report drafting, approval, and sending the report to the facility are required to be completed within 60 days of the unannounced site visit. (page 57)

Timeliness of Site Visit Reports

For FY21 through FY23, auditors found that 20 of the 42 (48%) reports were sent outside of 60 days. During FY21, unannounced site visits had to be conducted remotely because of the public health emergency due to COVID-19. For the FY22 and FY23 unannounced site visits, information received showed that there were two site visit dates for each site visit. However, no supporting documentation could be provided to show that an OIG employee was on site for the second site visit date at each State-operated facility. Additionally, for FY22 and FY23, there was an excessive amount of time that passed between the first and second site visit dates for numerous site visits. During FY22, **the second site visit date for all 14 site visits occurred between 36 and 177 days after the initial site visit, with an average of 100 days between the dates**. During FY23, **the second site visit date for the 14 site visits occurred between 37 and 149 days after the initial site visit, with an average of 95 days between the dates**.

It is important that unannounced site visit reports are delivered to State-operated facilities in a timely manner in order to rectify any issues that are identified as a result of the unannounced site visit as quickly as possible and to promote the safety and well-being of the residents living within the facilities. (pages 58-60)

OIG Staffing Issues

As shown in Digest Exhibit 7, during the audit period, FY21 through FY23, the OIG requested to hire for 38 positions. **Of these 38 hiring requests**, 17 positions had been filled as of August 17, 2023, and **21 were still vacant**. Once the position was posted, two positions were filled within three months, **ten positions took between 4 and 6 months to fill, and five positions took between 7 and 12 months to fill after the hiring request was made.**

Digest Exhibit 7
TIMEFRAME FOR OIG HIRING REQUESTS TO GO THROUGH HIRING PROCESS
FY21 through FY23 (As of August 14, 2023)

	0-3 Months	4-6 Months	7-9 Months	10-12 Months	Over 12 Months
OIG hire request to position posted date[1]	33	4	0	0	0
Position posted date to hire date[2]	2	10	3	2	0
Positions vacant from hire request date[3]	5	7	7	2	0

[1] One hire request, which was made on 04/06/23, was not posted as of 08/14/23.
[2] 17 positions had been filled as of 08/17/23.
[3] 21 positions remained vacant as of 08/17/23.

Source: OAG analysis of OIG hiring data.

OIG officials stated that multiple bureaus have lost headcount; if there is a lack of investigators, then timeliness worsens and caseloads increase. According to OIG officials, they are unable to hire investigators fast enough to maintain their headcount. Additionally, OIG officials explained that **in the near future, there will be Bureau Chiefs that will be making less than lead investigators because of the current pay schedule, and there are currently employees that are applying for demotions.**

Review of OIG Salary Data

Because of the concerns raised by OIG officials regarding an imbalance in pay structure between Investigative Team Leaders and Bureau Chiefs, auditors reviewed the calendar 2023 salaries for all OIG investigative staff. Digest Exhibit 8 shows that 5 of 8 Investigative Team Leaders were making more than at least one Bureau Chief. Of these, four were making more than 2 of the 3 Bureau Chiefs, and one was making more than all three Bureau Chiefs. Of the 37 Investigators in the analysis, 27 were making more than at least one of the Investigative Team Leaders, and two of these Investigators were also making more than 2 of the 3 Bureau Chiefs. (pages 61-63)

Digest Exhibit 8
ANNUAL SALARY COMPARISON OF OIG INVESTIGATIVE STAFF[1]
CY23

	Yes	No
Investigative Team Leader Annual Salary Higher than Bureau Chief	5	3
Investigator Annual Salary Higher than Investigative Team Leader	27	10
Investigator Annual Salary Higher than Bureau Chief	2	35

[1] For the 48 employees with available Comptroller salary information. There are **3** Bureau Chiefs, **8** Investigative Team Leaders, and **37** Investigators within this analysis.

Source: OIG headcount and Illinois Comptroller Employee Salary database.

DHS State-Operated Facility Issues

Auditors reviewed the overtime hours reported for DHS State-operated facility staff for FY23. DHS reported that 5,024 of 7,206 (70%) State-operated facility employees had overtime during this time period. The 5,024 employees accumulated 1,606,962 hours of overtime during FY23; 793 of these employees accumulated between 501 and 997 hours of overtime, and 330 employees accumulated over 1,000 hours of overtime during FY23 (318 were

employees with a direct care job title). The additional income from accumulating an excessive amount of overtime could create an incentive for employees to continue working overtime when they physically and mentally should not be working.

Multiple academic studies have found that excessive amounts of overtime can have a detrimental effect on the care provided to residents or patients, as well as the health care workers providing the care. Many of the potential consequences may be attributable to sleep deprivation, which is strongly associated with excessive overtime. Digest Exhibit 9 shows the 318 direct care employees with over 1,000 hours of overtime accumulated during FY23 by job title. The job titles which had the highest number of employees with overtime are Mental Health Technician I, Mental Health Technician II, Mental Health Technician III, and Security Therapy Aide I. These four job titles account for 253 of the 318 employees with over 1,000 hours of overtime, and represent 349,138 of the 443,527 (79%) total hours of overtime accumulated by these 318 employees. The job descriptions for these positions show that direct interaction with residents is their primary responsibility.

Digest Exhibit 9
DHS FACILITY DIRECT CARE EMPLOYEES WITH OVER 1,000 HOURS OF OVERTIME
By Job Title for FY23

Job Title	Number of employees	Total OT Hours	Avg Hrs/ Employee
Mental Health Technician II	146	205,035	1,404
Security Therapy Aide I	41	54,702	1,334
Mental Health Technician I	36	47,353	1,315
Mental Health Technician III	30	42,049	1,402
Security Officer	16	22,424	1,402
Mental Health Technician IV	14	21,918	1,566
Registered Nurse II	14	18,279	1,306
Security Therapy Aide II	7	10,733	1,533
Registered Nurse I	5	6,783	1,357
Rehabilitation Workshop Instructor I	2	2,355	1,178
Rehabilitation Workshop Instructor II	2	4,567	2,283
Habilitation Program Coordinator	1	2,058	2,058
Mental Health Specialist Trainee	1	1,123	1,123
Physical Therapy Aide III	1	1,112	1,112
Residential Services Supervisor	1	1,964	1,964
Security Officer Sergeant	1	1,072	1,072
Totals	**318**	**443,527**	**1,395**

Source: OAG analysis of DHS data.

On June 7, 2023, the OIG released a report titled "Reducing Abuse and Neglect at Choate Mental Health and Developmental Center." The report outlined several issues the OIG found while conducting their review of the State-operated facility including: staffing shortages; employee fatigue; inappropriate staff behavior,

such as mocking residents; lack of individualized treatment for residents; cover-up culture; obstacles to residents reporting allegations of abuse and neglect; staff non-reporting of misconduct; retaliation for reporting allegations of abuse and neglect, including fear of losing their job; and misreporting allegations of abuse and neglect. The OIG has not conducted a similar review on any of the other State-operated facilities. However, because there are a high number of allegations at several of the other State-operated facilities, it is likely that many of the issues discussed within the report on Choate are also occurring within these facilities as well. **The OIG does not have the statutory authority to address many of these issues, which are potentially contributing to the abuse and neglect of residents.** (pages 64-70)

Audit Recommendations

This audit report contains 12 recommendations. Eight are directed to the Office of the Inspector General, two are directed to the Department of Human Services, and two are directed at both OIG and DHS. The OIG and DHS agreed with the recommendations. Complete responses are included in this report as Appendix F.

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

SIGNED ORIGINAL ON FILE

JOE BUTCHER
Division Director

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

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

FJM:PMR

Contents

Recommendations

Contents

Introduction

The Department of Human Services Act (Act) directs the Auditor General to conduct a program audit of the Department of Human Services (DHS), Office of the Inspector General (OIG) on an as-needed basis. Section 1-17(w) of the Act that establishes the authority for this audit can be seen in Appendix A. The Act specifically requires the audit to include the Inspector General's compliance with the Act and effectiveness in investigating reports of allegations occurring in any State-operated facility or community agency (20 ILCS 1305/1-17(w)).

The Office of the Auditor General has previously conducted 13 program audits that reviewed the OIG's effectiveness in investigating allegations of abuse and neglect. The first audit was released in 1990 and the most recent in 2021, which covered FY18 through FY20. This audit covers FY21 through FY23.

Background

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

State-Operated Facilities

A State-operated facility is a mental health facility or a developmental disabilities center operated by DHS. As of July 2023, there were 13 State-operated facilities, with one being a dual facility. Six of these facilities are mental health facilities, and six are developmental centers. Choate, located in southern Illinois, is both a mental health facility and a developmental disabilities center.

Exhibit 1
UNDUPLICATED INDIVIDUALS SERVED IN STATE-OPERATED FACILITIES
FY10 through FY23

Year	Developmental Centers	Mental Health Centers	Total
FY10	2,485	10,237	12,722
FY11	2,279	9,469	11,748
FY12	2,037	8,960	10,997
FY13	1,918	6,829	8,747
FY14	1,854	6,762	8,616
FY15	1,798	5,709	7,507
FY16	1,897	5,459	7,356
FY17	1,878	5,109	6,987
FY18	1,853	4,587	6,440
FY19	1,881	4,319	6,200
FY20	1,891	3,863	5,754
FY21	1,761	3,397	5,158
FY22	1,859	3,587	5,446
FY23	1,875	3,827	5,702

Source: OIG annual reports.

The number of individuals served in State-operated facilities has decreased slightly since our last audit. In FY20, there were 5,754 individuals at State-operated facilities compared to 5,702 in FY23. However, since FY10, the total number of unduplicated residents at all facilities has declined by 55 percent. The number served at State mental health centers has decreased by 63 percent, and the number served at State developmental centers has decreased by 25 percent. Exhibit 1 shows the number of unduplicated residents served at State-operated facilities for the period FY10 through FY23.

Community Agencies

A community agency is an agency that is licensed, funded, or certified by DHS to provide mental health services or developmental disabilities services, such as a CILA. Also falling under this category are programs licensed, funded, or certified by DHS to provide mental health services or developmental disabilities services, such as a day training program.

Abuse Reporting Practices at Choate Mental Health and Developmental Center

On September 1, 2022, the Secretary of DHS, requested that the OIG conduct a special review of the resident abuse reporting practices at Choate Mental Health and Development Center. The OIG released the report on June 7, 2023. The interview-based review contained several recommendations for DHS regarding how Choate Mental Health and Development Center could potentially reduce abuse and neglect at the facility.

Issues identified in the OIG review included:

- repeated instances of Choate staff deliberately covering up misconduct that they either engaged in or witnessed;
- repeated instances of Choate staff failing to report misconduct;
- individuals and Choate employees experiencing retaliation and being threatened with potential harm for making reports; and
- a lack of accuracy and thoroughness regarding the allegations that are reported to the OIG or documented through the Choate incident reporting system.

The report included recommendations, such as increasing security by adding cameras inside the State-operated facility and reviewing staffing levels for front-line and supervisory staff.

The issues identified may not be unique to the Choate Mental Health and Developmental Center. In July 2023, a DHS official stated the Department had announced a broader review of every facility DHS operates as part of its response to the reporting on Choate. The issues identified may have a direct impact on the substantiation rates at State-operated facilities because investigation findings are based on evidence, including interview-based evidence provided by facility staff.

Public Act 103-0076 (Senate Bill 0855)

While the OIG was conducting the special review of Choate, Senate Bill 0855 was filed and later passed as Public Act 103-0076 on June 9, 2023. The Public Act amends the DHS Act by adding "**material obstruction of an investigation**" to the potential findings of an investigation (20 ILCS 1305/1-17(b) and (m)). Material obstruction of an investigation is defined in Public Act 103-0076 as the purposeful interference with an investigation of physical abuse, sexual abuse, mental abuse, neglect, or financial exploitation and includes but is not limited to:

- the withholding or altering of documentation or recorded evidence;
- influencing, threatening, or impeding witness testimony;
- presenting untruthful information during an interview; and
- failing to cooperate with an investigation conducted by the Office of the Inspector General.

Obstruction of an investigation is considered material when it could significantly impair an investigator's ability to gather all relevant facts.

A substantiated finding of material obstruction of an investigation is an offense reportable to the Health Care Worker Registry. Public Act 103-0076 prohibits State-operated facilities and agencies licensed, certified, operated, or funded by DHS from employing any person identified by the Health Care Worker Registry as the subject of a substantiated finding of physical abuse, sexual abuse, financial exploitation, egregious neglect, or material obstruction of an investigation. The Public Act also adds "**presenting untruthful information**" to the list of definitions.

The changes enacted by Public Act 103-0076 did not impact investigations from the audit period, since the effective date of the Public Act is in the last month of the audit period.

OIG Organization

The DHS Inspector General reports to the Secretary of DHS. Peter Neumer was appointed as the Inspector General in November 2019. On August 16, 2023, Neumer resigned from his position as the Inspector General, and Charles Wright became the Acting Inspector General. Wright previously held the position of Deputy Inspector General.

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

Exhibit 2 shows the number of employees by job title and the bureau to which they were assigned as of June 2023.

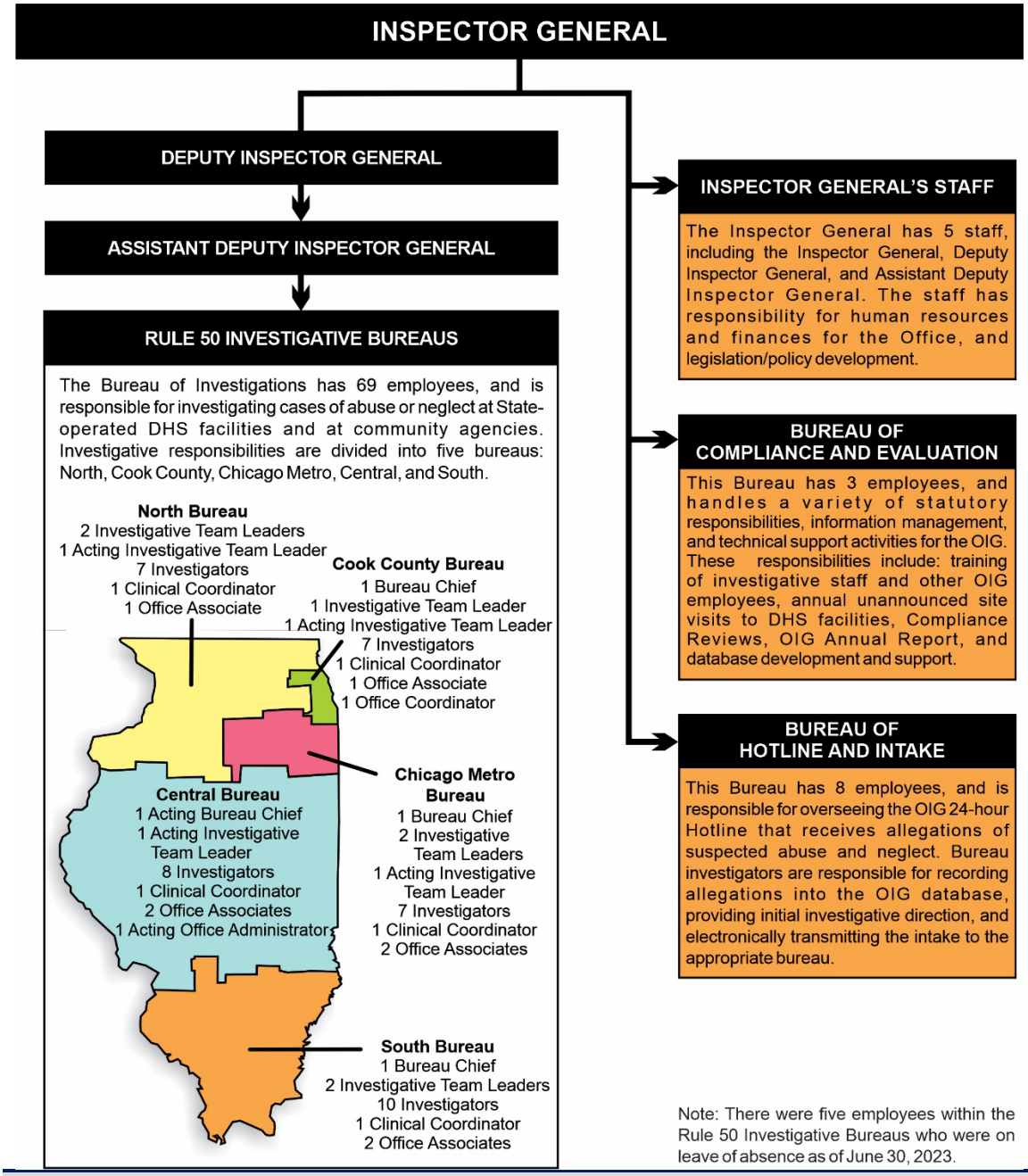
The headcount provided by the OIG shows the number of employees increased since our previous audit. As of June 30, 2023, the OIG had 85 employees, 11 of these employees were contractual (7 of the 11 were part-time contractual employees). In the FY18 through FY20 OIG audit, auditors reported the OIG had 78 employees and two were contractual.

The five OIG investigative bureaus are organized by region. According to information provided by the OIG, as of June 2023:

- The **North Bureau** is responsible for three facilities (Elgin Mental Health Center, Kiley Developmental Center, and Mabley Developmental Center) and 860 program sites operated by 56 community agencies in 20 counties in northern and northwestern Illinois.
- The **Cook County Bureau** is responsible for two facilities (Chicago-Read Mental Health Center and Madden Mental Health Center) and 1,460 program sites operated by 172 community agencies in Cook County.
- The **Chicago Metro Bureau** is responsible for two facilities (Shapiro Developmental Center and Ludeman Developmental Center) and 395 program

sites operated by 22 community agencies in five counties in the northeastern part of the State.

Exhibit 2
OIG ORGANIZATIONAL CHART
As of June 30, 2023



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

- The **Central Bureau** is responsible for three facilities (Fox Developmental Center, Packard Mental Health Center, and Alton Mental Health Center) and

964 program sites operated by 83 community agencies in 47 counties in the central part of the State.

- The **South Bureau** is responsible for three facilities (Chester Mental Health Center, Choate Mental Health Center/Developmental Center, and Murray Developmental Center) and 538 program sites operated by 61 community agencies in 29 counties in the southern part of the State.

Exhibit 3 summarizes the five OIG investigative bureaus and the number of counties, facilities, agencies, program sites, and square mileage each is responsible for investigating.

As of June 30, 2023, there were a total of 394 community agencies with 4,217 program sites under the investigative jurisdiction of the OIG. In the previous audit, auditors reported that there were 518 community agencies operating 4,401 programs. As is shown in Exhibit 3, OIG investigators in many cases are responsible for hundreds of program sites covering large areas of the State. For instance, the Cook County Bureau has seven investigators who are responsible for allegations reported for two State-operated facilities and 1,460 community agency program sites (**an average of 209 sites per investigator**). In the Central Bureau, eight investigators are responsible for three State-operated facilities and 964 community agency program sites across 47 counties, covering **28,588 square miles, which is 3,574 square miles per investigator**.

Exhibit 3
SUMMARY OF OIG INVESTIGATIVE BUREAUS AND RESPONSIBILITIES
As of June 30, 2023

OIG Bureau	Number of Investigators	Counties	Sq. Mileage by Bureau	State Facilities	Community Agencies	Program Sites
North	5	20	10,628	3	56	860
Cook County	7	1	946	2	172	1,460
Chicago Metro	7	5	3,391	2	22	395
Central	8	47	28,588	3	83	964
South	9	29	12,040	3[1]	61	538
Total	**36[2]**	**102**	**55,593**	**13**	**394**	**4,217**

[1] Includes Choate, which is a dual facility located in the South Bureau.

[2] Does not include three investigative staff who were on leave of absence as of June 30, 2023.

Source: OAG analysis and OIG data.

Exhibit 4 shows the locations of the five regional bureaus and the mental health and developmental centers.

- The **North Bureau** is located at Madden Mental Health Center with investigators located at Kiley Developmental Center, Elgin Mental Health Center, Mabley Developmental Center, and located within the city of Rockford.
- The **Cook County Bureau** is located at Madden Mental Health Center with investigators located at Madden and a DHS Teen Site.

- The **Chicago Metro Bureau** is also located at Madden Mental Health Center with investigators located at Madden, Ludeman Developmental Center, Elgin Mental Health Center, Shapiro Developmental Center, and a DHS Teen Site.
- The **Central Bureau** is located at Packard Mental Health Center with investigators located at Packard, and within the cities of Jacksonville, Mattoon, Alton, and Bloomington.
- The **South Bureau** is located at Choate Mental Health and Developmental Center with investigators located at Choate, within the city of Mt. Vernon, and Randolph, Madison, and St. Clair counties.

As of June 30, 2023, the OIG headcount data showed there were 43 investigative staff in the five investigative bureaus: North (8), Cook County (8), Chicago Metro (8), Central (9), and South (10). However, it is important to note that of these 43 investigative employees:

- five were part-time contractual (one of them was on a leave of absence);
- two were on a leave of absence; and
- four were in an acting supervisory position.

