LEGISLATIVE AUDIT COMMISSION

Program Audit of the
Office of the Inspector General
Department of Human Services

December 2017

622 Stratton Office Building
Springfield, Illinois 62706
217/782-7097

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RECOMMENDATIONS – 13
Repeated – 8

Accepted – 7
Implemented – 6

Background

The Department of Human Services Act (Act) (20 ILCS 1305/I-17(w)) 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. The Act requires the OIG to investigate allegations of abuse and neglect that occur in mental health and developmental disability facilities operated by DHS and in community agencies licensed, certified, or funded by DHS to provide mental health and developmental disability services. This is the 12th audit conducted of the OIG since 1990.

In FY17, DHS operated 14 State facilities. There were also a total of 421 community agencies with 4,552 program sites (i.e., CILAs, group homes, day programs, etc.) that were under the investigative jurisdiction of the OIG. This represents an increase of 1,079 program sites, or 31%, since the FY10 audit. In the FY10 audit there were 376 agencies operating 3,473 programs.

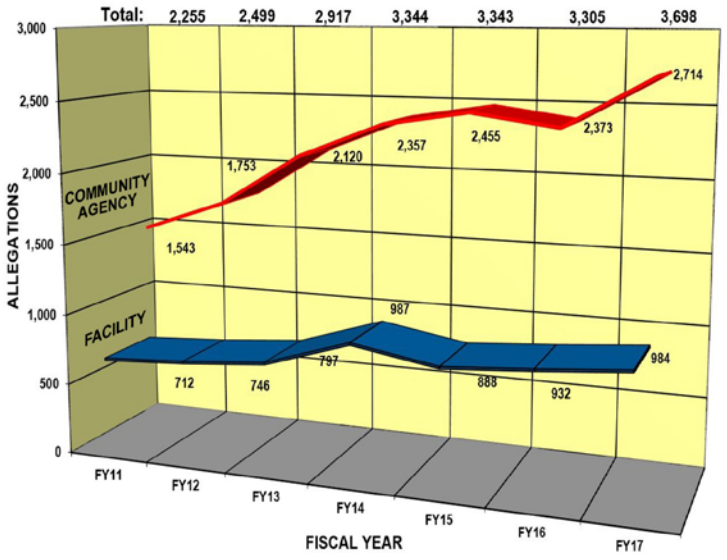
Total allegations of abuse and neglect reported to the OIG have increased since the 2010 audit. In FY10, 2,468 allegations were reported. Of the 2,468 allegations reported, 967 allegations were reported at State-operated facilities and 1,501 allegations were reported at community agencies. In FY17, allegations of abuse and neglect increased 50% to 3,698.

The increase in the number of allegations was primarily driven by an increase in allegations reported at community agencies. Allegations reported at community agencies increased from 1,501 in FY10 to 2,714 in FY17 or 81%. Allegations of abuse and neglect reported at State facilities also increased from 712 in FY11 to 984 in FY17. This increase occurred while the population of residents at State facilities decreased from 11,748 in FY11 to 6,987 in FY17.

Although allegations of both abuse and neglect have increased, allegations of neglect have more than doubled. For FY11 there were 1,652 allegations of abuse and 603 allegations of neglect. For FY17, there were 2,451 allegations of abuse and 1,247 allegations of neglect.

ABUSE AND NEGLECT ALLEGATIONS REPORTED TO OIG BY TYPE OF FACILITY

FY2011 through FY2017



Source: OIG data summarized by OAG.

OIG ORGANIZATION

The Inspector General reports to the Secretary of DHS and the Governor. The Inspector General as of June 30, 2017, Michael McCotter, was appointed to be the Acting Inspector General by former Governor Pat Quinn on December 7, 2012.

The OIG has reorganized somewhat since the 2010 audit. According to OIG officials, these changes were made over the past several years. Some of these organizational changes include:

- There is no longer a Domestic Abuse Bureau;
- A Cook County Investigative Bureau was added; and
- Investigative staff are now located around the State at various locations.