Each bureau has a Clinical Coordinator, and their primary job is to oversee death reviews and assist with investigations that involve medical issues. All of the investigative bureaus report to the Deputy Inspector General and Assistant Deputy Inspector General. Other bureaus at the OIG include:

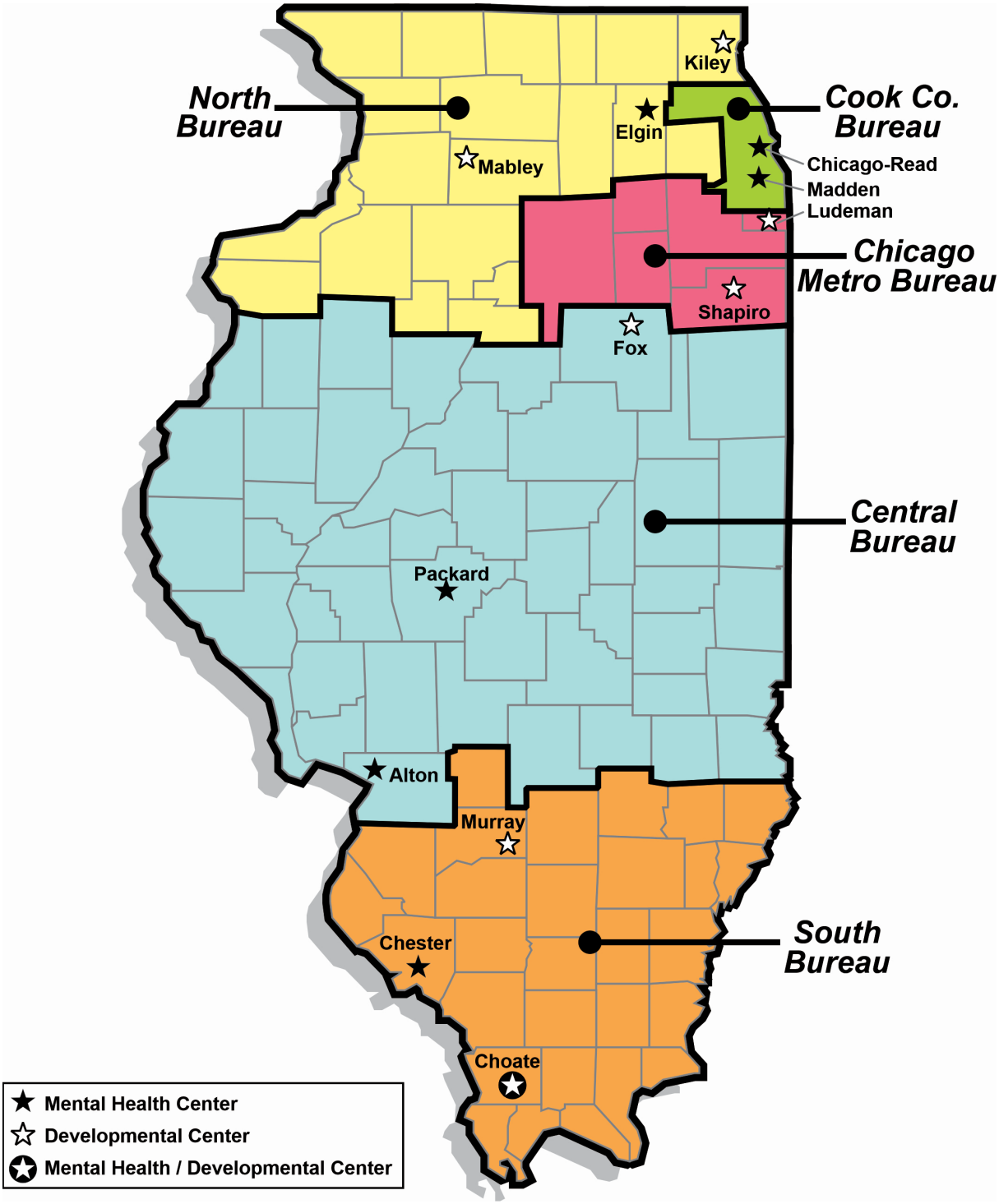
- **Bureau of Hotline and Intake:** Includes Hotline personnel who take calls reporting allegations of abuse or neglect. In June 2023, the headcount in this Bureau was eight, however, there were also four vacancies, including 2 investigators, 1 Investigative Team Leader, and 1 Bureau Chief.
- **Bureau of Compliance and Evaluation:** Includes functions such as statutory responsibility, information management, and training. The headcount in the Bureau of Compliance and Evaluation as of June 2023 was three.

In addition to the bureau staffing discussed above, the Inspector General has a staff of four employees (not including the Inspector General). The Inspector General's staff includes the Deputy Inspector General, the Assistant Deputy Inspector General, the Chief Administrative Officer, and the Policy Manager.

Investigations of Abuse and Neglect

The Office of the Inspector General is required by the Department of Human Services Act to investigate all reported incidents of suspected abuse, neglect, or financial exploitation at any State-operated mental health or developmental disability facility or any community agency licensed, funded, or certified by DHS (20 ILCS 1305/1-17). In addition to the requirements outlined in the statute, the OIG has promulgated administrative rules and established written directives that provide guidance regarding investigations.

Exhibit 4
DHS STATE-OPERATED FACILITIES AND OIG BUREAUS
As of August 9, 2023



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

Status of the Recommendations from the Previous Audit

The FY18 through FY20 audit of the OIG contained 16 recommendations: 13 to the OIG, 2 to DHS, and 1 to both DHS and the OIG. Exhibit 5 summarizes the status of each recommendation contained in the previous audit, as well as steps the OIG has taken to implement them. The recommendations noted as partially implemented or repeated are discussed in more detail later in this report.

Exhibit 5
STATUS OF OIG RECOMMENDATIONS FROM PRIOR AUDIT PERIOD

Rec. #	Subject	Current Status
1	Allegation Reporting	**Repeated.** For State-operated facility allegations, timeliness could not be determined for 23 percent of FY23 allegations, 18 percent of FY22 allegations, and 21 percent of FY21 allegations. For community agency allegations, timeliness could not be determined for 25 percent of FY23 allegations, 23 percent of FY22 allegations, and 19 percent of FY21 allegations.
2	Investigator Assignment	**Repeated.** For FY23, 7 percent of cases were not assigned to an investigator within three working days, for FY22, 8 percent of cases were not assigned within three working days, and for FY21, 9 percent of cases were not assigned within three working days.
3	Case Completion Timeliness Standards	**Partially Implemented.** Prior to this audit period, FY21 through FY23, DHS OIG held meetings with DCFS OIG Chief Labor Relations Administrator, as well as DHS' Labor Department. Labor facilitated multiple meetings with DHS OIG and AFSCME to discuss the addition of timeliness metrics similar to those in DCFS' directives. DHS OIG added some of these metrics into the Directives. DHS OIG also began holding Bureau meetings to focus on the completion of the oldest cases. During this audit period, 58 percent of cases were not completed within 60 working days during FY23, 48 percent of cases were not completed within 60 working days for FY22, and 50 percent of cases were not completed within 60 working days during FY21.
4	Timeliness of Interviews and Statements	**Partially Implemented.** OIG 50.30(f) training has been updated to direct initial statements to be gathered within 72 hours. During fieldwork testing, for investigations where a witness was identified, auditors found that 18 investigations took over 72 hours for a witness statement to be taken. For investigations with a verbal alleged victim, there were 5 investigations within the sample where the victim was not interviewed within 15 working days. There were also 5 investigations where the complainant was not interviewed within 15 working days. Lastly, there were 10 investigations within our sample in which a perpetrator was identified and it took over 60 working days to interview them.
5	Timeliness of Supervisory Review	**Partially Implemented.** OIG directives require the Investigative Team Leader or Bureau Chief to review cases within 15 working days absent extenuating circumstances. During this audit period, FY21 through FY23, it took 71, 66, and 86 calendar days to review substantiated cases, respectively.

Exhibit 5
STATUS OF OIG RECOMMENDATIONS FROM PRIOR AUDIT PERIOD

Rec. #	Subject	Current Status
6	Case Tracking and Closure Forms	**Repeated.** For 5 of 50 (10%) investigations sampled the Case Tracking Form was not completely filled out. For 26 of 50 (52%) investigations sampled it appeared that the Investigative Team Leader or Bureau Chief did not review the case file as required.
7	DHS Approval of Written Responses (*Not a recommendation within this audit because of OAG Compliance Examination finding*.)	**Repeated.** The Office of the Auditor General FY20 and FY21 Compliance Examination found that 4 of 21 (19%) investigations reviewed, the State-operated facility or community agency did not file the required written response within the 30 calendar day time frame allotted.
8	Quality Care Board (OIG and DHS) (*Recommendation 7 within this audit*.)	**Repeated.** The Quality Care Board did not meet the statutory requirement of having seven members during the audit period, and two members have been serving on expired terms.
9	Investigator Training (*Recommendation 8 within this audit*.)	**Repeated.** Auditors found that 6 of 9 (67%) newly hired investigative employees did not have documentation to support completion of the required trainings. Additionally, auditors found that for FY23, 27 of 53 (51%), for FY22, 34 of 56 (61%), and for FY21, 7 of 61 (11%) OIG employees did not have documentation to show they received the required training. According to OIG officials, OIG training and documentation is being transitioned to the DHS OneNet training system with the assistance of DoIT, but the OIG has not yet been able to use it to track new hire training.
10	Facility Prevention and Reporting Training *(Recommendation 9 within this audit.)*	**Partially Implemented.** Although data provided shows that there was an improvement when compared to the prior audit period, employees at State-operated facilities are not always receiving Rule 50 training annually, as required by DHS.
11	Community Agency Prevention and Reporting Training	**Implemented.** Auditors reviewed FY23 Rule 50 training information from the Division of Mental Health and found that DHS was monitoring mental health community agency employee compliance with training requirements. Auditors also reviewed a training report from the Division of Developmental Disabilities documenting FY21 through FY23 Rule 50 training for developmental disability community agency employees. Auditors found that DHS Division of Developmental Disabilities was monitoring community agency compliance with Rule 50 training requirements.
12	Rule 50.30(f) Training	**Not Repeated.** Information provided by the OIG showed that each State-operated facility had at least one 50.30(f) trained OIG Liaison during the audit period. The OIG also provided data showing the facility OIG Liaison employees were trained in Rule 50.30(f) during the audit period. Auditors did not request data for community agency OIG Liaison training because the requirement did not go into effect until April 4, 2023, which was three months prior to the end of the audit period.

Exhibit 5
STATUS OF OIG RECOMMENDATIONS FROM PRIOR AUDIT PERIOD

Rec. #	Subject	Current Status
13	Unannounced Site Visit Reports *(Recommendation 10 within this audit.)*	**Partially Implemented.** Auditors found that 64 percent of the FY23 site visit reports were not sent to the State-operated facility within the required 60-day time frame, and for FY22, 71 percent of the site visit reports were not sent to the State-operated facility within the required 60-day time frame. During FY21 unannounced site visits were conducted remotely because of the public health emergency due to COVID-19. Auditors found that all required officials were receiving the site visit reports.
14	Community Agency Site Visits	**Not Repeated.** DHS OIG's legal review of the recommendation concluded that conducting unannounced site visits at community agencies might not comport with the DHS Act because there are multiple governmental and non-governmental entities that are explicitly tasked with conducting site visits at community agencies, such as BALC, BQM, Equip for Equality, and several others. OIG has concern that the performance of site visits would be redundant of site visits already being conducted by other entities, and thus in violation of the letter and spirit of the DHS Act.
15	OIG Annual Reports	**Not Repeated.** OIG is including the timeliness of community agency cases compared to State-operated facility cases as part of their annual report. However, the OIG also stated that they cannot provide the annual abuse, neglect, and death allegations by community agency in a way that would be useful or actionable for a reader or consumer. OIG contacted the divisions of DD and MH and was informed that they do not maintain staff to individual ratios because the requirements vary considerably across settings.
16	OIG Data	**Not Repeated.** OIG has held discussions with staff about their responsibility to ensure accurate and timely entry of information into the database. OIG is currently working with DoIT to develop a new case tracking system. FY22 funds have been allocated for this purpose and outside developers have been sought to code and develop the new database. OIG is currently transitioning to DHS OneNet to initiate and track training and has provided staff with training in how to use this program. Additionally, the OIG hired a Chief Administrative Officer who is responsible for reviewing the OIG's training process.

Source: OAG summary of updated status of the FY18 through FY20 DHS OIG audit recommendations.

Administrative Code Requirements for OIG

The Inspector General is required to promulgate rules establishing minimum requirements for reporting allegations of abuse and neglect and initiating, conducting, and completing investigations (20 ILCS 1305/1-17(g)). The OIG rules generally contain the statutory requirements related to issues, such as reporting and other actions, but also contain more specific requirements for completing investigations.

Prior to May 26, 2017, the rules required investigative reports be submitted to the Inspector General within 60 working days from the assignment unless there were extenuating circumstances. **Changes to the rules removed the 60 working day requirement** from the OIG's administrative rules (59 Ill. Adm. Code 50.60). However, an OIG directive on conducting an investigation requires the Investigative Bureau Chief to ensure investigations are completed within 60 working days from assignment absent extenuating circumstances.

The OIG rules were updated on April 4, 2023, and some of these changes are discussed below. Since the audit period ended June 30, 2023, these did not impact the majority of the audit period. Auditors reviewed the changes and noted the more substantial changes below.

Definitions

The updated OIG rules contain additions to the definitions (59 Ill. Adm. Code 50.10), including:

- **OIG Liaison** – the community agency or State-operated facility staff who has been appointed to act as the OIG's investigative point of contact and who is responsible for coordinating the agency's or facility's initial incident response.
- **Referral** – OIG directing an OIG-received complaint to another entity for possible investigation or administrative action.

Reporting an Allegation of Abuse, Neglect, or Financial Exploitation and Death Reports

The training and technical assistance subsection includes additional requirements (59 Ill. Admin. Code 50.20(d)(3) & (4)). As of April 2023, each State-operated facility and community agency is **required to have a designated OIG Liaison**. Community agency or State-operated facility employees designated as OIG Liaisons or whose duties include completing the initial incident response as set forth in Section 50.30(f) are **required to take OIG's Section 50.30(f) training**. OIG State-operated facility and community agency Liaison 50.30(f) training is discussed later in this report.

Responsibilities of OIG for Intake Assessment

Section 50.30(f)(4) was updated to state the Authorized Representative of the involved community agency or State-operated facility or their designee shall unless otherwise directed by the OIG, initiate the preliminary steps of the investigation by a Section 50.30(f)-trained OIG Liaison.

Section 50.30(e) was also expanded to provide more specific guidance on circumstances in which the OIG may refer cases to another entity. The new information in Section 50.30(e) states:

- When an allegation concerns the actions of a community agency or State-operated facility employee, but the described conduct does not rise to the level of a reportable offense (e.g., an allegation that an employee was late to work), where appropriate, OIG shall forward the allegation to the appropriate authorized representative.
- When an allegation does not concern the actions of either a community agency or State-operated facility employee, the intake investigator shall transfer or refer the caller to the appropriate local, State, or federal agency or organization, as appropriate.
- When OIG has jurisdiction over an allegation, it may make a referral of that allegation to the involved State-operated facility or community agency where, among other factors:
  - the primary facts relevant to the allegation have been identified and additional investigative work by the OIG would be of minimal value;
  - the community agency or State-operated facility is better positioned to immediately address the allegation;
  - the allegation, if true, would be unlikely to result in a report to the Registry (e.g., mental abuse, non-egregious neglect); or
  - the allegation does not indicate an emergency situation or that an individual is in imminent danger.

OIG Procedures for Investigative Reports, Referrals, Reconsideration, and Clarification Requests

Section 50.60(b) on Referrals was added and states:

- with respect to allegations within the OIG's jurisdiction that the OIG refers to a community agency or State-operated facility, after the community agency or State-operated facility has completed its inquiry, the agency or facility shall notify the following parties:
  - the complainant;
  - the individual who was allegedly abused, neglected, or financially exploited or the legal guardian, if applicable; and
  - the person(s) alleged to have committed the offense.

Written Responses

Section 50.80(b) was added and states:

- with respect to allegations within the OIG's jurisdiction that the OIG refers to a community agency or State-operated facility**, the community agency or State-operated facility shall submit a written response on a prescribed**

form to the OIG and the respective DHS program division **within 45 calendar days** after the community agency or State-operated facility has completed its inquiry. The prescribed form will be sent to the community agency or State-operated facility. The written response shall address any action that the community agency or State-operated facility has taken or will take to protect individuals from abuse, neglect, or financial exploitation.

Trends in Reported Allegations of Abuse and Neglect

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

Exhibit 6
ALLEGATIONS OF ABUSE AND NEGLECT REPORTED
FY11 through FY23

Year	Facility Allegations	Community Agency Allegations	Total
FY11	712	1,543	2,255
FY12	746	1,753	2,499
FY13	797	2,120	2,917
FY14	987	2,357	3,344
FY15	888	2,455	3,343
FY16	932	2,373	3,305
FY17	984	2,713	3,697
FY18	1,172	2,700	3,872
FY19	1,152	2,423	3,575
FY20	915	1,886	2,801
FY21	948	1,475	2,423
FY22	1,044	1,728	2,772
FY23	1,335	1,946	3,281

Note: Beginning in FY21, OIG included death reports as part of total allegations received in the annual reports. Death reports are not included in this exhibit in order to remain consistent with prior OIG audits.

Source: OIG annual reports and OIG data.

Exhibit 6 shows the total number of allegations decreased in FY20 and FY21 before increasing again in FY22 and FY23. The total number of allegations in FY21 (2,423) was the lowest number of allegations received since FY11 (2,255). For FY11 through FY23, community agency allegations accounted for 59 to 73 percent of all reported allegations of abuse or neglect. For FY21, FY22, and FY23, community agency allegations accounted for 61 percent, 62 percent, and 59 percent of all reported allegations of abuse or neglect, respectively.

In March 2020, the Governor issued a Gubernatorial Disaster Proclamation for the COVID-19 public health emergency. The Disaster Proclamation ended on May 11, 2023. The COVID-19 public health emergency was in effect during the majority of the audit period and affected how the OIG conducted investigations due to the Stay-At-Home Order, and as reported in the FY20 audit, impacted allegation reporting as well.

OIG Investigation Process

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

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

For substantiated cases, the Investigative Team Leader or Bureau Chief is required to complete a Supervisory Review Checklist. Once the Bureau Chief reviews and approves a substantiated case of physical abuse, sexual abuse, financial exploitation, or egregious neglect, the report will then be sent to the Inspector General or their designee for review.

Investigations are to be completed within 60 working days of investigator assignment unless there are extenuating circumstances. **In May 2017, the 60 working day requirement and all case file requirements for investigations were removed from the OIG's administrative rules.** The requirement to complete cases within 60 working days is still included in the OIG's directives.

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

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

To begin the reconsideration process, the OIG sends notice of the outcome of the investigation to the complainant, the individual who was allegedly abused or neglected or their legal guardian, and the person alleged to have committed the offense. Any of these parties may submit, in writing, a request for reconsideration or clarification of the finding (59 Ill. Adm. Code 50.60). Requests for

reconsideration or clarification must be submitted within 15 calendar days after the receipt of the report or notification of the finding(s).

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

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

Death Reviews

The Act requires that absent an allegation of abuse or neglect, deaths are to be reported by phone to the OIG Hotline within 24 hours after initial discovery. This includes any death at a State-operated facility or community agency or any death occurring within 14 calendar days after discharge or transfer of an individual from a residential program or facility (20 ILCS 1305/1-17(k)(2)).

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

If the Clinical Coordinator determines that a death is not due to abuse or neglect, the Clinical Coordinator will notify the Bureau Chief and assume primary responsibility for the review. This includes conducting necessary interviews,

collecting relevant documentation, and completing the death report. For these cases, the Bureau Chief is also the final reviewer.

Health Care Worker Registry

If an investigation results in a substantiated allegation of physical abuse, sexual abuse, egregious neglect, or financial exploitation, the Inspector General is required by the Act to report the identity of the accused employee to the Health Care Worker Registry. The Health Care Worker Registry is discussed later in this report.

Sanctions

The Act and the OIG administrative rules allow the Inspector General to recommend to the Secretary of DHS that sanctions be imposed against State-operated facilities or community agencies to protect residents. The OIG may recommend sanctions, including termination of licensing, funding, or certification. If the Secretary of DHS issues a sanction, the Act allows the Inspector General to seek the assistance of the Attorney General or the State's Attorney for imposing sanctions (20 ILCS 1305/1-17(r), 59 Ill Adm. Code 50.70(g)).

The Inspector General has established a directive that specifies criteria regarding when to recommend sanctions to the Secretary of DHS. The directive includes procedures the OIG is to follow when recommending sanctions against an entity under the jurisdiction of the OIG. These procedures state that:

The Inspector General shall utilize the following criteria to make determinations about when to recommend sanctions to the Secretary of the Department of Human Services (DHS):

1. *A determination of imminent danger to the well-being of the individual(s);*
2. *A community agency or a State-operated facility has repeatedly failed to respond to critical recommendations made by the Inspector General that impacts the well-being of individuals served;*
3. *A community agency or a State-operated facility has failed to cooperate with an investigation;*
4. *Other instances deemed necessary by the Inspector General.*

According to Department officials, no sanctions were recommended nor implemented during the audit period.

Annual Report

The Office of the Inspector General is required by the Act to provide an annual report to the General Assembly and Governor by January 1 each year reporting investigatory work and other required functions, such as:

- a summary of reports and investigations made in the prior fiscal year for individuals receiving mental health or developmental disabilities services;

- the imposition of any sanctions;
- the disposition of any corrective or administrative actions directed by the Secretary;
- objective data identifying trends in the number of reported allegations;
- trends in the timeliness of OIG investigations;
- disposition of investigations for facilities and department-wide, for the most recent three-year period;
- direct care staff to patient ratios by facility; and
- detailed recommended administrative actions and matters for consideration by the General Assembly (20 ILCS 1305/1-17(v)).

Other State Agencies

While the Act requires the OIG to investigate abuse and neglect, other State agencies, including the Illinois State Police, the Department of Children and Family Services, and the Department of Public Health, also have statutory responsibility to investigate potential instances of abuse or neglect. The Act requires the OIG to promulgate rules that set forth instances where two or more State agencies could investigate an allegation so that OIG investigations do not duplicate other investigations (20 ILCS 1305/1-17(g)).

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

Illinois State Police

The OIG has an agreement with the Illinois State Police, which clarifies the reporting and investigative responsibilities of each agency. The agreement requires that upon determining a possible criminal act has been committed, the OIG is to immediately notify the Illinois State Police. The Illinois State Police is to notify the OIG within 15 working days if they are opening an investigation, or sooner when possible. The Illinois State Police is also required to inform the OIG of any allegations of abuse or neglect received within one working day.

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

Department of Public Health

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

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

The current interagency agreement between the OIG and DPH was executed in October 2022 and is set to expire on December 31, 2024. The agreement clarifies that:

- The OIG will refer allegations and reports of incidents received regarding DPH licensed long-term care facilities to the DPH Long-Term Care Residents Reporting Hotline; and
- DPH will refer all allegations and reports of incidents occurring at programs within DHS OIG's jurisdiction to the OIG.

Department of Healthcare and Family Services

The OIG has also entered into an interagency agreement with the Department of Healthcare and Family Services (HFS) for the purposes of sharing investigative information. Pursuant to the Intergovernmental Cooperation Act (5 ILCS 220), the OIG and HFS entered into an interagency agreement for the purposes of the OIG sharing information regarding investigative reports for Illinois residents enrolled in the Home and Community-Based Service Waiver for Adults with Developmental Disabilities. The purpose of the agreement is to facilitate HFS' access to OIG investigative reports regarding alleged incidents of abuse, neglect, financial exploitation, and death in order to comply with federal requirements, including the prevention of further incidents. The current agreement is set to expire December 31, 2024.

Timeliness of Reporting Allegations

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

For FY21 through FY23, the percentage of allegations not reported within the statutorily required four hours for **community agencies** was between 15 and 16 percent. For **State-operated facilities** during the same time period, the number of allegations not reported within the four-hour time frame was 7 percent during FY21, 10 percent during FY22, and 9 percent during FY23. There was a significant percentage of allegations for which auditors could not determine if the incident was reported within the required four hours. For **State-operated facilities**, the number of cases where timeliness could not be determined ranged from 18 percent in FY22 to 23 percent in FY23. For **community agencies** the number of cases where timeliness could not be determined ranged from 19 percent in FY21 to 25 percent in FY23.

Timeliness of Reporting Allegations

The Act and the OIG's administrative rules require that allegations be reported to the OIG Hotline within four hours of initial discovery of the incident of alleged abuse or neglect. Failure of a required reporter to comply is a Class A misdemeanor (20 ILCS 1305/1-17(k)).

Exhibit 7
ALLEGATIONS OF ABUSE AND NEGLECT NOT REPORTED WITHIN FOUR HOURS OF DISCOVERY
FY21 through FY23

Fiscal Year	Facility	Community Agency
FY21	7%	16%
FY22	10%	15%
FY23	9%	16%

Source: OAG analysis of OIG data.

Exhibit 7 shows allegations of abuse and neglect not reported within four hours of discovery for State-operated facilities and community agencies for FY21 through FY23. For FY21 through FY23, the percent of allegations not reported within the statutorily required four hours for community agencies was between 15 and 16 percent. For State-operated facilities during the same time period, the number of allegations not reported within the four-hour time frame was 7 percent during FY21, 10 percent during FY22, and 9 percent during FY23.

Timeliness Could Not Be Determined

Additionally, there was a significant percentage of allegations for which auditors could not determine if the incident was reported within the required four hours for FY21 through FY23.

Timeliness could not be determined because the incident discovered time/date field was reported as unknown, the incident time recorded was not specific (i.e. "ongoing", "during the day", or "evening"), or a time range was given. Also, the database did not contain one or more of the required date and time fields necessary to determine timely reporting for several cases. For the cases where a time range was given, the incident may have been reported timely, but the elapsed time could not be calculated accurately.

Exhibit 8
TIMELINESS OF REPORTING COULD NOT BE DETERMINED
FY21 through FY23

Fiscal Year	Facility	Community Agency
FY21	21%	19%
FY22	18%	23%
FY23	23%	25%

Source: OAG analysis of OIG data.

For State-operated facilities, the percentage of cases where timeliness could not be determined ranged from 18 percent in FY22 to 23 percent in FY23. For community agencies, the percentage of cases where timeliness could not be determined ranged from 19 percent in FY21 to 25 percent in FY23. (See Exhibit 8.)

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

Allegation Assignment

RECOMMENDATION NUMBER 1

The Office of the Inspector General should:

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

Office of the Inspector General Response:

OIG accepts the recommendation. OIG agrees obtaining accurate date and time information regarding when the incident occurred and was discovered is important to the investigation. Generally, when an intake contains vague date and time information, it is due to the caller being unable to provide more specific information. Many times, the caller is presenting 2nd and 3rd hand information, or the caller is the victim or an individual, who cannot provide such detailed information. OIG intake investigators are trained to gather as much specific detail from the caller about date and times as required by OIG's Directives which specifically requires that when a caller does not know or is unable to provide the specific date or time the incident occurred or was discovered, the Intake Investigator is to enter into the database whatever information the caller can provide regarding the occurrence date/time or discovery date/time (e.g., unknown, January 2020, between 1/19/20 and 1/20/20). If the caller did not discover the incident but knows the identity of the person who did, the Intake Investigator will enter that person's name into the database for follow-up by the assigned bureau Investigator. Because of OIG's training and the hard work of OIG intake investigators and supervisors, OIG is confident this is being done and when vague dates and times are entered into the database, this was all the information the caller was able to provide. OIG will continue training with Intake staff to attempt to gather as detailed information as possible.

OIG's Rule 50 training highlights the important four-hour time frame requirement for the reporting of allegations to the OIG hotline. Also, after the last audit, OIG sent out special memoranda to all State-operated Facilities (SOF) and community agencies (CA) about this requirement. However, ultimately, the timeliness of reporting depends on the SOF/CA staff and is outside OIG's control. In those cases,

OIG will continue to make appropriate recommendations about these issues to SOF/CA. OIG will continue to work with IDHS to ensure that SOFs and CA staff are aware of this important requirement through its trainings and recommendations.

Investigation Timeliness

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

For investigations closed and not referred to the Illinois State Police, local law enforcement, or initially determined to be non-reportable, 91 percent of FY21 cases (2,433 of 2,662) were assigned within three working days, 92 percent of FY22 cases (2,367 of 2,573) were assigned within three working days, and 93 percent of FY23 cases (2,519 of 2,704) were assigned within three working days.

During fieldwork testing of 50 investigations, auditors found that for the 39 investigations where a victim could be interviewed, 18 (46%) took over the 72-hour requirement to be completed. For the 41 investigations where an alleged perpetrator was available for a statement to be taken, 28 (68%) took over the 72-hour requirement to be completed.

The timeliness of case file reviews has worsened since the last audit covering FY18 through FY20. During **FY20,** it took the OIG on average **41 days** to complete a supervisory review of substantiated cases. During this audit period, the average number of calendar days to review substantiated cases for **FY21** was **71 days**, for **FY22** was **66 days**, and for **FY23** was **86 days**.

Timeliness of Assignment

The OIG should improve the timeliness of assigning cases to investigators. OIG directives require that once an allegation has been determined to fall under the OIG's jurisdiction, the Intake bureau is to process the allegation within two working days absent extenuating circumstances. The appropriate investigative bureau then has one working day to assign the case to an OIG investigator, making the required time frame to assign a case to an investigator three working days from the time an allegation was received.

For investigations closed and not referred to the Illinois State Police, local law enforcement, or initially determined to be non-reportable, 91 percent of FY21 cases (2,433 of 2,662) were assigned within three working days, 92 percent of FY22 cases (2,367 of 2,573) were assigned within three working days, and 93 percent of FY23 cases (2,519 of 2,704) were assigned within three working days. (See Exhibit 9.)

OIG officials stated that it is often unclear whether or not the allegation should trigger an investigation, which may cause a delay in assignment in some instances. Also, during the majority of FY21 through FY23, the Intake bureau was not answering live calls. The answering service would answer the call, and then an Intake investigator would return calls to gather more information before determining whether or not a case should be opened. Additionally, OIG officials stated that there have been ongoing staffing issues, which may have also contributed to the untimely assignment of cases.

Exhibit 9
TIMELINESS OF ASSIGNMENT BY FISCAL YEAR
FY21 through FY23

	FY21	FY22	FY23
0-3 days (timely)	2,433 (91%)	2,367 (92%)	2,519 (93%)
4-10 days	212 (8%)	195 (8%)	166 (6%)
11-20 days	13 (<1%)	6 (<1%)	11 (<1%)
21-50 days	4 (<1%)	1 (<1%)	5 (<1%)
51-100 days	0	3 (<1%)	1 (<1%)
> 100 days	0	1 (<1%)	2 (<1%)
Totals	**2,662 (100%)**	**2,573 (100%)**	**2,704 (100%)**

Source: OAG analysis of OIG data.

Not assigning cases in a timely manner may make it difficult for investigators to collect critical evidence as it may no longer be available. Delays could also result in not being able to interview possible victims or witnesses while their recollection of events is more easily remembered, as well as the possibility of not being able to interview the alleged perpetrator in a time frame that is reasonable.

Investigator Assignment

RECOMMENDATION NUMBER 2

The Office of the Inspector General should ensure that cases are assigned to an investigator within three working days upon receiving an allegation of abuse or neglect, as required by OIG's directives.

Office of the Inspector General Response:

OIG accepts the recommendation. OIG agrees that timely assignment of allegations is important to the investigation and appreciates the audit report highlighting that in each of the three years audited, OIG assigned over 90% of the over 2,500 cases received each year within the 3 day-requirement. Additionally, as documented by the auditors, OIG has had a serious lack of staff over the past several years. The Bureau of Hotline and Intake was no different which has a severe shortage of intake investigators and bureau management due to retirements and significant delays related to the hiring process. Unfortunately, the ongoing staff shortage has persisted as overall calls, including reportable and non-reportable calls, have increased. As of October 2024, OIG has 6 intake investigators, and 5 unfilled intake investigator positions that are in various stages of the hiring process. Also, since the last audit, OIG created and filled another Intake Investigative Team Leader position to supervise and complete intakes.

In addition, for a portion of reportable allegations, determining whether an intake is reportable takes more time than the time frame requirements of the directive due to the lack of information from the caller, call backs to gather needed information, difficulty reaching the caller, spending more time to gather needed information with the caller (like a victim or individual) etc. OIG's Directives notes that allegations will be processed within two days absent extenuating circumstances and as such, allows for additional time to determine whether an intake is reportable. OIG will continue to train Intake staff to

ensure they are asking for as detailed information as possible and will continue to seek additional staff in an effort to improve timeliness of assignment.

Timeliness of Investigations

The time requirement of 60 working days for completing investigations is currently only found in an OIG directive. Effective May 26, 2017, the OIG's administrative rules were amended to remove the requirement that investigative reports be completed within 60 working days. The 60-day requirement was also removed from the Case Management System Directive policy statement. The directive now states the OIG **strives to complete investigations in 60 workdays**; however, the directive on conducting investigations requires the Investigative Bureau Chief to ensure investigations are completed within 60 days from assignment absent extenuating circumstances. Generally, 60 working days works out to over 80 calendar days. For consistency with prior audits, auditors will continue to report timeliness in both calendar and working days so that comparisons can be made over time.

Exhibit 10
CALENDAR DAYS TO COMPLETE ABUSE AND NEGLECT INVESTIGATIONS
FY21 through FY23

Days to Complete Cases	Percentage of Cases Completed FY21	FY22	FY23
0-60 Days	**36%**	**36%**	**22%**
61-90 Days	14%	17%	20%
91-120 Days	9%	10%	14%
121-180 Days	10%	11%	14%
181-200 Days	2%	3%	3%
>200 Days	28%	24%	27%
Percent > 60 Days	**64%**	**64%**	**78%**
Total Cases Completed	**2,496**	**2,350**	**2,551**

Note: Totals may not add due to rounding.

Source: OAG analysis of OIG data.

Timeliness of investigations has been an issue in all 13 of the previous audits. For FY20, 30 percent of cases were completed within 60 calendar days with an average of 180 calendar days to complete an investigation. For FY23, 22 percent of cases were completed within 60 calendar days, which represents an 8 percent decrease in timeliness from FY20 and a 14 percent decrease when compared to FY21 (36%) and FY22 (36%), as shown in Exhibit 10. Cases took an average of 205 calendar days to complete during FY23, or an increase of 25 days, when compared to FY20.

Exhibit 10 shows the percentage of cases completed in terms of ranges of the number of **calendar days** to completion for FY21, FY22 and FY23. Case completion is measured from the date the allegation of abuse or neglect is reported to the OIG to the date the investigative report is sent to the State-operated facility or community agency notifying them of the investigative outcome. Data analysis was conducted on the entire population of cases closed in each of the fiscal years.

Exhibit 11
PERCENTAGE OF CASES COMPLETED WITHIN 60 WORKING DAYS BY BUREAU
FY21 through FY23

Bureau	FY21	FY22	FY23
Central	55%	52%	45%
Cook	45%	55%	49%
Metro	27%	41%	28%
North	70%	62%	44%
South	58%	53%	46%
Totals	**50%**	**52%**	**42%**

Source: OAG analysis of OIG data.

Exhibit 11 shows that overall, the North Bureau had the highest number of cases

completed within 60 working days for FY21 and FY22 (70% and 62% respectively), while the Cook Bureau was highest in FY23 (49%). The Metro Bureau had the lowest for all three fiscal years (27%, 41%, and 28%).

Overall, the OIG has improved their timeliness in completing cases within 60 working days when compared to the prior audit period, FY18 through FY20. The percentage of cases completed within 60 working days in FY18 through FY20 was 44 percent, 38 percent, and 45 percent respectively. This improved to 50 percent in FY21 and 52 percent in FY22 before decreasing to 42 percent in FY23.

According to OIG officials, the decrease in completion of cases in under 60 working days in FY23 was related to a number of complexities including:

- slow hiring beginning in FY22, and staff shortages which had a negative impact on the OIG's overall operations;
- year over year increase in cases; and
- focusing on the backlog of older cases, which can lead to delays in newer cases.

Trends in Number of Allegations and Case Completion Times

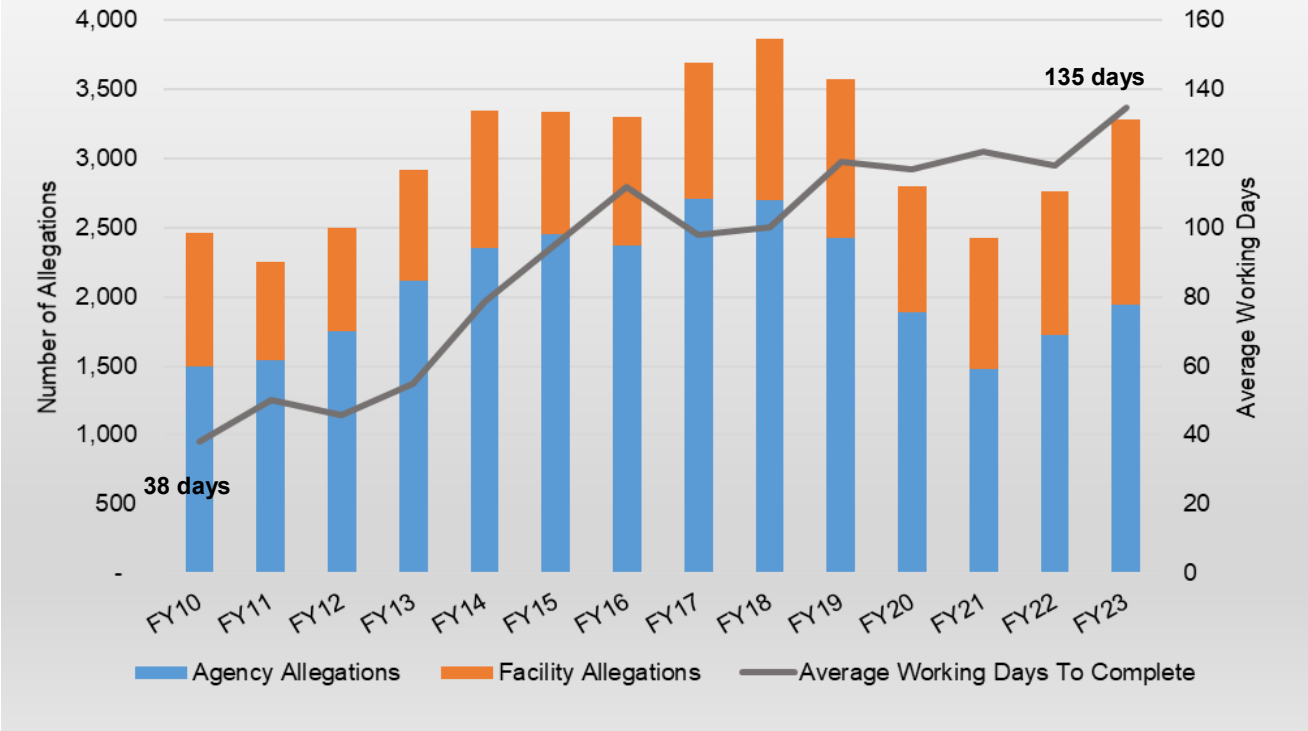
Exhibit 12 shows the total allegations by fiscal year as well as the average working days to complete investigations. Beginning in FY20, the total number of allegations of abuse and neglect declined when compared to prior years, before increasing again during FY23 to 3,281. During FY21, allegations dropped to under 2,500, which is the lowest number of allegations since FY10 through FY13. Excluding FY20 through FY22, the number of allegations have remained relatively steady since FY14, ranging from a low of 3,343 during FY15 to a high of 3,872 during FY18. During the audit period, community agency allegations have continued to be significantly higher than State-operated facility allegations. However, during FY23 there were 1,335 State-operated facility allegations, which is the highest number of State-operated facility allegations since at least FY10.

According to OIG data, the timeliness of completing cases has continued to decline. **During FY23, the OIG took an average of 135 working days (or 205 calendar days) to complete a case**. During FY23, the OIG's time to complete a case was more than double the 60 working day standard within the OIG's directives.

Exhibit 12 shows that for FY10 through FY19 there is a slight correlation between the increase in the number of allegations and the length of time it takes to complete a case. However, from FY20 through FY22, the correlation weakens because while the number of allegations declined during FY20 and FY21, completion timeliness remained steady (117 working days and 122 working days respectively). During FY22 there was an increase in allegations, but the case completion timeliness improved (118 working days). During FY23 there was an increase in allegations, and case completion timeliness decreased (135 working days). As mentioned in the previous section, OIG officials stated that they were facing numerous challenges, including delays in hiring new employees and staff

shortages. According to OIG officials, the delays in hiring during FY22 greatly impacted OIG operations during FY23.

Exhibit 12
AVERAGE WORKING DAYS TO COMPLETE INVESTIGATIONS AND TOTAL ALLEGATIONS
FY10 through FY23



Source: OIG annual reports FY10 through FY17; OIG data FY18 through FY23.

Investigations Taking More Than 200 Calendar Days to Complete

The number of OIG investigations taking more than 200 calendar days to complete remained steady throughout the audit period FY21 through FY23 and decreased when compared to FY20, which had 1,039 investigations taking over 200 calendar days to complete. Exhibit 13 shows that during FY21 there were 734 investigations that took over 200 calendar days to complete, while FY22 had 629, and FY23 had 730.

Although the total number of cases taking over 200 calendar days to complete has decreased since the last audit period, FY18 through FY20, the average completion time has increased significantly. For the 734 cases during FY21 that took over 200 days, **317 (43%) took 500 or more days to complete**. For FY22 cases, **275** of 629 **(44%) took 500 or more days to complete**, and for FY23 cases, **266** of 730 **(36%) took 500 or more days to complete**.

Exhibit 13
NUMBER OF CLOSED CASES OVER 200 CALENDAR DAYS TO COMPLETE BY TYPE OF ALLEGATION
FY21 through FY23

Type of Allegation	FY21	FY22	FY23
Neglect	301	300	301
Physical Abuse	275	180	240
Exploitation	31	29	25
Mental Injury/ Psychological Abuse	45	19	31
Sexual Abuse	21	18	29
Verbal Abuse	28	24	42
Death	33	59	62
Totals	**734**	**629**	**730**

Note: Analysis excludes cases investigated by the Illinois State Police.

Source: OAG analysis of OIG data.

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

Case Completion Timeliness

RECOMMENDATION NUMBER 3

The Office of the Inspector General should work to improve the timeliness of investigative case completion by identifying the barriers that are preventing timely completion and seeking the appropriate remedies for the issues identified.

Office of the Inspector General Response:

OIG accepts the recommendation. As documented by the auditors, there has been a shortage of investigative staff, investigative supervisors, and administrative support. This shortage impacts OIG processes at all stages of the investigative process, including case timeliness. OIG's staff shortage, together with the slow pace of hiring, has a direct impact on OIG's ability to complete timely investigations, which is an issue OIG highlighted in its FY23 Annual Report. Staff shortages result in growing case backlogs which further impact OIG's timeliness of case completion. OIG has worked closely with IDHS to increase headcount and is in the process of substantial additional hiring. However, it will take time for the new hires to make a noticeable impact on timeliness, as training takes time and significant effort from supervisory staff. OIG continuously reviews processes for timeliness improvements and training opportunities.

Clinical Coordinators

The OIG's Clinical Coordinators become involved in investigations that involve medical issues, as well as death cases. For cases that involve a medical issue, a Clinical Coordinator may be assigned to provide technical assistance to the primary investigator, or they may be involved with formulating an investigative plan and actively assist in the investigation. For death cases with no indication of abuse or neglect, the Clinical Coordinator assumes primary responsibility for the

review. As of June 30, 2023, the OIG had five Clinical Coordinators; however, two were contractual employees.

Death Reviews and Investigations

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

(i) Any death of an individual occurring within 14 calendar days after discharge or transfer of the individual from a residential program or State-operated facility;

(ii) Any death of an individual occurring within 24 hours of deflection from a residential program or State-operated facility; and

(iii) Any other death of an individual occurring at any community agency or State-operated facility or at any Department-funded site (20 ILCS 1305/1-17(k)(2)).

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

- Cases closed during FY21 included 199 death reviews and investigations (184 were assigned to a Clinical Coordinator, and 15 were assigned to investigative bureaus).
  - These 199 death reviews and investigations took on average 142 calendar days (97 working days) to complete.
  - Of these 199 death cases, 4 were substantiated neglect. The 4 substantiated neglect cases took an average of 565 calendar days (386 working days) to complete.
- Cases closed during FY22 included 237 death reviews and investigations (222 were assigned to a Clinical Coordinator, and 15 were assigned to investigative bureaus).
  - These 237 death reviews and investigations took on average 168 calendar days (114 working days) to complete.
  - Of these 237 death cases, 3 were substantiated neglect. The 3 substantiated neglect cases took an average of 642 calendar days (434 working days) to complete.
- Cases closed during FY23 included 188 death reviews and investigations (161 were assigned to a Clinical Coordinator, and 27 were assigned to investigative bureaus).
  - These 188 death reviews and investigations took on average 241 calendar days (163 working days) to complete.

- Of these 188 death cases, 14 were substantiated neglect. The 14 substantiated neglect cases took an average of 566 calendar days (382 working days) to complete.

OIG officials have previously stated that death cases can take longer to complete for several reasons, including:

- records from hospitals and medical examiners often take a long time to obtain;
- additional consultation may be needed;
- an allegation of neglect associated with the case;
- the cause of death;
- the location of the death (Chicago area vs. downstate); and
- the type of community agency or State-operated facility where the death occurred.

Timeliness of Investigative Statements and Interviews

During fieldwork, a random sample of 50 investigations was selected for testing. As part of testing, the timeliness of statements taken and investigative interviews was reviewed.

OIG directives requires written statements to be taken by the **State-operated facility or community agency liaison immediately**, but no later than **72 hours** from the time the allegation was reported. However, during fieldwork testing, auditors found that for the 39 investigations where a victim could give a statement, 18 (46%) took over 72 hours. For the 41 investigations where an alleged perpetrator was available for a statement to be taken, 28 (68%) took over 72 hours to be completed.