Prior to July 1, 2013, the OIG's Bureau of Domestic Abuse investigated allegations of abuse and neglect related to adults in domestic settings. Pursuant to P.A. 98-0049 (effective July 1, 2013) the OIG's responsibility for investigating domestic cases under the Department of Human Service Act (20 ILCS 1305) and the Abuse of Adults with Disabilities Intervention Act (20 ILCS 2435), involving adults with disabilities, was transferred to the Department on Aging. Under a new statute, the Adult Protective Services Act (320 ILCS 20), the Department on Aging has jurisdiction to investigate allegations of abuse, neglect, and financial exploitation of adults living in their own homes and adults with disabilities aged 18-59 who live in domestic settings in the community.

As of July 1, 2017, the OIG had five investigative bureaus, which all report to the Deputy Inspector General--North, Cook, Chicago Metro, Central, and South). The OIG also has a Bureau of Hotline and Intake and a Bureau of Compliance and Evaluation that includes Clinical Coordinators that conduct death reviews.

As of July 2017, the OIG had a total of 60 employees, including 2 contractual employees. In July 2010, the OIG had a total of 59 employees. As of July 2017, there were a total of 43

employees in the five investigative bureaus: Cook (8), North (9), Chicago Metro (10), Central (8), and South (8). All of the investigative bureaus report to the Deputy Inspector General.

OVERVIEW OF OIG INVESTIGATIVE BUREAUS AND RESPONSIBILITIES
As of July 2017

OIG Bureau	Number of Investigators	Counties	State Facilities	Community Agencies	Program Sites
Cook County	7	1	2	81	1,285
North	7	20	3	190	931
Chicago Metro	7	5	2	91	723
Central	6	47	3	101	1,060
South	7	29	4	78	553
Total	**34[2]**	**102**	**14**	**421[1]**	**4,552[1]**

[1] Some agencies operate program sites in multiple OIG bureaus. Therefore, the count of agency and program sites by bureau includes some duplication and column totals may not add.
[2] Number of investigators includes Internal Security Investigators (ISI II) title employees including those in "acting" positions as Team Leader or Bureau Chief. Source: OAG analysis and OIG data.

Other bureaus at the OIG include the:

- **Bureau of Hotline and Intake**: Includes five Hotline personnel who take calls reporting allegations of abuse and neglect.
- **Bureau of Compliance and Evaluation**: Includes functions such as information management and training. Also, includes clinical coordinators that are responsible for investigations of deaths or serious injuries in State-operated facilities or community agencies. The total headcount in July 2017 was seven.

In addition to the seven bureaus, the Inspector General's staff is comprised of five employees including the Inspector General.

In FY17, DHS operated a total of 14 facilities in Illinois. Six locations served the developmentally disabled, six locations served the mentally ill, and one location served both.

DHS has closed four facilities since January 2010. These facilities include:

- Howe Developmental Center (closed June 21, 2010);
- Tinley Park Mental Health Center (closed June 30, 2012);
- Singer Mental Health Center (closed October 31, 2012); and
- Jacksonville Developmental Center (closed November 27, 2012).

UNDUPLICATED INDIVIDUALS SERVED AT STATE FACILITIES
FY10 through FY17

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

Source: OIG annual reports and DHS data.

According to DHS OIG officials, clients from these four facilities were either moved to another facility or were placed in a community agency.

Report Conclusions

The audit report contains a total of 13 recommendations to the Office of the Inspector General and the Department of Human Services as follows:

- Total allegations of abuse and neglect reported to the OIG increased from 2,468 in FY10 to 3,698 in FY17 or 50 percent.
- The timeliness of completion for OIG investigations has deteriorated significantly since the FY10 audit. For FY10, 85 percent of closed cases were completed within the 60 working day requirement. For FY17, 50 percent of closed cases were completed within 60 working days.
- OIG case reports reviewed generally were thorough, comprehensive, and addressed the allegation.
- The number of abuse and neglect investigations closed has increased substantially since FY10 (from 2,162 in FY10 to 3,601 in FY17); however, the substantiation rate has remained consistent. The substantiation rate for abuse and neglect investigations closed for FY10 was 12 percent, while it was 13 percent for FY17.
- DHS, in some cases, still takes an extended amount of time to receive and approve the actions taken by community agencies or State-operated facilities. For 4 of 20 investigations sampled (20%), the OIG could not provide an approved written response. These four investigations had been completed for an average of 180 days as of September 1, 2017, with a range of between 106 days to 289 days since the case was completed.
- The Quality Care Board did not have seven members during FY16 and FY17 as is required by the Act. In September 2017, a board member resigned leaving the Board with only three members. Four members are needed for a quorum.
- The OIG could not provide documentation to show that investigators had received the required initial training courses delineated in OIG Directives.

RECOMMENDATIONS

1. The Office of the Inspector General should consider updating its interagency agreement with the Department of Children and Family Services. (Repeated-2010)

Finding: The Abused and Neglected Child Reporting Act (325 ILCS 5/1 *et seq*.) mandates that many persons, including State employees, immediately report incidents of

suspected abuse and neglect of all persons under the age of 18 to the Department of Children and Family Services (DCFS). An interagency agreement was executed by DCFS and the OIG in November 2000. According to DHS officials, the agreement has not been terminated and is therefore still effective at this time.

The interagency agreement specifically states that the OIG is only to investigate those cases where a recipient is under the age of 18 if DCFS and Illinois State Police decline to investigate. In addition, the agreement requires the OIG to notify DCFS upon completion of these investigations and provide a copy of the investigation upon request. The agreement between DHS and DCFS contains outdated statutory cites that should be updated.

OIG Response: Disagree. OIG has met with DCFS about updating the current agreement. However, since there has been little jurisdictional overlap since FY2010, DCFS does not see the need for an updated agreement. Information in our database indicates there has not been an OIG investigation involving an individual under the age of 18 in the last three fiscal years. Based on this, OIG does not see a need to update the outdated interagency agreement with DCFS and will move to terminate that agreement. OIG will continue to coordinate and cooperate with DCFS if any jurisdictional overlap occurs.

Auditors' Comment: The OIG's current agreement with DCFS was signed in November 2000 and contains outdated statutory cites. This audit randomly sampled 130 investigations closed by the OIG in FY17. One of the investigations sampled involved a case that was eventually referred to DCFS after the OIG determined that it was out of its jurisdiction.

OIG Updated Response: Implemented. DHS-OIG has terminated IGA with DCFS and DCFS, DHS OIG and DHS have signed a termination agreement.

2. The Office of the Inspector General should:

- **Improve the collection of information regarding the date and time an 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 in the Department of Human Services Act and OIG's administrative rules. (Repeated-2010)**

Findings: The Department of Human Services Act requires that allegations be reported to the OIG hotline within four hours of initial discovery of the incident of alleged abuse and neglect. Although FY17 data provided by the OIG showed improvement in timely reporting of allegations of abuse and neglect, timeliness could not be determined for 20% of facility allegations and 22% of community allegations. This was because the incident discovered time/date was reported as unknown, was inaccurate, or the time/date recorded was not

specific. For FY17, the percent of allegations not reported within the statutorily required four hours was 11% at community agencies and 5% at State-operated facilities. Compared to FY10, late reporting at State facilities has decreased or improved from 10 percent in FY10 to 5 percent in FY17. For community agencies, late reporting improved from 13 percent in FY10 to 11% in FY17.

Even though the timeliness of incident reporting appears to have improved, there were also a significant percent of allegations for which auditors could not determine if the incident was reported within the required four hours.

- **State-Operated Facility Reporting** – Timeliness could not be determined for 20% of FY17 facility allegations because the incident discovered time/date was reported as unknown, or the incident time recorded was not specific (i.e. "one week ago" or "ongoing").
- **Community Agency Reporting** – Timeliness of reporting could not be determined for 22% of FY17 agency allegations because the incident discovered time/date was reported as unknown or the incident time was not specific (i.e. "ongoing," "night," "early morning," around noon, etc.).

OIG Updated Response: Implemented. OIG Intake investigators will continue to gather as much thorough and detailed information from the caller as possible by asking appropriate, specific questions. OIG will also remind community agencies and facilities of the four-hour requirement to report allegations of abuse/neglect and to provide detailed information about the time and date of discovery, if they know it, when calling in a report to the OIG hotline.