The OIG updated their investigative directive on February 18, 2022, to include time frames for OIG investigators interviewing the complainant and/or required reporter and the victim and/or guardian. An OIG directive requires the OIG to interview the complainant and/or required reporter and the victim and/or guardian within 15 working days of case assignment. All other necessary interviews are to be conducted in a timely manner. Of the 39 investigations within our sample which had a victim who was verbal, 5 (13%) were not interviewed within 15 working days. The length of time for the interview to occur for these five cases ranged from 24 to 536 working days. Of the 33 investigations within our sample where a complainant was able to be interviewed, 5 (15%) were not interviewed within 15 working days. The interviews took place between 49 and 573 working days for these five cases.

There is no requirement in the OIG's directives for the time frame to interview the alleged perpetrator. However, OIG's directives do require the case to be completed within 60 working days unless there are extenuating circumstances.

Within the sample, auditors identified 10 investigations, which took the OIG over 60 working days to interview the alleged perpetrator. For these 10 cases, it took between 61 and 859 working days to interview the alleged perpetrator.

Conducting interviews quickly is essential in conducting effective investigations. As time passes, victims who have a developmental disability or mental illness may be more likely to forget what happened or be unable to recount what happened accurately. It may be more difficult to contact the complainant or required reporter, victims or their guardians, as well as witnesses, or perpetrators due to moving or a change in employment.

Timeliness of Interviews and Statements

RECOMMENDATION NUMBER 4

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

- ***ensuring initial written statements are taken within 72 hours per OIG directive; and***
- ***ensuring the complainant and/or required reporter and the victim and/or guardian are interviewed by an OIG investigator within 15 working days of assignment per OIG directive.***

Office of the Inspector General Response:

OIG accepts the recommendation. OIG provides training and direction to State-operated Facilities (SOF) and Community Agencies (CA) about this important requirement. It should be noted the SOF/CA are also facing staff shortages which impacts their ability to complete this important task. OIG will continue to work with IDHS to provide more training and direction to improve these issues.

OIG agrees timely interviews of the victim(s) and complainant(s) are important to a good investigation. As documented by the auditors, the shortage of investigative staff has a direct impact on the ability for timely interviews. Recent staffing shortages have resulted in investigator caseloads growing significantly, making it challenging to complete interviews within the required time frame. OIG is in the process of hiring numerous investigators and supervisors, which is anticipated to improve interview timeliness over time. OIG will also continue to train investigators on this requirement and supervisors will continue to provide oversight and monitoring.

OIG also expects that an upcoming change in technology will help in this area. In 2025, OIG will have a new Case Management System which will better track and document when the investigator is unsuccessful in reaching the victim or complainant within the required time frames. Currently, these are documented in the Case Management System in the Case Actions.

Timeliness of Supervisory Review and Approval

The timeliness of case file reviews has worsened since our last audit in FY20. During **FY20,** it took the OIG on average **41 days** to complete a supervisory review of substantiated cases. Exhibit 14 shows that the average number of calendar days to review substantiated cases for **FY21** was **71 days**, for **FY22** it was **66 days**, and for **FY23** it was **86 days**.

Exhibit 14
AVERAGE CALENDAR DAYS FROM DATE SUBMITTED FOR REVIEW TO FINAL REVIEW
FY21 through FY23[1]

	Cases Substantiated			Cases Not Substantiated		
Bureau	**FY21**	**FY22**	**FY23**	**FY21**	**FY22**	**FY23**
Cook	42	54	107	16	11	29
Metro	59	48	96	18	16	33
North	36	31	67	7	6	22
Central	72	73	73	38	45	47
South	116	100	91	12	22	22
Avg.[2]	**71**	**66**	**86**	**19**	**21**	**31**

[1] Days may include time when the Bureau Chief or Investigative Team Leader sends the case back to the investigator for further investigation.

[2] Calculated as weighted average.

Source: OAG analysis of OIG data.

OIG directives require the Investigative Team Leader or Bureau Chief to review cases within 15 working days of receipt absent extenuating circumstances. For cases closed during FY23, 42 percent (1,061 of 2,551) were approved within 15 working days of submission. During our last audit in FY20, 70 percent (2,524 of 3,582) were approved within 15 working days of submission. This represents a 28 percent decline in timeliness. If the case is substantiated physical abuse, sexual abuse, or egregious neglect, the case is also reviewed by the Inspector General or his designee.

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

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

Timeliness of Supervisory Review	
RECOMMENDATION NUMBER 5	***The Office of the Inspector General should ensure that investigations are reviewed by the Investigative Team Leader or Bureau Chief within fifteen working days of receipt absent extenuating circumstances as required by OIG directives.***

Office of the Inspector General Response:

OIG accepts the recommendation. Shortage of investigative staff has impacted review timeliness as Bureau Chiefs and Investigative Team Leaders are working investigations, assisting with interviews, writing reports, and training new investigators, which takes them away from reviewing investigations. Additionally, due to a shortage of Investigative Team Leaders and Bureau Chiefs in various bureaus during the audit period, other bureaus had to pick up additional reviews, which delayed review times across the board. As of October 2024, OIG is currently at headcount for Bureau Chiefs and Investigative Team Leaders, but many supervisors are new and still learning the job. Unfortunately, the extended shortage of Bureau Chiefs and Investigative Team Leaders resulted in a backlog of case reviews that will affect overall timeliness for a considerable period of time. While Investigative Team Leaders normally handle unfounded and unsubstantiated case reviews, OIG's Bureau Chiefs, Investigative Team Leaders, Assistant Deputy Inspector Generals, Policy Manager, Deputy Inspector General, and Inspector General have all recently been assigned unfounded and unsubstantiated case reviews to keep cases moving along. Also, OIG will be revising and clarifying OIG's Directives to match OIG's current review practice, which gives the Investigative Team Leaders and Bureau Chiefs up to 15 workdays each to review an investigation upon receipt. The current directive, which indicates that they get a total of 15 workdays together from initial receipt, is incorrect.

Other Timeliness Issues

In addition to the timeliness issues discussed above, there are other factors that may affect the timeliness of case completion. Cases referred to either the Illinois State Police, Local Law Enforcement, or to OIG's Clinical Coordinators may add to the overall time it takes OIG to complete cases. In addition, investigator caseloads may also increase the time it takes to complete cases.

Referrals to Illinois State Police and Local Law Enforcement

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

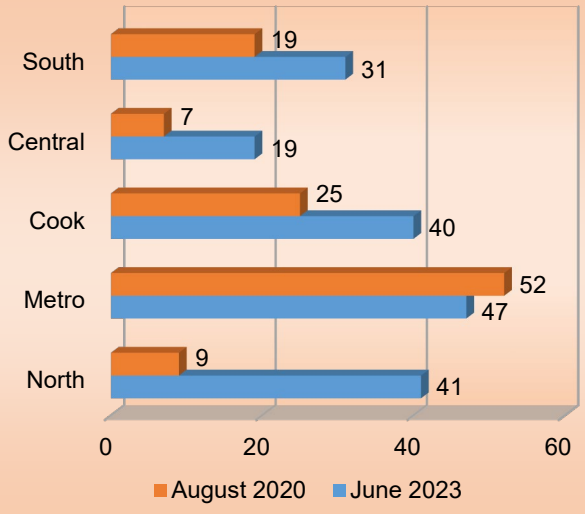
Within 24 hours after determining that there is credible evidence indicating that a criminal act may have been committed or that special expertise may be required in an investigation, the Inspector General shall notify the Illinois State Police or other appropriate law enforcement authority, or ensure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

Exhibit 15
DISPOSITION OF CASES REFERRED TO ILLINOIS STATE POLICE
FY21 through FY23

Disposition	Number of Cases FY21	FY22	FY23
Referred back to OIG without investigation	16	13	14
Declined by Prosecutor	9	10	11
Not Sustained	15	27	18
Conviction	4	3	1
Unfounded	2	3	3
Dismissed	7	0	3
Administratively Closed	1	3	1
Open/Pending	0	3	11
Totals	**54**	**62**	**62**

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

Exhibit 16
AVERAGE INVESTIGATOR CASELOADS BY BUREAU
As of August 2020 and June 2023



Source: OIG data summarized by OAG.

The Illinois State Police either conducts an investigation or refers the case back to the OIG. In some instances, the OIG will conduct an investigation in a case even if the Illinois State Police conducted an investigation. The Illinois State Police investigation is a criminal investigation, and the OIG investigation is administrative. According to the OIG's investigative guidance, the OIG conducts no further investigative activity when the Illinois State Police accepts a case unless requested to do so by the Illinois State Police. Exhibit 15 shows the number of cases referred to the Illinois State Police and the disposition of those cases.

Open Cases and Investigator Caseloads

Open cases and average caseloads have increased significantly since our 2020 audit. Overall, open cases increased from 1,093 as of August 2020, to 2,645 as of July 1, 2023, an increase of 142 percent.

Exhibit 16 shows the average investigator caseloads by bureau for 2020 and 2023. Caseload averages as of August 2020 ranged from a high of 52 cases per investigator in the Metro Bureau to a low of 7 in the Central Bureau. For June 2023, caseload averages ranged from a high of 47 cases per investigator in the Metro Bureau to a low of 19 in the Central Bureau. The average caseload per investigator has increased significantly since our last audit. The largest increase in case load was in the North Bureau, going from 9 cases per investigator as of August 2020 to 41 cases per investigator as of June 2023, which is a 356 percent increase. The Metro Bureau did show a slight improvement over the same time period, going from an average of 52 cases per investigator during August 2020 to 47 cases during June 2023, or an improvement of approximately 10 percent.

Thoroughness of Abuse and Neglect Investigations

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

In 5 of the 50 (10%) investigations sampled, the Case Tracking Form was not completely filled out. The section, which identified the accused party and the finding, was left blank. For 26 of the 50 (52%) investigations sampled, according to the Case Closure Checklist, it appeared that the Investigative Team Leader or Bureau Chief did not review the case file as required. Instead the initial reviewer either signed or initialed for the Bureau Chief, which circumvents the purpose of the second review. For three investigations (6%) there was no signature or initials for the Investigative Team Leader or Bureau Chief, and for one investigation (2%) the Case Closure Checklist was not filled out.

Fieldwork Testing Sample Selection

Auditors randomly selected a sample of 50 closed investigations from FY23. The sample was weighted and stratified by OIG investigative bureau and by the number of closed community agency investigations and closed State-operated facility investigations. The results of testing are not projectable to the population.

Auditors reviewed each investigation from the sample for compliance with the Department of Human Services Act (Act), Administrative Rules (59 Ill. Adm. Code 50), and OIG's investigative directives. The results are discussed below.

Investigation Thoroughness

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

Collection of Evidence

Evidence for OIG investigations includes items such as signed statements, interview summaries, photographs, other physical evidence, and various documentation. The case files from FY23 were generally thorough and contained the appropriate documentation.

OIG's investigative directives require the case file to contain investigatory evidence, including written statements, documentary evidence, and photographs. For example, the directives require photographs to be taken whenever an allegation of abuse or neglect is received alleging an injury, whether or not an injury is visible. However, the directives also state that when there is no visible injury consistent with the allegation, the OIG investigator can exercise discretion in determining whether photographs are necessary.

During testing, auditors checked for evidence including interviews, photographs, medical records/treatment plans/progress notes, injury reports, and restraint/seclusion records. During testing, auditors found:

- **Photographs:** Photographs were not in the case file for 1 of 15 (7%) investigations sampled where there was an injury sustained as a result of an abuse or neglect allegation.
- **Medical Records/Treatment Plans/Progress Notes:** Medical records, treatment plans, or progress notes were present within all 49 investigations sampled where they were required. Medical plans, treatment plans, or progress notes may provide valuable information about an alleged victim that could not otherwise be collected. This information could lead to a deeper insight into how an incident adversely affected the alleged victim. Without relevant documentation about the alleged victim's diagnoses (i.e. phobias, supervision requirements, etc.) it would be much more difficult to assess whether certain actions are detrimental.
- **Injury Reports:** All 22 investigations sampled that required an injury report contained one.

Interview Thoroughness

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

In our testing:

- Of the 39 investigations sampled where the alleged victim was verbal, 2 investigations (5%) **did not contain** any OIG conducted interviews.
- Of the 41 investigations sampled where an alleged perpetrator was identified, 2 investigations (5%) **did not contain** an OIG interview or a statement taken by the State-operated facility or community agency. In one case, the OIG investigator attempted to interview the alleged perpetrator four months after the initial allegation was received.

Case Monitoring and Supervisory Review

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

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

Documentation of Case Monitoring and Review

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

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

A Case Tracking Form was present in 49 of the 50 investigations sampled. For the investigation sampled that was missing the Case Tracking Form, the OIG stated that it was inadvertently missing from the file, and it had been added. However, for 5 of the investigations sampled (10%), the Case Tracking Form was not completely filled out. The section that identified the accused along with the finding was left blank.

The Case Closure Checklist is used as a quality assurance check before the investigation is closed. It ensures that the necessary documents such as the intake form and completed case report are in the file and other documents such as the Case Tracking Form and Case Routing/Approval Form are completed. Two separate reviews are required in order to ensure that all of the necessary documentation is present, the first by a case reviewer, and the second by either the Investigative Team Leader or Bureau Chief. There are designated signature/date lines for both reviewers at the bottom of the Case Closure Checklist.

All 50 investigations sampled contained a Case Closure Checklist. However, for 26 of the investigations sampled (52%) it appeared that the Investigative Team Leader or Bureau Chief did not review the case file as required. Instead the initial reviewer either signed or initialed for the Bureau Chief, which circumvents the purpose of the second review. For three investigations (6%), there was no signature or initials for the Investigative Team Leader or Bureau Chief, and for one investigation sampled, the Case Closure Checklist was not filled out (2%).

Case Closure Checklists and Case Tracking Forms

RECOMMENDATION NUMBER 6

The Office of the Inspector General should ensure that all Case Closure Checklists are properly reviewed and Case Tracking Forms are completed.

Office of the Inspector General Response:

OIG accepts the recommendation. On July 1, 2024, OIG discontinued the use of these forms, as this information was also captured in the OIG Case Management System which OIG administrative staff were using to process and close cases. This revised process was included in OIG's Directives.

Appropriateness of Finding

In one investigation sampled, auditors questioned the outcome, which the OIG determined was unsubstantiated. The alleged victim in this case was hospitalized, where it was determined that they were severely underweight, had hyponatremia (dehydration), multiple bruises, and broken metatarsals (bones of the forefoot), as well as other medical issues that were identified. The outcome of the case was an unsubstantiated finding. Auditors informed the OIG of the issues identified, including the questionable finding. The OIG agreed with our conclusion and reopened the case for further investigation.

Investigative Reports

All of the investigations auditors reviewed contained an investigative report. The OIG investigative reports auditors reviewed were generally thorough, comprehensive, and addressed the allegation. A well-written investigative report is essential to an investigation because it often provides a basis for management's decision on the action recommended in the case. Once the investigator completes the investigative report, it is reviewed by management who must approve the case before a recommendation is sent to the State-operated facility or community agency. Therefore, it is important that the investigative report be clear and convincing. The report should address all relevant aspects of the investigation and clearly explain how the investigator arrived at their conclusion.

Recommended Actions, Written Responses, and Reporting to the Health Care Worker Registry

The number of abuse and neglect investigations closed remained consistent during the audit period, and the substantiation rates have generally remained consistent. The overall substantiation rate for all abuse and neglect investigations closed was 12 percent for FY21 and 11 percent for FY22 and FY23. The number of recommended actions for FY23 substantiated cases has remained steady when compared to FY20, during the prior audit of the OIG. There were 324 substantiated cases during FY20, and there were 315 substantiated cases during FY23.

In 4 of the 21 (19%) investigations reviewed during the Office of the Auditor General FY20 and FY21 DHS compliance examination, the State-operated facility or community agency did not file the required written response within the 30 calendar day time frame allotted. These 4 written responses were filed between 10 and 47 days late. The Secretary was not notified that the reports were not submitted within the 30 calendar day allotment and did not determine the corrective action to be taken, as required by the Act.

The OIG's Annual Reports contain information about the number of individuals referred to the Health Care Worker Registry, the number of appeals made, and the status of those appeals. During FY21 and FY22, the OIG made final reports to the Health Care Worker Registry for 52 individuals each year. During FY23 the OIG made final reports to the Health Care Worker Registry for 81 employees with a total of 83 reportable findings.

Substantiated Abuse and Neglect Cases

The number of abuse and neglect investigations closed remained consistent during the audit period, and the substantiation rates have generally remained consistent. As shown in Exhibit 17, the overall substantiation rate for all abuse and neglect investigations closed was 12 percent for FY21 and 11 percent for FY22 and FY23.

Exhibit 17
ABUSE AND NEGLECT INVESTIGATIONS CLOSED AND SUBSTANTIATED
FY21 through FY23

Location	Closed Cases	Substantiated Cases	Substantiated Percent
Fiscal Year 2021			
Facility	932	48	5%
Agency	1,770	263	15%
Total	**2,702**	**311**	**12%**
Fiscal Year 2022			
Facility	894	45	5%
Agency	1,703	241	14%
Total	**2,597**	**286**	**11%**
Fiscal Year 2023			
Facility	1,090	67	6%
Agency	1,651	248	15%
Total	**2,741**	**315**	**11%**

Source: OAG analysis of OIG data.

For community agencies, the substantiation rate was between two and a half and three times higher than for State-operated facilities. For FY21, the community agency rate was 15 percent, and the State-operated facility rate at 5 percent. During FY22 the community agency substantiation rate was 14 percent, while the State-operated facility substantiation rate was 5 percent. In FY23, the community agency rate was at 15 percent, and the State-operated facility rate was 6 percent. This trend is consistent with previous audits of the OIG.

Recommended Actions

The number of recommended actions for FY23 substantiated cases has remained steady when compared to the previous OIG audit. Exhibit 18 shows there were 324 substantiated cases during FY20, and there were 315 substantiated cases during FY23.

Exhibit 18
RECOMMENDED ACTIONS FOR SUBSTANTIATED CASES
FY20 and FY23 Closed Cases

Recommended Action	FY20[1]	FY23
No Action	117	137
Retraining	70	29
Policy Creation or Revision	21	5
Other Administrative Action	56	62
Referral to Other Agency	0	1
Health Care Worker Registry	59	81
Total Substantiated	**324**	**315**

[1] One case did not have a recommended action but is included in the total for FY20.

Source: OAG analysis of OIG data.

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

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

After the report is sent, the State-operated facility or community agency generally takes some action to resolve the issues identified by the case. Exhibit 18 shows substantiated cases in FY20 and FY23 by the type of recommended action.

During FY23 the most recommended action in substantiated cases was "No Action," which was recommended in 137 of 315 substantiated cases or 43 percent. Auditors reviewed investigations data provided by the OIG for cases with a recommendation of "No Action" and found that for 134 cases a written response had been received (2 cases) or approved (132 cases), which indicates that some action had been taken. For the three remaining cases the database did not have an entry for recommended actions. According to OIG officials, the reason that "No Action" was chosen for these cases was because there was not a recommendation made in the investigation. Findings and recommendations are separate actions related to a case. A recommendation requires action by a State-operated facility, community agency, or Department to correct a systemic issue, problem, or deficiency identified during an investigation. However, a written response is still required from the State-operated facility or community agency to document the action taken in response to a substantiated finding even if there are no recommendations related to the investigation.

The second most recommended action for FY23 was reporting an individual to the Health Care Worker Registry; the OIG recommended reporting an individual

to the Health Care Worker Registry for 81 of 315 (26%) substantiated cases closed in FY23. Appendix C contains the number of cases closed and the substantiation rate by State-operated facility and community agencies for FY21 through FY23.

Actions Taken by State-Operated Facilities or Community Agencies

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

According to the OIG's FY23 Annual Report the OIG received 178 approved written responses from State-operated facilities, and 442 from community agencies, for a total of 620 written responses. The FY23 OIG Annual Report contains data regarding the actions taken on the 620 written responses received for investigations that were substantiated or had other issues that needed to be addressed. Exhibit 19 shows the actions taken by State-operated facilities or community agencies for these 620 investigations. Some investigations had multiple actions taken.

Exhibit 19
ACTIONS TAKEN ON SUBSTANTIATED CASES OR INVESTIGATIONS WITH OTHER ISSUES
FY23 Approved Written Responses

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

Source: FY23 OIG Annual Report

OIG Substantiated Cases and Written Responses

For investigative reports, the Department of Human Services Act (Act) (20 ILCS 1305/1-17(m)) requires:

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

For written responses, the Act further states:

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

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

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

Exhibit 20
WRITTEN RESPONSE COMPLIANCE REVIEWS CONDUCTED
FY21 through FY23

Location	FY21	FY22	FY23
Agency	85	83	76
Facility	26	25	34
Totals	**111**	**108**	**110**

Source: OIG annual reports.

Exhibit 20 shows the number of reviews conducted by the OIG during the audit period, FY21 through FY23. According to OIG annual reports, during FY21 the OIG received a total of 720 approved written responses and conducted 111 reviews. During FY22, the OIG received 599 written responses and conducted 108 reviews. During FY23, OIG received 620 approved written responses and conducted 110 reviews.

DHS Approval of Written Responses

As previously discussed, the Act requires that within 30 calendar days from receipt of a substantiated investigative report or an investigative report that contains recommendations, absent a reconsideration request, the State-operated facility or community agency must file a written response. If the written response is not filed within the allotted 30 calendar day period, the Secretary of DHS shall determine the appropriate corrective action to be taken (20 ILCS 1305/1-17(n) and (p)).

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

The previous audit contained a recommendation to DHS to ensure that written responses are received and approved in a timely manner. If DHS does not receive and approve written responses and corrective actions in a timely manner, the OIG cannot effectively monitor the implementation of actions by facilities and community agencies. Additionally, not ensuring that appropriate actions are taken may allow individuals served to be in an environment where they are at risk.

The Office of the Auditor General Compliance Examination covering FY20 and FY21 tested 21 investigations which resulted in the facility or community agency being required to file a written response. In 4 of the 21 (19%) investigations reviewed, the State-operated facility or community agency did not file the required written response within the 30 calendar day time frame allotted. These 4 written responses were submitted between 10 and 47 days late. The Secretary was not notified that the reports were not submitted within the 30 calendar day allotment and did not determine the corrective action to be taken, as required by the Act. This is finding 2021-030 in the DHS Compliance Examination for the two years ended June 30, 2021.

Appeals Process in Substantiated Cases

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

Reconsideration or Clarification

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

reconsideration of a finding is the only appeals process where an OIG substantiated finding against a person can be changed.

Results from the annual reports:

- According to the FY21 OIG Annual Report, the OIG received 101 requests for reconsideration of a finding for 98 investigations. Of the 101 requests, the OIG granted 29 and denied 72. For the 29 requests that were granted, the OIG reopened the investigation in 10 instances and issued an amended report in the remaining 19. The OIG issued an amended report in 6 instances of the 72 requests that were denied.
- The FY22 OIG Annual Report shows that the OIG received 99 requests for reconsideration of a finding for 92 investigations. Of the 99 requests, the OIG granted 22 and denied 77. For the 22 requests that were granted, the OIG reopened the investigation in 10 instances and issued an amended report in the remaining 12. The OIG issued an amended report in 12 instances of the 77 requests that were denied.
- For FY23, the OIG Annual Report shows that the OIG received 71 requests for reconsideration of a finding for 65 investigations. Of the 71 requests, the OIG granted 18 and denied 53. For the 18 requests that were granted, the OIG reopened the investigation in 9 instances and issued an amended report in the remaining 9 instances. The OIG issued an amended report in 5 of the 53 requests that were denied.

Health Care Worker Registry

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

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

The Department of Human Services Act requires the OIG to report individuals with substantiated finings of physical or sexual abuse, financial exploitation, or

egregious neglect to the Health Care Worker Registry. The purpose is to protect those who are the most vulnerable from possible harm. State-operated facilities and agencies must verify the Registry status before hiring an employee to ensure that there are no findings of physical or sexual abuse, financial exploitation, or egregious neglect. These individuals are prohibited from working with people who reside in a State-operated facility or community agency. The Illinois Department of Public Health has a waiver process, but it does not apply to OIG findings, which are administrative and have a separate hearing process.

Health Care Worker Registry Appeals

The Illinois Administrative Code allows an employee to request a hearing with the Department of Human Services and present evidence supporting why their finding does not warrant reporting to the Health Care Worker Registry (59 Ill. Adm. Code 50.90). The purpose of the hearing is to determine whether or not the adverse finding against an employee will be reported on the Registry.

Exhibit 21
HEALTH CARE WORKER REGISTRY APPEALS
FY21 through FY23

Appeal Outcomes	FY21	FY22	FY23
Petitioner Lost Appeal (Referred to Registry)	2	0	4
Appeal Dismissed (Referred to Registry)	0	0	16
Petitioner Won Appeal (Not Referred)	1	0	3
Stipulation Order (Not Referred)	1	5	10
Appeal Withdrawn (Referred to Registry)	1	0	7
Pending	13	22	12
Totals	**18**	**27**	**52**[1]

[1]There were 35 petitions to appeal from prior years that were decided during FY23.

Source: OIG annual reports.

The OIG's Annual Reports contain information about the number of individuals referred to the Registry, the number of appeals made, and the status of those appeals. During FY21 and FY22, the OIG made final reports to the Registry for 52 individuals each year. During FY23, the OIG made final reports to the Registry for 81 employees with a total of 83 reportable findings.

According to OIG annual reports and data provided by the OIG, during FY21, 13 employees filed appeals challenging the reporting of their names and findings. All 13 of those appeals remained pending because of the COVID-19 restrictions. However, five appeals filed prior to FY21 were decided. For three of those appeals, the petitioner was referred to the Registry, and the remaining two were not.

During FY22, 22 employees filed appeals challenging the reporting of their names and findings. Although hearings resumed in the spring of 2022, all 22 appeals remained pending as of December 2022 when the OIG's Annual Report was released. There were five appeals that were not referred during FY22 because of a stipulated order to dismiss.

During FY23, 18 employees filed appeals challenging the reporting of their names and findings. Five of those employees were placed on the Registry, two withdrew their petition to appeal, and three were dismissed for failure to appear. One petition to appeal was dismissed because of resolution prior to the hearing. At the end of FY23, 12 appeals remained pending. There were also 35 petitions to

appeal that were from prior years that were decided during FY23. These included:

- four petitioners lost their appeal and were placed on the Registry;
- 13 appeals were dismissed, and the petitioner's names and findings were placed on the Registry;
- three petitioners won their appeal and their names and findings were not placed on the registry;
- five petitioners withdrew their appeal, and their names and findings were placed on the registry; and
- ten petitioners were not placed on the registry because of a stipulated order to dismiss.

Exhibit 21 contains the outcomes of the appeals for FY21 through FY23 in more detail.

Stipulated Motion to Dismiss Process

Prior to an administrative rule change on April 4, 2023, the stipulated motion to dismiss process could only be triggered when both the OIG and the employee jointly requested that the administrative law judge consider the stipulated motion to dismiss and the Secretary agreed. The administrative rule change, effective April 4, 2023, now only requires that the Inspector General request a stipulated disposition of the investigative report and for the Secretary to agree (59 Ill. Adm. Code 50.90). As shown in Exhibit 21, the OIG chose not to refer a case to the Registry based on a stipulated motion to dismiss for a total of 16 cases during the audit period.

Quality Care Board, Training, and Unannounced Site Visits

The Quality Care Board did not meet the statutory requirement of having seven members during the audit period and two members were serving on expired terms. However, as of September 10, 2024, the boards and commissions website showed that there were seven members on the Quality Care Board, which meets the statutory requirement.

Auditors received training data for OIG employees, including the hire date for new employees, the trainings completed, the date of each training, and each employee's job title for FY21, FY22, and FY23. Auditors found 6 of 9 (67%) newly hired investigative employees did not have documentation to support completion of the required new hire trainings. For continuing trainings, during FY21, 7 of 61 (11%) OIG employees did not receive all required trainings. During FY22 and FY23 compliance with the required trainings was significantly worse. During FY22, 34 of 56 (61%) OIG employees and during FY23, 27 of 53 (51%) OIG employees did not receive all required trainings.

Data provided to auditors showed that there was an improvement in State-operated facility employee Rule 50 training when compared to the prior audit period; however, employees at State-operated facilities are still not always receiving Rule 50 training annually, as required by DHS. Not ensuring that all State-operated facility employees receive Rule 50 training on the prevention and reporting of abuse and neglect may put the health and safety of residents and patients at risk.

The Department of Human Services Act (Act) requires the Inspector General to conduct unannounced site visits to each State-operated facility at least annually (20 ILCS 1305/1-17(i)). Within 60 days of completing the unannounced site visit, a report is to be sent to the State-operated facility. During FY21, unannounced site visits had to be conducted remotely because of the public health emergency due to COVID-19. During FY22, 71 percent of the site visit reports were not sent to the State-operated facility within the required 60-day time frame, and 64 percent of the site visit reports were not sent to the State-operated facility within the required 60-day time frame during FY23.

In past audits, unannounced site visits typically took place on consecutive days and documentation was provided to show that an OIG employee was on site during the second date of the site visit. However, during FY22, **the second site visit date for all 14 site visits occurred between 36 and 177 days after the initial site visit, with an average of 100 days between the dates**. During FY23, **the second site visit date for the 14 site visits occurred between 37 and 149 days after the initial site visit, with an average of 95 days between the dates**. Also, no supporting documentation showing an OIG employee was on site during the second day of the site visit was provided to auditors. Therefore, auditors calculated the amount of time to disseminate reports using the first date of the site visit.

Quality Care Board

The Act establishes a Quality Care Board (Board) within the Office of the Inspector General. The Board is required to monitor and oversee the operations, policies, and procedures of the Inspector General to ensure the prompt and thorough investigation of allegations of neglect and abuse. The Act requires the Board to be composed of seven members appointed by the Governor with the

advice and consent of the Senate. Two members are required to be a person with a disability or a parent of a person with a disability. Four members constitute a quorum, which is required for the Board to conduct business. In fulfilling these responsibilities, the Board may do the following:

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

Board Membership

The OIG continues to show improvement in meeting the statutorily required Board membership. In the FY20 OIG audit, auditors reported that the Board had five members as of May 12, 2020, which was an improvement compared to the FY17 audit, which only reported four members. Exhibit 22 shows six members serving on the Board as of June 28, 2023, their term status, and expiration dates. While the Board did include two people that are either a person with a disability or a parent of a person with a disability the statutory requirement for full Board membership was not met during the audit period. However, as of September 10, 2024, the boards and commissions website showed that there were seven members on the Board, which meets the statutory requirement; however, there were three members who were serving on expired terms.

Exhibit 22
QUALITY CARE BOARD
As of June 28, 2023

Board Member	Appointed	Expiration Date	Status
Saul J. Morse (Chair)	06/02/2021	11/03/2023	Current
Angela Hearts-Glass	10/08/2019	11/02/2025	Current
Megan Norlin	10/18/2019	11/02/2025	Current
Jae Jin Pak	11/08/2019	11/03/2021	Expired
Shirley Perez	10/18/2019	06/14/2022	Expired
Nancy Sage	09/30/2022	11/03/2025	Current
Vacant	N/A	N/A	Vacant

Source: OIG and the Governor's Boards and Commissions website.

Board meeting minutes show that staffing issues have been an ongoing concern for the OIG during the three-year audit period. OIG staff raised concern with the hiring process and with the increased caseloads of investigators caused by promotions. The minutes also discussed measures taken to mitigate risks because of COVID-19. Other issues, such as training and administrative business, were discussed as well. Overall, the Board appeared to be engaged with the OIG during meetings, and the minutes showed that Board members raised relevant

questions and initiated discussion about issues and changes the OIG was considering implementing.

Exhibit 23
QUALITY CARE BOARD MEETINGS
FY21-FY23

Meeting Date	Members Attending	Quorum
FY21 Meetings		
07/14/2020	4	Yes
08/11/2020	4	Yes
10/13/2020	4	Yes
12/08/2020	3	No
02/09/2021	5	Yes
04/13/2021	5	Yes
06/15/2021	3	No
FY22 Meetings		
08/17/2021	3	No
10/19/2021	4	Yes
12/21/2021	5	Yes
02/15/2022	5	Yes
04/19/2022	5	Yes
06/21/2022	4	Yes
FY23 Meetings		
08/16/2022	4	Yes
10/18/2022	6	Yes
12/20/2022	6	Yes
02/21/2023	5	Yes
04/18/2023	4	Yes
06/20/2023	4	Yes

Source: Quality Care Board meeting minutes.

The Act requires that the Board meet quarterly and four members constitute a quorum, which is necessary for conducting business. As shown in Exhibit 23, the Board satisfied the quarterly meeting requirement, meeting seven times during FY21, six times in FY22, and six times during FY23. There was also a quorum in at least one of each of the quarterly meetings. However, during the August 17, 2021 Board meeting, only three members were present, and members voted to adopt the meeting minutes from the two previous meetings, which is in violation of the Act because the Act requires four members present to constitute a quorum (20 ILCS 1035/1-17(u)). During the next audit, auditors will review this issue and determine if further action is needed.

The Board did not meet the statutory requirement of having seven members during the audit period, and two members had been serving on expired terms. Statutory requirements regarding Board membership state that upon the expiration of each member's term, a successor shall be appointed. In the case of a vacancy in the office of any member, the Governor shall appoint a successor for the remainder of the unexpired term. The Board cannot fully function as directed by statute to "monitor and oversee the operations, policies, and procedures of the Inspector General" with vacancies and neglected membership requirements (20 ILCS 1305/1-17(u)).

Quality Care Board

RECOMMENDATION NUMBER 7

The Secretary of the Department of Human Services and the Inspector General should work with the Governor's Office to appoint members to the Quality Care Board and ensure that members who are serving on expired terms are reappointed or replaced in order to fulfill statutory requirements in the Department of Human Services Act (20 ILCS 1305/1-17(u)).

The Department of Human Services and the Office of the Inspector General Response:

IDHS accepts the recommendation and will work with the OIG and the Office of the Governor to appoint members to the Quality Care Board, to ensure that all Board positions are filled, and to ensure that Board members are not serving on expired terms.

Training

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

- *Establish a comprehensive program to ensure every person authorized to conduct investigations receives ongoing training relative to investigation techniques, communication skills, and the appropriate means of interacting with persons receiving treatment for mental illness, developmental disability, or both mental illness and developmental disability; and*
- *Establish and conduct periodic training programs for facility and agency employees concerning the prevention and reporting of any one or more of the following: mental abuse, physical abuse, sexual abuse, neglect, egregious neglect, or financial exploitation…Nothing in this section shall be deemed to prevent the Office of Inspector General from conducting any other training as determined by the Inspector General to be necessary or helpful.*

Investigator Training

OIG directives contain training requirements for newly hired and continuing employees. New hire requirements include trainings in the Act, OIG directives, and Rule 50. According to the directives, newly hired OIG employees should receive the required training within six months of employment.

In addition, continuing employees must take at least three training courses per fiscal year within the subjects of investigative skills, computer skills, or personal and professional growth. All employees must receive annual trainings covering ethics, sexual harassment, HIPAA, and Rules 50, 115, 116, and 119. According to the OIG directives, trainings are recorded in the training database through forwarding evaluation forms, attendance sheets, email verification, or online transcripts to the data-entry person.

Auditors received training data for OIG employees, including hire date for new employees, the trainings completed, the date of each training, and each employee's job title for FY21, FY22, and FY23. Auditors found 6 of 9 (67%) newly hired investigative employees did not have documentation to support completion of the required new hire trainings.

Auditors also reconciled the training information provided for OIG employees required to have continuing training. During FY21, 7 of 61 (11%) OIG employees were missing between 1 and 7 trainings. During the prior audit, 5 of the 61 (8%) employees who were required to have continuing training in FY20 did not complete it, which is comparable to FY21. However, for FY22 and FY23, compliance with the required trainings was significantly worse. During FY22, 34 of 56 (61%) OIG employees did not meet the training requirements. These 34 employees were missing between 2 and 6 trainings. During FY23, 27 of 53 (51%) OIG employees did not meet the training requirements. These 27 employees were missing between 1 and 7 trainings.

According to OIG officials, while the staff were provided with OIG new hire training, the OIG was unable to find the records. The OIG has been focusing on hiring investigative staff and not administrative staff, so the OIG did not and does not have dedicated staff to oversee training documentation, and it is currently handled by each bureau. The OIG is working with the Department of Innovation and Technology to use OneNet to track training but has not yet been able to use it to track new hire training. The OIG has started the process to hire two training coordinators (North and South) to monitor and maintain training records, including new-hire training.

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

Investigator Training

RECOMMENDATION NUMBER 8

The Office of the Inspector General should:

- ***ensure that employees are receiving all required trainings; and***
- ***determine and implement a more effective method of tracking employee training to ensure that each employee has received the required training.***

Office of the Inspector General Response:

OIG accepts the recommendation. OIG will ensure that all staff receive the required training and that proof of the same is adequately documented. Coordinating and documenting OIG training has been an ongoing issue due to a lack of dedicated management staff to coordinate and document internal training. For the past several years, OIG has been focused on hiring investigative staff to deal with the ever-growing caseload. This left the responsibility of training to be spread out amongst multiple management staff across the state without optimal coordination. OIG has created and is in the process of filling two Training Coordinator positions: one for the three northern bureaus and one for the three southern bureaus. The coordinators will be responsible for ensuring OIG staff receive their required training and that training is appropriately documented.

OIG also has not had a central location to document completed training. OIG's database was used to document training but was not always reliable. In response to the last audit, OIG documented that OIG would work with the State's Department of Innovation and Technology (DoIT) to use the OneNet training functionality to document OIG training. However, transitioning to using OneNet to track training has not been a seamless process, as several issues arose during implementation. First, this project was competing with a number of other State's IT priorities. Second, while OIG is making progress on using OneNet for training, the system is challenging to navigate and requires a great deal of training and coordination with DoIT. OIG continues to work with DoIT and expects use of the system to become easier and more effective for OIG's needs.

Rule 50 Training

As noted previously, the Act states, *"The Inspector General shall… establish and conduct periodic training programs for facility and agency employees concerning the prevention and reporting of any one or more of the following: mental abuse,*

physical abuse, sexual abuse, neglect, egregious neglect, or financial exploitation (20 ILCS 1305/1-17(h)).*"* The OIG's administrative rules outline the training requirements for State-operated facility and community agency employees. This training is commonly referred to as "Rule 50 training." The OIG provides State-operated facilities and community agencies with Rule 50 training materials through PowerPoint presentations on the DHS website, and the community agency or State-operated facility provides the training for its employees. All employees at community agencies and State-operated facilities are required to have Rule 50 training upon being hired, and then at least biennially thereafter (59 Ill. Adm. Code 50.20(d)(2)).

The Act does not require the OIG to monitor compliance with training; it only requires that the OIG establish and conduct training concerning prevention and reporting of abuse and neglect.

DHS State-Operated Facility Rule 50 Training

Documentation provided by DHS showed that employees at State-operated facilities did not always receive the statutorily required Rule 50 training. Auditors requested information from DHS' Division of Developmental Disabilities and the Division of Mental Health related to Rule 50 training. Both divisions provided summaries of staff trained in Rule 50 for each State-operated facility for the audit period. However, the Division of Mental Health could not provide calendar year 2021 Rule 50 training at facilities; they could only provide an aggregate total for calendar years 2016 through 2021. **For that time period the overall percentage for compliance with Rule 50 training was 87 percent**. In an email, DHS officials explained that prior to 2022, training was conducted on a facility-by-facility basis, and in order to calculate the rate for 2021, it would require reviewing the training records for the 2,000 plus State-operated facility employees manually.

Exhibit 24
DHS RULE 50 TRAINING BY FACILITY
CY21 through CY23

Facility	% of Staff Trained in Rule 50		
MH Facilities	**CY21[1]**	**CY22**	**CY23**
Alton		99%	100%
Chester		99%	100%
Chicago-Read		98%	99%
Choate		98%	98%
Elgin		100%	100%
Madden		97%	94%
Packard		99%	100%
DD Facilities	**CY21**	**CY22**	**CY23**
Choate	98%	100%	100%
Fox	99%	100%	100%
Kiley	100%	100%	99%
Ludeman	98%	100%	89%
Mabley	98%	100%	92%
Murray	100%	100%	90%
Shapiro	93%	83%	100%

[1] For CY21 MH Facilities, DHS could only provide the number of employees trained for the time period 2016 through 2021 in the aggregate.

Source: DHS Divisions of Mental Health and Developmental Disabilities.

The information provided shows that none of the State-operated facilities reached 100 percent compliance with the Rule 50 training requirement for all three calendar years 2021 through 2023. Shapiro had the lowest completion percentage of the Developmental Centers (83% during CY22), and Madden had the lowest completion percentage of the Mental Health Centers (94% during CY23). Auditors could not determine the completion percentages for the Mental Health Centers for calendar year 2021 for reasons explained previously. (See Exhibit 24.)

During the prior audit, auditors were provided State-operated facility employee Rule 50 training information for fiscal years 2018 through 2020. When comparing the Developmental Centers from this audit period, there is an overall improvement in employees receiving Rule 50 training. During the last audit period, one Developmental Center reported only having 48 percent of their staff trained on Rule 50 during FY19, and during FY20, a different Developmental Center reported only 12 percent of their staff were trained on Rule 50. For the Mental Health Centers during the last audit period, the lowest completion rate for Rule 50 training was 88 percent, which occurred during FY18. Calendar years 2022 and 2023 show that there was an improvement when compared to the prior audit period.

In the prior audit, DHS officials stated that training on Rule 50 is required annually as a proactive measure to ensure that employees are well versed regarding Rule 50 and the expectations regarding treatment of and for residents/patients. Although the data provided shows that there was an improvement when compared to the prior audit period, employees at State-operated facilities are still not always receiving Rule 50 training annually, as required by DHS. Not ensuring that all State-operated facility employees receive Rule 50 training on the prevention and reporting of abuse and neglect may put the health and safety of residents and patients at risk.

Abuse, Neglect, and Exploitation Prevention and Reporting Training at Facilities

RECOMMENDATION NUMBER 9

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

Department of Human Services Response:

IDHS accepts the recommendation and will particularly focus on those facilities who did not have 100% training completion in CY23. Each State-Operated Facility has a staff development specialist who assigns and monitors the completion of required trainings annually. IDHS has mandatory deadlines for required staff training to be completed and progressive discipline is used if those deadlines are not met.

Community Agency Rule 50 Training

Community agency training is mandated through agency contractual agreements with DHS; the DHS divisions of Mental Health and Developmental Disabilities along with the Bureau of Accreditation, Licensure, and Certification are responsible for ensuring compliance with contractual agreements. Additionally, OIG's administrative rules require all community agency employees to be trained in Rule 50 (59 Ill. Adm. Code 50.20(d)(2)).

Since the prior program audit of the OIG, DHS implemented processes for sampling Rule 50 training documentation through the Division of Mental Health

and the Division of Developmental Disabilities to ensure community agency employees are receiving Rule 50 training upon being hired and at least biennially thereafter.

Auditors received and reviewed FY23 Rule 50 training information from the Division of Mental Health and found DHS was monitoring mental health community agency employee compliance with training requirements. Auditors also received and reviewed a training report from the Division of Developmental Disabilities documenting FY21 through FY23 Rule 50 training for developmental disability community agency employees. Auditors found the Division of Developmental Disabilities was monitoring community agency compliance with Rule 50 training requirements.

Rule 50.30(f) Training

Effective April 4, 2023, 59 Ill. Adm. Code 50 was changed to require community agencies to have an OIG Liaison. Prior to this change, only State-operated facilities were required to have an OIG Liaison. The Administrative Code requires that a 50.30(f) trained OIG Liaison begin the initial steps of the investigation unless otherwise directed by the OIG. An OIG Liaison is defined as "*The Community Agency or facility staff who has been appointed to act as OIG's investigative point of contact and who is responsible for coordinating the agency's or facility's initial incident response* (59 Ill. Adm. Code 50.10)."

The OIG provides training, which contains information and procedures on conducting the initial steps of an investigation as outlined in 59 Ill. Adm. Code 50.30(f). The training includes:

- securing the scene;
- preserving evidence;
- identifying and separating potential witnesses, then taking statements;
- securing all relevant documents;
- securing all physical evidence;
- photographing the scene;
- photographing injuries when applicable; and
- any further actions deemed necessary by the OIG.

Information provided by the OIG showed that each State-operated facility had at least one 50.30(f) trained OIG Liaison during the audit period. The OIG also provided data showing the OIG Liaison community agency employees that were trained in Rule 50.30(f) during the audit period. The community agency employee data showed that 860 employees from community agencies had received the training. However, because the requirement to have an OIG Liaison at each community agency was not in effect until April 4, 2023, three months prior to the end of the audit period, auditors did not reconcile this data to ensure that each community agency operating within the State had at least one Rule

50.30(f) trained OIG Liaison, as it would not have been enough time to reasonably expect each community agency to be in compliance. Auditors will follow up on this requirement during the next audit period.

Unannounced Site Visits

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

According to OIG directives, the unannounced site visit process includes:

- developing a schedule for the unannounced site visits, determining the issues to be reviewed, and developing a protocol for the issues to be reviewed and a plan to evaluate them;
- requesting and reviewing documentation from the facilities related to the issues to be reviewed;
- convening an entrance conference during the site visit, interviewing relevant staff, touring homes/units, and holding an exit conference; and
- compiling data and information to complete an unannounced site visit report for each State-operated facility.

The Inspector General reviews and approves the unannounced site visit report, and the approved report is sent to the State-operated facility. Report drafting, approval, and sending the report to the facility are required to be completed within 60 days of the unannounced site visit.

FY21 through FY23 Unannounced Site Visits

The scope of the OIG FY21 site visits consisted of a review of the staff training, key processes, and documentation related to the individuals who are on one-to-one supervision or one-to-one special observation while residing in State-operated facilities. The FY21 planning memo outlined the objective of the site visits: to evaluate each facility's implementation of DHS's one-to-one supervision and special observation policies; and to review the quality of staff training in accordance with these directives.

The FY22 unannounced site visits focused on restraint usage in State-operated developmental disability centers and mental health centers. The planning memo outlined the scope of the OIG FY22 site visits, which involved examining staff training, key processes, and documentation concerning the use of restraints for individuals residing in State-operated facilities. The planning memo also outlined the objectives of the FY22 site visits, which included evaluating each State-operated facility's implementation of DHS' restraint policy and procedures, and reviewing and assessing the quality of staff training in accordance with the relevant program directives regarding restraint use.

The FY23 unannounced site visits focused on sentinel event management in State-operated developmental disability centers and mental health centers. A sentinel event is an event that involves unexpected occurrences leading to death or serious injury, requiring immediate investigation and responses to prevent a reoccurrence. The scope of the OIG FY23 site visits consisted of a review of the five most recent sentinel events for each State-operated facility. The FY23 unannounced site visits objective was to ensure that each State-operated facility provided reasonable assurance that it is responding to sentinel events by following the mandated sentinel event process.

Exhibit 25 shows the date of the unannounced site visits and the total recommendations identified for each fiscal year.

Timeliness of Site Visit Reports

OIG directives require that within 60 days of the site visit, a report is sent to the State-operated facility director or hospital administrator and other stakeholders. For FY21 through FY23, auditors found that 20 of the 42 (48%) reports were sent outside of 60 days.

Exhibit 25
UNANNOUNCED SITE VISIT DATES
FY21 through FY23

Facility	Date of Site Visit		
MH Facilities	**FY21**	**FY22**	**FY23**
Alton	Mar 2	Mar 3	Nov 2
Chester	Apr 22	Mar 16	Nov 16
Chicago-Read	May 15	Nov 16	Sept 14
Choate	Mar 15	May 10	Apr 17
Elgin	May 29	April 12	Sept 21
Madden	May 11	Oct 20	Oct 6
Packard	Mar 1	Nov 30	Oct 21
DD Facilities	**FY21**	**FY22**	**FY23**
Choate	Mar 15	May 12	Apr 17
Fox	Feb 26	Mar 10	Mar 7
Kiley	Apr 20	Oct 14	Apr 12
Ludeman	Mar 12	Nov 2	Feb 8
Mabley	Mar 12	Apr 19	May 2
Murray	May 18	Mar 31	Feb 21
Shapiro	Jun 21	Dec 7	Mar 6
Recommendations	**53**	**85**	**44**

Source: OIG annual reports and OAG analysis of site visits.

Auditors requested documentation to support the day or days that each site visit occurred at each State-operated facility that an OIG employee was on site for each site visit, the final site visit reports, and other documentation related to the unannounced site visits conducted during the audit period.

During FY21, unannounced site visits had to be conducted remotely because of the public health emergency due to COVID-19. For the FY22 and FY23 unannounced site visits, information received showed that there were two site visit dates for each site visit. However, no supporting documentation could be provided to show that an OIG employee was on site for the second site visit date at each State-operated facility. During

prior audits of the OIG, documentation was provided for each day of the site visit, which showed that an OIG employee was on site. Additionally, for FY22 and FY23, there was an excessive amount of time that passed between the first and second site visit dates for numerous site visits. During FY22, **the second site visit date for all 14 site visits occurred between 36 and 177 days after the initial site visit, with an average of 100 days between the dates**. During FY23, **the second site visit date for the 14 site visits occurred between 37 and 149 days after the initial site visit, with an average of 95 days between the dates**.

As stated previously, no supporting documentation could be provided to show that an OIG employee was on site during the second date of the site visit. Because the OIG was able to provide supporting documentation to show an OIG employee was on site for each date of the site visit during prior audits, and the dates of the site visit were typically consecutive days during prior audits, auditors calculated the amount of time to disseminate reports using the date of the first site visit and the date the report was received by the State-operated facility. As shown in Exhibit 26, 71 percent of the site visit reports were not sent to the State-operated facility within the required 60-day time frame during FY22, and 64 percent of the site visit reports were not sent to the State-operated facility within the required 60-day time frame during FY23.

Exhibit 26
UNANNOUNCED SITE VISIT REPORTS SENT MORE THAN 60 DAYS FROM SITE VISIT
FY21 through FY23

Fiscal Year	Number of Reports			
	Late	On Time	Total[1]	% Late
2021	1	13	14	7%
2022	10	4	14	71%
2023	9	5	14	64%
Total	**20**	**22**	**42**	**48%**

[1] Site visits were conducted at all 13 State-operated facilities; Choate is a dual facility in the South Bureau.

Source: OAG analysis of OIG site visit reports.

It is important that unannounced site visit reports are delivered to State-operated facilities in a timely manner in order to rectify any issues that are identified as a result of the unannounced site visit as quickly as possible and to promote the safety and well-being of the residents living within the facilities.

Timeliness of Unannounced Site Visit Reports

RECOMMENDATION NUMBER 10

The Office of the Inspector General should take steps to ensure that unannounced site visit reports are sent to State-operated facilities within 60 days of the site visit being completed as required by OIG Directive.

Office of the Inspector General Response:

OIG accepts the recommendation. In recent years, OIG decided to restructure its site visit process. In order to closely align OIG process with the nationally recognized standards, the planning, structure, execution, and writing of OIG's annual site visits are now based on the Government Accountability Office's (GAO) Generally Accepted Government Auditing Standards (GAGAS), commonly referred to as the "Yellow Book." OIG leadership decided to model its site visits after Yellow Book performance audits. The purpose of this model is to produce site visit reports that have more structured and substantive findings and recommendations. Ultimately, the goal is to put the OIG site visit team in a better position to identify systemic issues at the facilities that relate to the reporting and prevention of abuse and neglect of individuals receiving services in the facilities.

Because OIG is statutorily mandated to conduct unannounced site visits at all IDHS State-Operated Facilities (SOFs), OIG's site visit team visits each facility, in succession, as quickly as possible, so facilities do not have a significant period of time to share information and prepare for OIG's visit. After OIG completes its unannounced visits at all of the facilities, OIG staff begin to work on each individual site visit report. The site visit reports go through a rigorous review process that requires approval from the Chief Administrative Officer and Inspector General. Completed reports go to the facility for response which OIG includes in the final version of the report. This process explains the gap between when staff initially visit the facility and when the final version of the report is released to the Facility, Division, and Secretary's Office.

To meet this recommendation, OIG will revise OIG's Directives to better suit its new site visit process. OIG will now consider the exit conference the conclusion of the site visit. Furthermore, it will require staff to submit the site visit report to the required stakeholders within 60 working days of the exit conference.

OIG Staffing Issues

During the audit period, FY21 through FY23, the OIG requested to hire for 38 positions. **Of these 38 hiring requests**, 17 positions had been filled as of August 17, 2023, and **21 were still vacant**. Once position requests were posted, two positions were filled within three months, **ten positions took between 4 and 6 months to fill**, **and five positions took between 7 and 12 months to fill after the hiring request was made.**

OIG officials stated that multiple bureaus have lost headcount; if there is a lack of investigators, then timeliness worsens and caseloads increase. According to OIG officials, they are unable to hire investigators fast enough to maintain their headcount. Additionally, OIG officials explained that **in the near future, there will be Bureau Chiefs that will be making less than lead investigators because of the current pay schedule, and there are currently employees applying for demotions.**

OIG Staffing Issues

As of June 30, 2023, the OIG had 43 investigative staff, of which 36 were being assigned cases to investigate. During FY21 through FY23, the OIG opened 9,171 cases including death reports, or an average of 3,057 per fiscal year. Concerns with staffing were mentioned several times by the Inspector General during meetings of the Quality Care Board during the audit period, and also in the FY22 and FY23 OIG Annual Reports to the Governor and General Assembly. Issues raised involved staff shortages and concerns with the hiring process. Auditors requested the number of staff that the OIG had requested to hire during the audit period, the date the hiring request was made, the date the position was posted on the Illinois hiring portal, and the date the position was filled (or if the position was still vacant).

Exhibit 27 shows that during the audit period, FY21 through FY23, the OIG requested to hire for 38 positions. **Of those 38 hiring requests**, 17 positions had been filled as of August 17, 2023, and **21 were still vacant**. Of those positions, 33 were posted within three months. Four positions were posted between four and six months after the request was made, and one position, which was requested on April 6, 2023, had still not been posted as of August 14, 2023 (see note [1] in Exhibit 27). Once position requests were posted, two positions were filled within three months, **10 positions took between 4 and 6 months to fill**, **and five positions took between 7 and 12 months to fill after the hiring request was made.**

Exhibit 27
TIME FRAME FOR OIG HIRING REQUESTS TO GO THROUGH HIRING PROCESS
FY21 through FY23 (As of August 14, 2023)

	0-3 Months	4-6 Months	7-9 Months	10-12 Months	Over 12 Months
OIG hire request to position posted date[1]	33	4	0	0	0
Position posted date to hire date[2]	2	10	3	2	0
Positions vacant from hire request date[3]	5	7	7	2	0

[1] One hire request, which was made on 04/06/23, was not posted as of 08/14/23.
[2] 17 positions had been filled as of 08/17/23.
[3] 21 positions remained vacant as of 08/17/23.

Source: OAG analysis of OIG hiring data.

Personnel Issues Raised by OIG

During the entrance conference for this audit, OIG officials stated that multiple bureaus have lost headcount. According to OIG officials, if there is a lack of investigators, then timeliness worsens and caseloads increase. Lateral transfers from one position to another (i.e. transferring from one bureau to another) cause even more delays because they do not increase headcount, but a vacant position still needs to be filled. The OIG has not been able to hire investigators fast enough to maintain headcount. To address these challenges, the OIG had hired people on 75-day contracts during the audit period.

OIG Personnel Issues

"In the near future, there will be Bureau Chiefs that will be making less than lead investigators because of the current pay schedule, and there are currently employees applying for demotions."

OIG officials also stated that in the near future, there will be Bureau Chiefs that will be making less than lead investigators because of the current pay schedule, and there are currently employees that are applying for demotions.

Lastly, regarding personnel challenges, OIG officials stated that it is difficult to keep employees because they are being overloaded with work, and vacancies require employees to take on additional responsibilities.

Review of OIG Salary Data

Because of the concerns raised by OIG officials regarding an imbalance in pay structure between Investigative Team Leaders and Bureau Chiefs, auditors reviewed the calendar 2023 salaries for all OIG investigative staff. Exhibit 28 shows that 5 of 8 Investigative Team Leaders were making more than at least one Bureau Chief. Of these, four were making more than 2 of the 3 Bureau Chiefs, and one was making more than all three Bureau Chiefs. Of the 37 Investigators in the analysis, 27 were making more than at least one of the Investigative Team Leaders, and two of these Investigators were also making more than two of the three Bureau Chiefs.

Timeliness of Case Completion

OIG officials stated that a lack of investigators worsens timeliness and increases caseloads. As discussed previously within this audit, during FY23, it took the OIG an average of 205 calendar days to complete a case. The requirement for completing cases per OIG directives is 60 working days, which roughly equates to 80 calendar days. During the audit period, the OIG completed only 50 percent of cases within 60 working days during FY21, 52 percent during FY22, and 42 percent during FY23. This does represent a slight improvement when compared to the prior audit period, FY18 through FY20. **However, there were also 858 cases during the audit period that took 500 or more days to complete**. In general, the longer an investigation takes to complete, the more its usefulness is diminished. Additionally, residents are potentially at risk of ongoing abuse or neglect during this time period.

Exhibit 28
ANNUAL SALARY COMPARISON OF OIG INVESTIGATIVE STAFF[1]
CY23

	Yes	No
Investigative Team Leader Annual Salary Higher than Bureau Chief	5	3
Investigator Annual Salary Higher than Investigative Team Leader	27	10
Investigator Annual Salary Higher than Bureau Chief	2	35

[1] For the 48 employees with available Comptroller salary information. There are **3** Bureau Chiefs, **8** Investigative Team Leaders, and **37** Investigators within this analysis.

Source: OIG headcount and Illinois Comptroller Employee Salary database.

OIG Hiring and Personnel Issues

RECOMMENDATION NUMBER 11

The Office of the Inspector General and the Department of Human Services should work together in order to:

- ***identify and mitigate the bottlenecks in the hiring process; and***
- ***address pay structure imbalances for management positions.***

The Department of Human Services and the Office of the Inspector General Response:

IDHS accepts the recommendation and will continue to work to identify and mitigate delays in the hiring process for which we have the authority and ability to do so. The OIG merit comp staff salaries were examined and increases to existing and new Bureau Chief salaries were made in 2024. It is important to note that increases to existing salaries, and salary offers for newly hired positions must be approved by the Department of Central Management Services and is not in the sole discretion of IDHS.

DHS State-Operated Facility Issues

Auditors reviewed the overtime hours reported for DHS State-operated facility staff for FY23. DHS reported that 5,024 of 7,206 (70%) State-operated facility employees had overtime during this time period. **The 5,024 employees accumulated 1,606,962 hours of overtime during FY23; 793 of these employees accumulated between 501 and 997 hours of overtime, and 330 employees accumulated over 1,000 hours of overtime during FY23**. The additional income from accumulating an excessive amount of overtime could create an incentive for employees to continue working overtime when they physically and mentally should not be working.

Multiple academic studies have found that excessive amounts of overtime can have a detrimental effect on the care provided to residents or patients, as well as the health care workers providing the care. Many of the potential consequences may be attributable to sleep deprivation, which is strongly associated with excessive overtime. The job titles which had the highest number of employees with overtime are Mental Health Technician I, Mental Health Technician II, Mental Health Technician III, and Security Therapy Aide I. **These four job titles account for 253 of the 318 direct care employees with over 1,000 hours of overtime, and represent 349,138 of the 443,527 (79%) total hours of overtime accumulated by these 318 employees**. **The job descriptions for these positions show that direct interaction with residents is their primary responsibility.**

On June 7, 2023, the OIG released a report titled "Reducing Abuse and Neglect at Choate Mental Health and Developmental Center." The report outlined several issues the OIG found while conducting their review of the State-operated facility including: staffing shortages; employee fatigue; inappropriate staff behavior, such as mocking residents; lack of individualized treatment for residents; cover-up culture; obstacles to residents reporting allegations of abuse and neglect; staff non-reporting of misconduct; retaliation for reporting allegations of abuse and neglect, including fear of losing their job; and misreporting allegations of abuse and neglect. The OIG has not conducted a similar review on any of the other State-operated facilities. However, because there are a high number of allegations at several of the other State-operated facilities, it is likely that many of the issues discussed within the report on Choate are also occurring within these facilities as well. **The OIG does not have the statutory authority to address many of these issues, which are potentially contributing to the abuse and neglect of residents.**

Issues at DHS State-Operated Facilities

Because of the nature of the allegations of abuse and neglect occurring at State-operated facilities within the OIG data received by auditors, and a report released by the OIG on Choate Mental Health and Developmental Center, auditors asked OIG officials if they could provide insight into the causes of these occurrences. OIG officials responded that:

"*Several systemic issues lead to increased levels of abuse and neglect at facilities, a few of which are highlighted below.*

***Staff shortages**, which have been affecting facilities, **lead to staff working extended amounts of overtime and experiencing burnout**. When staff experience burnout, they are more likely to make poor decisions or react poorly to situations,*

which can lead to abuse and neglect. The staffing shortages also mean that facilities have to rely more on contractual staff who are not as experienced or trained as full-time state employees.

***Cover-up culture** also contributes to abuse and neglect at facilitates. **At some facilities, staff are able to intimidate new employees and contractual employees from reporting allegations or to provide false information for investigations.** With this culture, and given that discipline can be overturned through the grievance process, some **staff feel they can act with a sense of impunity**.*

*Lastly, as highlighted by Equip for Equality and in OIG's 2023 Choate Review, **a lack of active, individualized treatment and therapy for individuals residing at facilities can result in additional behaviors, which can provoke overreactions by burned out staff.***

In summary, although Rule 50 training is and will continue to be a critical part of OIG's role, larger, systemic issues will need to be addressed in order to prevent abuse and neglect in the long term." (emphasis added)

Overtime at DHS State-Operated Facilities

Because of the response provided by OIG officials, auditors reviewed the overtime hours reported for DHS State-operated facility staff for FY23. Auditors found that **during FY23, DHS State-operated facility employees were compensated for 1,606,962 hours of overtime**, which represents 72 percent of the total overtime hours reported by DHS (2,239,229 hours). DHS reported that 5,024 of 7,206 (70%) State-operated facility employees had overtime during this time period. Of these 5,024 employees:

- **330 employees accumulated over 1,000 hours of overtime during FY23 (29 accumulated over 2,000 hours); and**
- **793 employees accumulated between 501 and 997 hours of overtime during FY23.**

It is important to note that the hours of overtime reported do not necessarily reflect the amount of overtime worked. This can occur for multiple reasons, such as different rates of overtime pay for holidays, or the number of hours already worked in a day. Another reason this may occur is if a more senior employee is not offered a shift of overtime and files a successful grievance, the employee may be paid for that shift of overtime although they did not work during that shift. However, even when taking these instances into consideration, the amount of overtime being worked by State-operated facility employees appears excessive.

Exhibit 29
TOP 10 DHS FACILITY EMPLOYEES WITH OVERTIME
FY23 overtime hours, CY23 salary and actual pay

Employee #	FY23 OT Hours	CY23 Annual Rate of Pay	CY23 Gross Pay - Annual Rate of Pay	CY23 Gross Pay	CY23 Gross Pay as % of Annual Rate of Pay
1	3,331	$66,000	$161,800	**$227,800**	**345%**
2	2,745	$68,400	$135,300	**$203,700**	**298%**
3	2,627	$57,600	$109,400	**$167,000**	**290%**
4	2,622	$84,000	$159,600	**$243,600**	**290%**
5	2,582	$70,800	$134,000	**$204,800**	**289%**
6	2,526	$60,000	$89,300	**$149,300**	**249%**
7	2,496	$70,800	$118,600	**$189,400**	**268%**
8	2,475	$54,000	$90,100	**$144,100**	**267%**
9	2,453	$60,000	$114,000	**$174,000**	**290%**
10	2,429	$58,800	$104,000	**$162,800**	**277%**

Note: Hours of overtime is from data received from DHS and was by fiscal year; gross pay and annual rate of pay is from the Comptroller's website which is reported by calendar year. The Comptroller's website reports the rate of pay and year to date gross pay rounded pursuant to Public Act 100-0253.

Source: DHS and Illinois Comptroller Employee Salary database.

Exhibit 29 shows the 10 employees with the highest accumulated overtime hours for the State-operated facilities for FY23 as well as their CY23 annual rate of pay, CY23 gross pay per the Illinois Office of Comptroller's Employee Salary database, and the ratio of the employees' annual rate of pay to the gross amount paid to the employee for CY23. Overtime hours were from data received from DHS and were by fiscal year; annual rate of pay and gross pay was from the Comptroller's website, which was reported by calendar year.

The additional income from accumulating an excessive amount of overtime could create an incentive for employees to continue working overtime when they physically and mentally should not be working. Appendix E contains the top ten employees with the most overtime accumulated for FY23 from each DHS State-operated facility. As discussed below, working an excessive amount of overtime in a health care setting increases the risk of injury to residents, as well as to the employees.

Risks of Excessive Overtime

Excessive overtime creates an unsafe environment due to employee fatigue. Multiple academic studies have found that excessive amounts of overtime can have a detrimental effect on the care provided to residents or patients, as well as the health care workers providing the care. Many of the potential consequences may be attributable to sleep deprivation, which is strongly correlated with excessive overtime. Highlights of the potential consequences from the research auditors reviewed include:

- increased fatigue and errors in health care settings;
- association between long work hours and higher patient mortality rates;

- increased employee motor vehicle accidents;
- slowed reaction time;
- compromised problem solving abilities;
- burnout;
- decreased patient satisfaction;
- increased risk faced by staff, especially in settings serving aggressive populations;
- negative emotional states and impaired communication skills resulting from sleep deprivation; and
- higher rates of injuries to and neglect of patients.

The studies reviewed also discussed circumstances that may lead to health care workers working excessive amounts of overtime, such as economic pressures or mandatory overtime to cope with staffing shortages.

Of the 330 State-operated facility employees that accumulated over 1,000 hours of overtime during FY23, 318 had direct care job titles. Exhibit 30 shows that the job titles which had the highest number of employees with overtime are Mental Health Technician I, Mental Health Technician II, Mental Health Technician III, and Security Therapy Aide I. **These four job titles account for 253 of the 318 employees, and represent 349,139 of the 443,527 (79%) total hours of overtime accumulated by these 318 employees**. **The job descriptions for these positions show that direct interaction with residents is their primary responsibility.** It is crucial that employees with jobs that involve direct caregiving as the primary responsibility are not working an amount of overtime that causes fatigue. Allowing or requiring direct care employees to work excessive amounts of overtime can create an unsafe environment for residents and employees.

Exhibit 30
DHS FACILITY DIRECT CARE EMPLOYEES WITH OVER 1,000 HOURS OF OVERTIME
By Job Title for FY23

Job Title	Number of employees	Total OT Hours	Avg Hrs/ Employee
Mental Health Technician II	146	205,035	1,404
Security Therapy Aide I	41	54,702	1,334
Mental Health Technician I	36	47,353	1,315
Mental Health Technician III	30	42,049	1,402
Security Officer	16	22,424	1,402
Mental Health Technician IV	14	21,918	1,566
Registered Nurse II	14	18,279	1,306
Security Therapy Aide II	7	10,733	1,533
Registered Nurse I	5	6,783	1,357
Rehabilitation Workshop Instructor I	2	2,355	1,178
Rehabilitation Workshop Instructor II	2	4,567	2,284
Habilitation Program Coordinator	1	2,058	2,058
Mental Health Specialist Trainee	1	1,123	1,123
Physical Therapy Aide III	1	1,112	1,112
Residential Services Supervisor	1	1,964	1,964
Security Officer Sergeant	1	1,072	1,072
Totals	**318**	**443,527**	**1,395**

Source: OAG analysis of DHS data.

State-Operated Facility Allegations and Other Issues

On June 7, 2023, the OIG released a report titled "Reducing Abuse and Neglect at Choate Mental Health and Developmental Center." The report outlined several issues the OIG found while conducting their review of the facility including:

- staffing shortages;
- employee fatigue;
- inappropriate staff behavior, such as mocking residents;
- lack of individualized treatment for individuals;
- cover-up culture;
- obstacles to residents reporting allegations of abuse and neglect;
- staff non-reporting of misconduct;
- retaliation for reporting allegations of abuse and neglect, including fear of losing their job; and
- misreporting allegations of abuse and neglect.

During the audit period, FY21 through FY23, Choate Developmental Center had 606 allegations of abuse and neglect, which is the highest among State-operated facilities. The OIG has not conducted a similar review on any of the other State-operated facilities. **However, because there are a high number of allegations at several of the other State-operated facilities, it is likely that many of the issues discussed within the report on Choate are also occurring within these facilities as well**. (See Exhibit 31.)

Exhibit 31
ABUSE AND NEGLECT ALLEGATIONS BY FACILITY
FY21 through FY23

State-Operated Facility	Number of Allegations
Choate Developmental Center[1]	679
Elgin Mental Health Center	583
Kiley Developmental Center	386
Chester Mental Health Center	310
Ludeman Developmental Center	235
Shapiro Developmental Center	221
Alton Mental Health Center	218
Murray Developmental Center	200
Chicago-Read Mental Health Center	181
Packard Mental Health Center	156
Madden Mental Health Center	84
Mabley Developmental Center	62
Fox Developmental Center	13
Total Allegations	**3,328**

[1] Choate is a dual facility.

Source: OAG analysis of OIG data.

The OIG does not have the statutory authority to address many of these issues which are potentially contributing to the abuse and neglect of residents. **However, because of these issues, the OIG cannot effectively carry out their statutory mandate of investigating allegations of abuse and neglect, especially if instances of abuse or neglect are covered up, not reported at all, or they are misreported.**

As discussed in the background section of this audit, Public Act 103-0076 adds "**Material obstruction of an investigation**" to the list of potential findings of an investigation, which is reportable to the Health Care Worker Registry. If utilized, it may be a deterrent for some of the issues related to covering up or not truthfully reporting allegations. However, issues such as staffing shortages, employee fatigue, and not having individualized treatment plans for residents creates an environment where abuse and neglect are more likely to occur. These issues are not within the authority of the OIG to address. **All of the underlying issues must be effectively addressed to allow the OIG to perform investigations of abuse and neglect and fulfill their mandated obligation, which is imperative to ensuring the safety of residents living within State-operated facilities.**

Additionally, because of the inherent risks to residents and employees living and working within State-operated facilities associated with excessive overtime, specifically the risks for increased instances of abuse and neglect towards residents, DHS should work towards a solution to ensure that staffing levels are adequate at facilities. DHS should also work to reduce overtime to a level that fosters a more transparent and safe environment for State-operated facility residents and employees.

DHS State-Operated Facilities Staffing Levels

RECOMMENDATION NUMBER 12

The Department of Human Services should conduct a staffing analysis to determine if staffing levels at State-operated facilities are adequate. The staffing analysis should take into consideration the need to reduce excessive amounts of employee overtime, especially for direct care employees.

Department of Human Services Response:

The Department of Human Services accepts the recommendation. IDHS is in the process of reviewing current staffing levels at State-operated Facilities (SOF) in an effort to ensure staffing levels are adequate and appropriate. For FY20 through FY23, IDHS has onboarded over 2,000 Mental Health Technicians across its State-operated Facilities. Furthermore, IDHS has worked to implement changes to the collective bargaining agreements in an effort to expedite the hiring process for these positions and is in the preliminary stages of establishing positions that would be dedicated to performing ongoing staffing analysis for the Department.

IDHS's staffing has been challenged by retirement and retention problems that have been experienced nationally, for 24/7 facilities and for the behavioral health workforce, in particular. IDHS addressed this, in part, during and following the COVID-19 Public Health Emergency, through the use of contractual employees to help bolster the State employee workforce at its SOFs, always prioritizing the use of State employees over contractual ones. Based on and in response to a grievance and arbitration, IDHS has virtually eliminated the use of contractual employees serving in Mental Health Technician positions, while, at the same time, continuing to aggressively hire and take steps to ensure the retention of State employees at the SOFs.

The use of and rules governing overtime is negotiated and collectively bargained between the State and its labor partners. Within the limitations of how many actual, physical shifts an individual employee can work, overtime is first offered voluntarily and, if needed, and in the absence of volunteers, mandated, as necessary.

Appendix A

Department of Human Services Act
(20 ILCS 1305/1-17)

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

Appendix B

Audit Scope and Methodology

This audit was conducted in accordance with the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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

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

This audit covers the period FY21, FY22, and FY23. Initial work began on this audit in June 2023 and fieldwork was concluded in May 2024. We interviewed or contacted representatives from the DHS Inspector General's Office, DHS Internal Audit, and the Illinois State Police. We also reviewed documents and data from the DHS Inspector General's Office, the DHS Division of Developmental Disabilities, the DHS Division of Mental Health, and the Illinois State Police. We examined the current OIG organizational structure, policies and procedures, and investigation requirements. We also reviewed internal controls over the investigation process.

We analyzed investigations data provided by the OIG from its electronic database for FY21 through FY23.

We also analyzed training data provided by the OIG from its electronic database for FY21 through FY23. We reviewed OIG's compliance with training

requirements outlined in its directives and the Department of Human Services Act (20 ILCS 1305/17(h)).

We analyzed FY21 through FY23 hiring information provided by the OIG and State-operated facility overtime data for FY23 provided by DHS as well as salary information for OIG investigative employees and DHS facility employees from the Comptroller's employee salary database.

We assessed risk by reviewing recommendations from previous OIG audits conducted by the Office of the Auditor General, OIG internal documents, policies and procedures, management controls, and the OIG's administrative rules. We reviewed management controls relating to the audit objectives that were identified in section 1-17(w) of the Department of Human Services Act (20 ILCS 1305) (see Appendix A). The audit reports on any weaknesses in those controls and includes them as recommendations.

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

Testing and Analytical Procedures

From cases closed in FY23, we selected a random sample of 50 cases with a proportionate distribution by Bureau, and by facility and agency. The distribution of cases in this manner allowed us to focus more specifically on areas that have a higher risk associated with them. For FY23, 58.9 percent of total closed cases were from community agencies, and 41.1 percent were from State-operated facilities. By using this methodology, the sample more accurately reflects the current overall population of case distribution at the OIG, and additionally allows more in depth audit reporting where there is greater risk. Using a data collection instrument, we gathered certain information from case files and developed a database of sample information to analyze. That information included verification of data from the OIG electronic system. The sample distribution of our sample between facilities and agencies is below:

- The total population of investigations closed at State-operated facilities in FY23 was 1,061. We sampled 21 of these investigations; and
- The total population of investigations closed at community agencies in FY23 was 1,519. We sampled 29 of these investigations.

Testing results cannot be extrapolated to the overall population.

We also performed analyses based on an electronic database of OIG reported cases from FY21 through FY23 and did comparisons of similar data from prior OIG audits. These databases represent a snapshot at the time we received the information. The validity of electronic data was verified as part of our case file testing described above.

The Office of the Auditor General has conducted 13 prior OIG audits to assess the effectiveness of its investigations into allegations of abuse and neglect, as

required by statute. These audits were released in 1990, 1993, 1994, 1996, 1998, 2000, 2002, 2004, 2006, 2008, 2010, 2017, and 2021.

Auditors held an exit conference to discuss the draft audit report with officials from the Department of Human Services and the Department of Human Services Office of the Inspector General. The date of the Exit Conference and the attendees are noted below:

Exit Conference	**October 24, 2024**
Agency	**Name and Title**
Illinois Department of Human Services	• Dulce Quintero, Secretary Designate • Tiffany Blair, Chief of Staff • Amy Macklin. Chief Internal Auditor • Matt Sporlein, Internal Auditor • Christopher Finley, Internal Auditor • Robert Brock, Chief Financial Officer • John Schomberg, General Counsel • Ryan Thomas, Acting Assistant Secretary of Operations • David Albert, Director, Division of Mental Health • Tonya Piephoff, Director, Division of Developmental Disabilities • Debra Muhlstadt, Public Service Administrator • Ryan Rollison, LCSW, Chief of Staff • Christofer Albert, Public Service Administrator
Illinois Department of Human Services Office of the Inspector General	• Charles Wright, Inspector General • Bill Diggins, Assistant Deputy Inspector General • Jesus Escarpita, OIG Chief Administrative Officer
Illinois Office of the Auditor General	• Patrick Rynders, Senior Audit Manager • Alison Storm, Audit Supervisor • Joshlyn Lomax, Staff Auditor • Marcellus Romious, Staff Auditor

Appendix C

Rate of Substantiated Abuse or Neglect Cases by Facility and Agency

FY21, FY22, and FY23

Facility/ Community Agencies	Fiscal Year 2021			Fiscal Year 2022			Fiscal Year 2023		
	Number Closed	Number Substantiated	Substantiation Rate	Number Closed	Number Substantiated	Substantiation Rate	Number Closed	Number Substantiated	Substantiation Rate
Alton	54	4	7%	86	4	5%	65	4	6%
Chester	122	9	7%	90	8	9%	88	3	3%
Chicago-Read	45	2	4%	40	0	0%	67	1	1%
Choate[1]	197	4	2%	153	8	5%	235	21	9%
Elgin	104	1	1%	129	0	0%	147	0	0%
Fox	6	1	17%	7	1	14%	10	1	10%
Kiley	95	1	1%	105	4	4%	147	12	8%
Ludeman	108	16	15%	77	10	13%	45	7	16%
Mabley	23	3	13%	15	0	0%	27	4	15%
Madden	28	3	11%	24	1	4%	18	1	6%
Murray	58	4	7%	74	5	7%	81	5	6%
Packard	37	0	0%	55	2	4%	61	5	8%
Shapiro	55	0	0%	39	2	5%	99	3	3%
Community Agencies[2]	1,770	263	15%	1,703	241	14%	1,651	248	15%
Totals	**2,702**	**311**	**12%**	**2,597**	**286**	**11%**	**2,741**	**315**	**11%**

[1] Choate is a dual facility (DD/MH); the allegations, substantiated cases, and substantiation rate are combined.

[2] Community Agency closed cases, substantiated cases, and substantiation rate are reported in the aggregate.

Source: OAG analysis of OIG data.

Appendix D

Allegations by Facility and Community Agencies

FY21, FY22, and FY23

Location	Abuse Allegations								
	A1 Physical abuse – imminent danger			A2 Physical abuse – serious injury			A3 Other physical abuse		
	FY21	FY22	FY23	FY21	FY22	FY23	FY21	FY22	FY23
Alton	-	-	-	1	-	1	25	19	21
Chester	3	-	-	5	8	11	55	56	55
Chicago-Read	-	-	-	4	3	4	17	10	17
Choate[1]	11	1	4	4	6	9	95	75	130
Elgin	-	-	-	2	3	3	32	72	92
Fox	-	-	-	-	-	-	1	1	1
Kiley	-	-	-	3	5	13	48	79	55
Ludeman	-	-	-	1	13	9	27	33	40
Mabley	-	-	-	1	2	5	6	10	10
Madden	-	-	-	-	1	3	3	9	12
Murray	2	-	1	2	3	9	18	44	48
Packard	-	-	1	1	3	3	17	23	22
Shapiro	-	-	-	5	2	12	26	47	67
Community Agencies[2]	7	3	8	42	55	43	458	541	547
Totals	**23**	**4**	**14**	**71**	**104**	**125**	**828**	**1,019**	**1,117**

[1] Choate is a dual facility (DD/MH); the allegations are combined.

[2] Community Agency allegations are reported in the aggregate.

Source: OAG analysis of OIG data.

Abuse Allegations											
A4 Sexual abuse			A5 Verbal abuse			A6 Psychological abuse			A7 Financial exploitation		
FY21	FY22	FY23	FY21	FY22	FY23	FY21	FY22	FY23	FY21	FY22	FY23
4	6	16	17	16	9	6	9	11	8	6	4
6	5	1	9	7	13	12	2	5	1	1	-
6	4	7	7	7	12	5	8	11	-	4	6
16	9	16	49	23	33	38	16	24	2	2	5
16	28	31	30	24	37	14	16	31	20	12	16
-	-	-	-	-	1	-	-	-	-	-	-
3	8	7	18	11	12	7	1	7	-	2	3
-	-	-	5	8	7	3	1	4	-	1	-
-	1	-	-	-	1	3	-	2	1	-	-
1	2	6	2	7	7	4	6	1	1	-	-
-	1	3	1	1	4	1	3	4	-	1	2
4	10	4	4	13	3	3	15	4	4	3	2
3	1	4	5	1	7	2	2	8	-	-	-
70	64	64	140	161	225	132	132	159	62	92	118
129	**139**	**159**	**287**	**279**	**371**	**230**	**211**	**271**	**99**	**124**	**156**

Location	Neglect Allegations								
	N1 Neglect – imminent danger			N2 Neglect – serious injury			N3 Neglect – non-serious injury		
	FY21	FY22	FY23	FY21	FY22	FY23	FY21	FY22	FY23
Alton	-	-	-	1	-	1	1	3	5
Chester	-	-	-	-	1	3	2	1	2
Chicago-Read	-	-	1	-	-	1	1	1	8
Choate[1]	1	-	1	2	2	7	3	9	6
Elgin	-	1	-	-	-	7	8	9	13
Fox	-	-	-	1	1	1	-	-	-
Kiley	1	1		6	2	11	7	9	19
Ludeman	-	-	1	7	7	3	2	4	4
Mabley	-	-	-	-	4	3	-	-	1
Madden	-	-	-	1	-	1	2	-	1
Murray	-	-	-	2	7	4	2	4	8
Packard	-	-	-	-	-	-	-	1	3
Shapiro	-	-	-	1	2	7	1	1	1
Community Agencies[2]	6	2	5	57	90	102	75	107	131
Totals	**8**	**4**	**8**	**78**	**116**	**151**	**104**	**149**	**202**

[1] Choate is a dual facility (DD/MH); the allegations are combined.

[2] Community Agency allegations are reported in the aggregate.

Source: OAG analysis of OIG data.

Neglect Allegations															
N4 Neglect in an individual's absence			N5 Neglect in recipient sexual activity			N6 Neglect in theft of recipient property			N7 Neglect with risk of harm or injury			N9 Neglect with risk of COVID-19		
FY21	FY22	FY23	FY21	FY22	FY23	FY21	FY22	FY23	FY21	FY22	FY23	FY21	FY22	FY23
-	-	-	-	-	-	-	-	-	13	9	6	-	-	-
-	-	-	-	1	-	-	-	-	11	19	11	3	1	-
1	1		1	2	1				5	8	14			4
-	1	1	10	-	1	-	-	-	25	16	24	1	1	-
-	-	-	-	-	-	-	1	-	8	23	31	2	1	-
-	-	-	-	-	-	-	-	-	2	1	2	1	-	-
1	3	1	-	1	-	-	-	-	5	14	22	1	-	-
-	3	-	-	-	-	-	-	-	12	18	10	12	-	-
1	-	-	-	1	-	-	-	-	1	4	5	-	-	-
-	-	1	-	-	-	-	-	-	5	4	4	-	-	-
-	-	1	-	-	1	-	-	-	9	4	9	-	-	1
-	-	-	-	-	-	-	-	-	7	2	4	-	-	-
-	-	-	-	1	1	-	-	-	3	3	8	-	-	-
38	44	18	7	5	9	1	2	-	350	417	514	30	12	3
41	**52**	**22**	**18**	**11**	**13**	**1**	**3**	**0**	**456**	**542**	**664**	**50**	**15**	**8**

Location	Death Reports								
	D1 Suicide in program			D2 Suicide within 14 days after discharge			D4 Death in residential program		
	FY21	FY22	FY23	FY21	FY22	FY23	FY21	FY22	FY23
Alton	-	-	-	-	-	-	-	-	-
Chester	1	-	-	-	-	-		-	-
Chicago-Read	-	-	-	-	-	-	-	-	-
Choate[1]	-	-	-	-	-	-	-	-	-
Elgin	-	-	-	-	-	-	1		
Fox	-	-	-	-	-	-	2	2	1
Kiley	-	-	-	-	-	-	-	2	1
Ludeman	-	-	-	-	-	-	1	4	3
Mabley	-	-	-	-	-	-	2	1	-
Madden	-	-	1	-	-	-	-	-	-
Murray	-	-	-	-	-	-	2	3	5
Packard	-	-	-	-	-	-	-	-	-
Shapiro	-	-	-	-	-	-	2	3	1
Community Agencies[2]	-	-	1	-	-	-	65	68	72
Totals	**1**	**0**	**2**	**0**	**0**	**0**	**75**	**83**	**83**

[1] Choate is a dual facility (DD/MH); the allegations are combined.

[2] Community Agency death reports are shown in the aggregate.

Source: OAG analysis of OIG data.

Death Reports											
D5 Death not in a residential program			D6 Death due to natural cause in a program			D7 Any other reportable death			D9 Death due to COVID-19		
FY21	FY22	FY23	FY21	FY22	FY23	FY21	FY22	FY23	FY21	FY22	FY23
-	-	-	-	-	-	-	-	-	-	-	-
1	1	-	-	-	1	-	-	-	-	-	-
-	-	-	1	1	-	-	-	-	1	-	-
-	2	-	-	-	-	-	1	-	1	-	-
1	2	1				2	2	1	2		
1	-	2	1	1	-	-	-	2	-	-	-
3	1	-	-	-	-	-	-	-	-	1	-
1	3	3	1	-	-	-	-	3	-	-	-
2	1	1	-	-	-	-	1	-	-	-	-
1	-	-	-	1	-	-	-	-	-	-	-
2	2	1	2	1	2	-	1	2	1	-	-
-	-	-	1	-	-	-	-	-	1	-	-
2	4	3	-	1	-	1	-	-	1	-	-
55	73	65	40	42	20	3	12	26	26	7	3
69	**89**	**76**	**46**	**47**	**23**	**6**	**17**	**34**	**33**	**8**	**3**

Appendix E

Top 10 DHS Facility Employees With Overtime

FY23 Overtime, CY23 Annual Rate of Pay and Gross Pay

Alton Mental Health Center

Employee #	FY23 OT Hours	CY23 Annual Rate of Pay	CY23 Gross Pay - Annual Rate of Pay	CY23 Gross Pay	CY23 Gross Pay as % of Annual Rate of Pay
1	2,122	$57,600	$87,000	$144,600	251%
2	1,559	$57,600	$54,500	$112,100	195%
3	1,441	$55,200	$62,100	$117,300	213%
4	1,359	$64,800	$49,900	$114,700	177%
5	1,228	$60,000	$44,900	$104,900	175%
6	1,213	$84,000	$60,300	$144,300	172%
7	1,187	$55,200	$53,900	$109,100	198%
8	1,133	$55,200	$39,400	$94,600	171%
9	1,093	$64,800	$45,800	$110,600	171%
10	1,080	$55,200	$44,600	$99,800	181%

Chester Mental Health Center

Employee #	FY23 OT Hours	CY23 Annual Rate of Pay	CY23 Gross Pay - Annual Rate of Pay	CY23 Gross Pay	CY23 Gross Pay as % of Annual Rate of Pay
1	2,622	$84,000	$159,600	$243,600	290%
2	2,582	$70,800	$134,000	$204,800	289%
3	1,670	$62,400	$70,700	$133,100	213%
4	1,615	$79,200	$89,200	$168,400	213%
5	1,613	$55,200	$60,200	$115,400	209%
6	1,529	$55,200	$68,100	$123,300	223%
7	1,442	$78,000	$97,100	$175,100	224%
8	1,284	$55,200	$65,300	$120,500	218%
9	1,242	$55,200	$22,700	$77,900	141%
10	1,188	$55,200	$59,300	$114,500	207%

Chicago-Read Mental Health Center					
Employee #	FY23 OT Hours	CY23 Annual Rate of Pay	CY23 Gross Pay - Annual Rate of Pay	CY23 Gross Pay	CY23 Gross Pay as % of Annual Rate of Pay
1	2,627	$57,600	$109,400	$167,000	290%
2	1,769	$58,800	$34,200	$93,000	158%
3	1,690	$93,600	$124,400	$218,000	233%
4	1,543	$49,200	$23,900	$73,100	149%
5	1,504	$97,200	$124,500	$221,700	228%
6	1,504	$93,600	$112,200	$205,800	220%
7	1,481	$93,600	$102,800	$196,400	210%
8	1,480	$54,000	$56,200	$110,200	204%
9	1,471	$86,400	$120,500	$206,900	239%
10	1,422	$55,200	$63,300	$118,500	215%

Choate Mental Health and Developmental Center					
Employee #	FY23 OT Hours	CY23 Annual Rate of Pay	CY23 Gross Pay - Annual Rate of Pay	CY23 Gross Pay	CY23 Gross Pay as % of Annual Rate of Pay
1	2,058	$92,400	$86,000	$178,400	193%
2	1,964	$84,000	$122,400	$206,400	246%
3	1,839	$63,600	$90,200	$153,800	242%
4	1,540	$68,400	$76,600	$145,000	212%
5	1,328	$54,000	$59,000	$113,000	209%
6	1,261	$54,000	$39,900	$93,900	174%
7	1,208	$84,000	$67,100	$151,100	180%
8	1,182	$46,800	$36,000	$82,800	177%
9	1,095	$55,200	$48,100	$103,300	187%
10	1,086	$54,000	$41,900	$95,900	178%

Elgin Mental Health Center					
Employee #	FY23 OT Hours	CY23 Annual Rate of Pay	CY23 Gross Pay - Annual Rate of Pay	CY23 Gross Pay	CY23 Gross Pay as % of Annual Rate of Pay
1	2,745	$68,400	$135,300	$203,700	298%
2	2,496	$70,800	$118,600	$189,400	268%
3	2,136	$52,800	$68,300	$121,100	229%
4	1,922	$57,600	$88,400	$146,000	253%
5	1,660	$70,800	$77,200	$148,000	209%
6	1,628	$55,200	$64,600	$119,800	217%
7	1,584	$57,600	$72,400	$130,000	226%
8	1,548	$69,600	$66,100	$135,700	195%
9	1,465	$62,400	$60,400	$122,800	197%
10	1,437	$81,600	$83,300	$164,900	202%

Fox Developmental Center					
Employee #	FY23 OT Hours	CY23 Annual Rate of Pay	CY23 Gross Pay - Annual Rate of Pay	CY23 Gross Pay	CY23 Gross Pay as % of Annual Rate of Pay
1	1,087	$58,800	$39,800	$98,600	168%
2	1,008	$61,200	$49,400	$110,600	181%
3	981	$66,000	$31,800	$97,800	148%
4	926	$97,200	$77,800	$175,000	180%
5	916	$54,000	$43,300	$97,300	180%
6	797	$58,800	$35,000	$93,800	160%
7	696	$54,000	$26,500	$80,500	149%
8	667	$61,200	$20,200	$81,400	133%
9	660	$55,200	$24,100	$79,300	144%
10	650	$99,000	$59,200	$158,200	160%

Kiley Developmental Center					
Employee #	FY23 OT Hours	CY23 Annual Rate of Pay	CY23 Gross Pay - Annual Rate of Pay	CY23 Gross Pay	CY23 Gross Pay as % of Annual Rate of Pay
1	2,453	$60,000	$114,000	$174,000	290%
2	2,341	$58,800	$101,400	$160,200	272%
3	2,048	$51,600	$94,200	$145,800	283%
4	2,041	$57,600	$58,900	$116,500	202%
5	1,952	$58,800	$101,600	$160,400	273%
6	1,717	$58,800	$82,900	$141,700	241%
7	1,705	$55,200	$55,300	$110,500	200%
8	1,680	$55,200	$71,700	$126,900	230%
9	1,678	$46,800	$44,900	$91,700	196%
10	1,671	$61,200	$73,500	$134,700	220%

Ludeman Developmental Center					
Employee #	FY23 OT Hours	CY23 Annual Rate of Pay	CY23 Gross Pay - Annual Rate of Pay	CY23 Gross Pay	CY23 Gross Pay as % of Annual Rate of Pay
1	3,331	$66,000	$161,800	$227,800	345%
2	2,526	$60,000	$89,300	$149,300	249%
3	2,475	$54,000	$90,100	$144,100	267%
4	2,429	$58,800	$104,000	$162,800	277%
5	2,257	$54,000	$86,500	$140,500	260%
6	2,187	$54,000	$88,200	$142,200	263%
7	2,144	$62,400	$67,800	$130,200	209%
8	2,060	$58,800	$88,600	$147,400	251%
9	1,988	$54,000	$74,300	$128,300	238%
10	1,973	$54,000	$82,500	$136,500	253%

Mabley Developmental Center					
Employee #	FY23 OT Hours	CY23 Annual Rate of Pay	CY23 Gross Pay - Annual Rate of Pay	CY23 Gross Pay	CY23 Gross Pay as % of Annual Rate of Pay
1	1,312	$56,400	$49,300	$105,700	187%
2	1,174	$61,200	$34,100	$95,300	156%
3	1,134	$56,400	$46,300	$102,700	182%
4	1,087	$61,200	$54,200	$115,400	189%
5	1,068	$61,200	$56,100	$117,300	192%
6	1,055	$56,400	$42,900	$99,300	176%
7	969	$56,400	$46,900	$103,300	183%
8	962	$61,200	$51,500	$112,700	184%
9[1]	947	$50,400	$48,300	$98,700	196%
10	912	$56,400	$46,400	$102,800	182%

[1]During CY23 this employee earned less than their base salary, however the CY23 OT hours reported still show that they were in the top 10 for Mabley. Therefore their CY22 Base Salary, OT Pay, and Actual Pay is reported.

Madden Mental Health Center					
Employee #	FY23 OT Hours	CY23 Annual Rate of Pay	CY23 Gross Pay - Annual Rate of Pay	CY23 Gross Pay	CY23 Gross Pay as % of Annual Rate of Pay
1	2,233	$61,200	$103,900	$165,100	270%
2	1,351	$76,800	$96,800	$173,600	226%
3	1,110	$73,200	$72,800	$146,000	199%
4	1,087	$98,400	$97,700	$196,100	199%
5	981	$58,800	$32,000	$90,800	154%
6	980	$98,400	$81,100	$179,500	182%
7	975	$58,800	$30,600	$89,400	152%
8	968	$58,800	$30,900	$89,700	153%
9	899	$60,000	$39,600	$99,600	166%
10	892	$97,200	$92,100	$189,300	195%

Murray Developmental Center					
Employee #	FY23 OT Hours	CY23 Annual Rate of Pay	CY23 Gross Pay - Annual Rate of Pay	CY23 Gross Pay	CY23 Gross Pay as % of Annual Rate of Pay
1	2,057	$58,800	$91,600	$150,400	256%
2	1,492	$61,200	$60,300	$121,500	199%
3	1,451	$55,200	$59,800	$115,000	208%
4	1,382	$93,600	$79,200	$172,800	185%
5	1,138	$49,200	$27,000	$76,200	155%
6	1,123	$55,200	$32,200	$87,400	158%
7	1,113	$54,000	$37,400	$91,400	169%
8	1,020	$54,000	$45,300	$99,300	184%
9	978	$54,000	$38,100	$92,100	171%
10	960	$66,000	$47,900	$113,900	173%

Packard Mental Health Center					
Employee #	FY23 OT Hours	CY23 Annual Rate of Pay	CY23 Gross Pay - Annual Rate of Pay	CY23 Gross Pay	CY23 Gross Pay as % of Annual Rate of Pay
1	1,577	$97,200	$152,300	$249,500	257%
2	1,355	$99,600	$122,400	$222,000	223%
3	1,297	$54,000	$51,300	$105,300	195%
4	1,087	$61,200	$40,400	$101,600	166%
5	1,082	$54,000	$36,100	$90,100	167%
6	1,027	$55,200	$44,400	$99,600	180%
7	1,006	$97,200	$74,900	$172,100	177%
8	963	$90,000	$57,300	$147,300	164%
9	917	$49,200	$36,000	$85,200	173%
10	914	$55,200	$26,800	$82,000	149%

Shapiro Developmental Center					
Employee #	**FY23 OT Hours**	**CY23 Annual Rate of Pay**	**CY23 Gross Pay - Annual Rate of Pay**	**CY23 Gross Pay**	**CY23 Gross Pay as % of Annual Rate of Pay**
1	2,421	$58,800	$103,200	$162,000	276%
2	2,358	$54,000	$87,400	$141,400	262%
3	2,276	$54,000	$82,500	$136,500	253%
4	2,156	$49,200	$47,000	$96,200	196%
5	2,153	$58,800	$90,000	$148,800	253%
6	2,028	$63,600	$83,500	$147,100	231%
7	2,019	$54,000	$73,400	$127,400	236%
8	1,936	$58,800	$29,100	$87,900	149%
9	1,934	$49,200	$70,600	$119,800	243%
10	1,931	$54,000	$59,000	$113,000	209%

Note: Hours of overtime is from data received from DHS and was by fiscal year; gross pay and annual rate of pay is from the Comptroller's website which is reported by calendar year. The Comptroller's website reports the rate of pay and year to date gross pay rounded pursuant to Public Act 100-0253.

Source: DHS and Illinois Office of Comptroller State Employee Salary Database.

Appendix F
Agency Responses

JB Pritzker, *Governor*

IDHS ILLINOIS DEPARTMENT OF HUMAN SERVICES

Dulce M. Quintero, *Secretary Designate*

October 30, 2024

Patrick Rynders
Illinois Office of the Auditor General
400 W. Monroe
Suite 306

Re: Program Audit of Illinois Department of Human Services Office of Inspector General

Patrick,

Attached are management responses for the recommendations resulting from the Program Audit of the Illinois Department of Human Services Office of Inspector General for the period ended June 30, 2023.

If you require any additional information or have questions, please contact Amy Macklin, Chief Internal Auditor, at (217) 720-9370.

Sincerely,

SIGNED ORIGINAL ON FILE

Amy Macklin, CPA
Chief Internal Auditor

cc:
Dulce Quintero, IDHS, Secretary Designate
Tiffany Blair, IDHS, Chief of Staff
Charles Wright, IDHS OIG, Inspector General
John Schomberg, IDHS, General Counsel
Ryan Thomas, IDHS, Assistant Secretary of Operations
Matthew Sporlein, IDHS, Audit Liaison

Recommendation-1 Allegation Reporting

Recommendation: ***The Office of the Inspector General should: improve the collection of information regarding the date and time the incident is discovered; and continue to work with State-operated facilities and community agencies to improve the number of allegations of abuse and neglect that are reported within the four-hour timeframe specified within the Department of Human Services Act and the OIG's administrative rules.***

Management Response:
OIG accepts the recommendation. OIG agrees obtaining accurate date and time information regarding when the incident occurred and was discovered is important to the investigation. Generally, when an intake contains vague date and time information, it is due to the caller being unable to provide more specific information. Many times, the caller is presenting 2nd and 3rd hand information, or the caller is the victim or an individual, who cannot provide such detailed information. OIG intake investigators are trained to gather as much specific detail from the caller about date and times as required by OIG's Directives which specifically requires that when a caller does not know or is unable to provide the specific date or time the incident occurred or was discovered, the Intake Investigator is to enter into the database whatever information the caller can provide regarding the occurrence date/time or discovery date/time (e.g., unknown, January 2020, between 1/19/20 and 1/20/20). If the caller did not discover the incident but knows the identity of the person who did, the Intake Investigator will enter that person's name into the database for follow-up by the assigned bureau Investigator. Because of OIG's training and the hard work of OIG intake investigators and supervisors, OIG is confident this is being done and when vague dates and times are entered into the database, this was all the information the caller was able to provide. OIG will continue training with Intake staff to attempt to gather as detailed information as possible.

OIG's Rule 50 training highlights the important four-hour time frame requirement for the reporting of allegations to the OIG hotline. Also, after the last audit, OIG sent out special memoranda to all State Operated Facilities (SOF) and community agencies (CA) about this requirement. However, ultimately, the timeliness of reporting depends on the SOF/CA staff and is outside OIG's control. In those cases, OIG will continue to make appropriate recommendations about these issues to SOF/CA. OIG will continue to work with IDHS to ensure that SOFs and CA staff are aware of this important requirement through its trainings and recommendations.

Recommendation-2 Investigator Assignment

Recommendation: ***The Office of the Inspector General should ensure that cases are assigned to an investigator within three working days upon receiving an allegation of abuse or neglect, as required by OIG's directives.***

Management Response:
OIG accepts the recommendation. OIG agrees that timely assignment of allegations is important to the investigation and appreciates the audit report highlighting that in each of the three years audited, OIG assigned over 90% of the over 2,500 cases received each year within the 3 day-requirement. Additionally, as documented by the auditors, OIG has had a serious lack of staff over the past several years. The Bureau of Hotline and Intake was no different which has a severe shortage of intake investigators and bureau management due to retirements and significant delays related to the hiring process. Unfortunately, the ongoing staff shortage has persisted as overall calls, including reportable and non-reportable calls, have increased. As of October 2024, OIG has 6 intake investigators, and 5 unfilled intake investigator positions that are in various stages of the hiring process. Also, since the last audit, OIG created and filled another Intake Investigative Team Leader position to supervise and complete intakes.

In addition, for a portion of reportable allegations, determining whether an intake is reportable takes more time than the timeframe requirements of the directive due to the lack of information from the caller, call backs to gather needed information, difficulty reaching the caller, spending more time to gather needed information with the caller (like a victim or individual) etc. OIG's Directives notes that allegations will be processed within two days absent extenuating circumstances and as such, allows for additional time to determine whether an intake is reportable. OIG will continue to train Intake staff to ensure they are asking for as detailed information as possible and will continue to seek additional staff in an effort to improve timeliness of assignment.

Recommendation-3 Case Completion Timeliness

Recommendation: ***The Office of the Inspector General should work to improve the timeliness of investigative case completion by identifying the barriers that are preventing timely completion and seeking the appropriate remedies for the issues identified.***

Management Response:
OIG accepts the recommendation. As documented by the auditors, there has been a shortage of investigative staff, investigative supervisors, and administrative support. This shortage impacts OIG processes at all stages of the investigative process, including case timeliness. OIG's staff shortage, together with the slow pace of hiring, has a direct impact on OIG's ability to complete timely investigations, which is an issue OIG highlighted in its FY23 Annual Report. Staff shortages result in growing case backlogs which further impact OIG's timeliness of case completion. OIG has worked closely with IDHS to increase headcount and is in the process of substantial additional hiring. However, it will take time for the new hires to make a noticeable impact on timeliness, as training takes time and significant effort from supervisory staff. OIG continuously reviews processes for timeliness improvements and training opportunities.

Recommendation-4 Timeliness of Interviews and Statements

Recommendation: ***The Office of the Inspector General should work to improve the timeliness of OIG conducted interviews, and State-operated facility and community agency liaison conducted statements, including ensuring initial written statements are taken within 72 hours per OIG directive; and ensuring the complainant and/or required reporter and the victim and/or guardian are interviewed by an OIG investigator within 15 working days of assignment per OIG directive.***

Management Response:
OIG accepts the recommendation. OIG provides training and direction to State Operated Facilities (SOF) and Community Agencies (CA) about this important requirement. It should be noted the SOF/CA are also facing staff shortages which impacts their ability to complete this important task. OIG will continue to work with IDHS to provide more training and direction to improve these issues.

OIG agrees timely interviews of the victim(s) and complainant(s) are important to a good investigation. As documented by the auditors, the shortage of investigative staff has a direct impact on the ability for timely interviews. Recent staffing shortages have resulted in investigator caseloads growing significantly, making it challenging to complete interviews within the required timeframe. OIG is in the process of hiring numerous investigators and supervisors, which is anticipated to improve interview timeliness over time. OIG will also continue to train investigators on this requirement and supervisors will continue to provide oversight and monitoring.

OIG also expects that an upcoming change in technology will help in this area. In 2025, OIG will have a new Case Management System which will better track and document when the investigator is unsuccessful in reaching the victim or complainant within the required timeframes. Currently, these are documented in the Case Management System in the Case Actions.

Recommendation-5 Timeliness of Supervisory Review

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

Management Response:
OIG accepts the recommendation. Shortage of investigative staff has impacted review timeliness as Bureau Chiefs and Investigative Team Leaders are working investigations, assisting with interviews, writing reports, and training new investigators, which takes them away from reviewing investigations. Additionally, due to a shortage of Investigative Team Leaders and Bureau Chiefs in various bureaus during the audit period, other bureaus had to pick up additional reviews, which delayed review times across the board. As of October 2024, OIG is currently at headcount for Bureau Chiefs and Investigative Team Leaders, but many supervisors are new and still learning the job. Unfortunately, the extended shortage of Bureau Chiefs and Investigative Team Leaders resulted in a backlog of case reviews that will affect overall timeliness for a considerable period of time. While Investigative Team Leaders normally handle unfounded and unsubstantiated case reviews, OIG's Bureau Chiefs, Investigative Team Leaders, Assistant Deputy Inspector Generals, Policy Manager, Deputy Inspector General, and Inspector General have all recently been assigned unfounded and unsubstantiated case reviews to keep cases moving along. Also, OIG will be revising and clarifying OIG's Directives to match OIG's current review practice, which gives the Investigative Team Leaders and Bureau Chiefs up to 15 workdays each to review an investigation upon receipt. The current directive, which indicates that they get a total of 15 workdays together from initial receipt, is incorrect.

Recommendation-6 Case Closure Checklists & Case Tracking Checklists

Recommendation: ***The Office of the Inspector General should ensure that all Case Closure Checklists are properly reviewed, and Case Tracking Checklists are completed.***

Management Response:
OIG accepts the recommendation. On July 1, 2024, OIG discontinued the use of these forms, as this information was also captured in the OIG Case Management System which OIG administrative staff were using to process and close cases. This revised process was included in OIG's Directives.

Recommendation-7 Quality Care Board

Recommendation: ***The Secretary of the Department of Human Services and the Inspector General should work with the Governor's Office to appoint members to the Quality Care Board and ensure that members who are serving on expired terms are reappointed or replaced in order to fulfill statutory requirements in the Department of Human Services Act (20 ILCS 1305/1-17(u)).***

Management Response:
IDHS accepts the recommendation and will work with the OIG and the Office of the Governor to appoint members to the Quality Care Board, to ensure that all Board positions are filled, and to ensure that Board members are not serving on expired terms.

Recommendation-8 Investigator Training

Recommendation: ***The Office of the Inspector General should: ensure that employees are receiving all required trainings; and determine and implement a more effective method of tracking employee training to ensure that each employee has received the required training.***

Management Response:
OIG accepts the recommendation. OIG will ensure that all staff receive the required training and that proof of the same is adequately documented. Coordinating and documenting OIG training has been an ongoing issue due to a lack of dedicated management staff to coordinate and document internal training. For the past several years, OIG has been focused on hiring investigative staff to deal with the ever-growing caseload. This left the responsibility of training to be spread out amongst multiple management staff across the state without optimal coordination. OIG has created and is in the process of filling two Training Coordinator positions: one for the three northern bureaus and one for the three southern bureaus. The coordinators will be responsible for ensuring OIG staff receive their required training and that training is appropriately documented.

OIG also has not had a central location to document completed training. OIG's database was used to document training but was not always reliable. In response to the last audit, OIG documented that OIG would work with the State's Department of Innovation and Technology (DoIT) to use the OneNet training functionality to document OIG training. However, transitioning to using OneNet to track training has not been a seamless process, as several issues arose during implementation. First, this project was competing with a number of other State' IT priorities. Second, while OIG is making progress on using OneNet for training, the system is challenging to navigate and requires a great deal of training and coordination with DoIT. OIG continues to work with DoIT and expects use of the system to become easier and more effective for OIG's needs.

Recommendation-9 Abuse, Neglect, and Exploitation Prevention and Reporting Training at Facilities

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

Management Response:
IDHS accepts the recommendation and will particularly focus on those facilities who did not have 100% training completion in CY23. Each State Operated Facility has a staff development specialist who assigns and monitors the completion of required trainings annually. IDHS has mandatory deadlines for required staff training to be completed and progressive discipline is used if those deadlines are not met.

Recommendation-10 Timeliness of Unannounced Site Visit Reports

Recommendation: ***The Office of the Inspector general should take steps to ensure that unannounced site visit reports are sent to State-operated facilities within 60 days of the site visit being completed as required by OIG Directive.***

Management Response:
OIG accepts the recommendation. In recent years, OIG decided to restructure its site visit process. In order to closely align OIG process with the nationally recognized standards, the planning, structure, execution, and writing of OIG's annual site visits are now based on the Government Accountability Office's (GAO) Generally Accepted Government Auditing Standards (GAGAS), commonly referred to as the "Yellow Book." OIG leadership decided to model its site visits after Yellow Book performance audits. The purpose of this model is to produce site visit reports that have more structured and substantive findings and recommendations. Ultimately, the goal is to put the OIG site visit team in a better position to identify systemic issues at the facilities that relate to the reporting and prevention of abuse and neglect of individuals receiving services in the facilities.

Because OIG is statutorily mandated to conduct unannounced site visits at all IDHS State Operated Facilities (SOFs), OIG's site visit team visits each facility, in succession, as quickly as possible, so facilities do not have a significant period of time to share information and prepare for OIG's visit. After OIG completes its unannounced visits at all of the facilities, OIG staff begin to work on each individual site visit report. The site visit reports go through a rigorous review process that requires approval from the Chief Administrative Officer and Inspector General. Completed reports go to the facility for response which OIG includes in the final version of the report. This process explains the gap between when staff initially visit the facility and when the final version of the report is released to the Facility, Division, and Secretary's Office.

To meet this recommendation, OIG will revise OIG's Directives to better suit its new site visit process. OIG will now consider the exit conference the conclusion of the site visit. Furthermore, it will require staff to submit the site visit report to the required stakeholders within 60 working days of the exit conference.

Recommendation-11 OIG Hiring and Personnel Issues

Recommendation: ***The Office of the Inspector General and the Department of Human Services should work together in order to: identify and mitigate the bottlenecks in the hiring process; and address pay structure imbalances for management positions.***

Management Response:
IDHS accepts the recommendation and will continue to work to identify and mitigate delays in the hiring process for which we have the authority and ability to do so. The OIG merit comp staff salaries were examined and increases to existing and new Bureau Chief salaries were made in 2024. It is important to note that increases to existing salaries, and salary offers for newly hired positions must be approved by the Department of Central Management Services and is not in the sole discretion of IDHS.

Recommendation-12 DHS State-Operated Facilities Staffing Levels

Recommendation: ***The Department of Human Services should conduct a staffing analysis to determine if staffing levels at State-operated facilities are adequate. The staffing analysis should take into consideration the need to reduce excessive amounts of employee overtime, especially for direct care employees.***

Management Response:
The Department of Human Services accepts the recommendation. IDHS is in the process of reviewing current staffing levels at State Operated Facilities (SOF) in an effort to ensure staffing levels are adequate and appropriate. For FY20 through FY23, IDHS has onboarded over 2,000 Mental Health Technicians across its State Operated Facilities. Furthermore, IDHS has worked to implement changes to the collective bargaining agreements in an effort to expedite the hiring process for these positions and is in the preliminary stages of establishing positions that would be dedicated to performing ongoing staffing analysis for the Department.

IDHS's staffing has been challenged by retirement and retention problems that have been experienced nationally, for 24/7 facilities and for the behavioral health workforce, in particular. IDHS addressed this, in part, during and following the COVID-19 Public Health Emergency, through the use of contractual employees to help bolster the State employee workforce at its SOFs, always prioritizing the use of State employees over contractual ones. Based on and in response to a grievance and arbitration, IDHS has virtually eliminated the use of contractual employees serving in Mental Health Technician positions, while, at the same time, continuing to aggressively hire and take steps to ensure the retention of State employees at the SOFs.

The use of and rules governing overtime is negotiated and collectively bargained between the State and its labor partners. Within the limitations of how many actual, physical shifts an individual employee can work, overtime is first offered voluntarily and, if needed, and in the absence of volunteers, mandated, as necessary.

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