- A statewide memorandum was transmitted to DHS mental health and developmental centers and DD and MH community agencies regarding the importance of the four-hour time frame for reporting allegations of abuse and neglect per Rule 50 and were instructed to provide as much specific information regarding the time and date of the incident and discovery as possible. The memo and a PowerPoint presentation were sent on February 5, 2018.
- DHS-OIG met with OIG Intake staff to discuss the importance of obtaining as detailed of information about the time and date of the incident and discovery as possible. Follow-up through a memorandum to staff was completed on March 20, 2018.

3. The Office of the Inspector General should work to improve the timeliness of:

- **Initial entry of cases into the OIG database;**
- **Case notification to Bureau Chiefs and Investigative Team Leaders; and**
- **Assignment and reassignment of cases to investigators. (Repeated-2010)**

Finding: The effectiveness of an investigation is diminished if it is not conducted in a timely manner. Timely initiation and completion of investigations is critical for an effective investigation.

OIG directives require that investigations be assigned to an investigator within one working day of the Bureau Chief or Investigative Team Leaders (ITL) receiving the intake. For investigations closed during FY17, 96% (3,643 of 3,797) were initially assigned within one working day of the allegations being added to the OIG database. Four percent (154 of 3,797) were assigned between 2 and 193 days of the allegation being entered.

However, when compared to the date reported, 50% (1,891 of 3,797) of investigations took two or more working days to be assigned to an investigator. Five percent (196 of 3,797) took 5 or more working days to assign to an investigator from the date the allegation was reported. Part of the reason for this delay is that approximately 35% (1,337 of 3,797) of the cases closed in FY17 took two working days or longer to enter into the database. Of these, 128 cases took between 5 and 32 working days before being initially entered into the database.

The OIG initially provided auditors with the last assignment date for investigations closed in FY17. Auditors reviewed 140 cases in which the last assignment date was more than 100 days after the allegation was reported to the hotline. Additional data provided by the OIG for these cases showed that these 140 investigations were assigned or reassigned a total of 308 times. Four investigations were assigned only once while the remaining 136 investigations were assigned between 2 and 5 times. According to OIG officials, investigations may be reassigned due to caseload, transfer of cases between clinical and investigative staff, and because of investigators on leave.

OIG Response: Agree. If a case has not been assigned within one day and before it goes to two days, the database has been modified to automatically assign it to the respective bureau chief and send them an e-mail detailing the assignment, which requires them to take any needed action.

There is sometimes a delay between the time an allegation is called in to the time the bureau chief receives the intake due to the need to make follow-up contact with the caller to get more detail or clarify already provided details to determine if it is a reportable incident. In order to facilitate the entering of cases into the database, OIG is developing a web-based intake that will allow agencies/facilities to directly enter cases. The intake is then pulled into the OIG database where it is reviewed and processed by Intake staff. This should eliminate the necessity of calling complainants back. OIG is also meeting with the answering service to develop a way to receive more detailed information when they answer calls, allowing Intake staff to better prioritize calls.

Over the past two years, OIG reassigned cases, some multiple times, due to changes in personnel status and attempts to equalize caseloads. Stabilization of our personnel situation and case management practices implemented over the past several years should reduce the overall need to reassign cases multiple times.

OIG Updated Response: Accepted and Partially Implemented.

- DHS-OIG has implemented automatic case assignment to the Bureau Chief at the end of first day if the case has not already been assigned to ensure each case is assigned within one day of receipt of intake by Bureau. This process was implemented on June 30, 2017.
- DHS-OIG will develop a web based intake form for agencies and facilities to complete to increase timeliness of intakes being sent to the bureaus. The web based intake form has been developed. DHS is currently working on technical issues and limited test roll out. Next DHS will implement statewide training and rollout. The Department also needs to hire and train new OIG database personnel. Implementation is expected to be completed by October 31, 2018.

4. The Office of the Inspector General should work to improve the timeliness of investigations of abuse and neglect including the time it takes to interview alleged victims and perpetrators. (Repeated-2010)

Finding: Prior OIG investigative guidance required that investigations be completed as expeditiously as possible and should not exceed 60 calendar days absent extenuating circumstances. The OIG changed the definition of days in its administrative rules in January 2002 to be working rather than calendar days. Effective May 26, 2017, the OIG's administrative rules were amended to remove the requirement that investigative reports be completed within 60 working days. This requirement is, however, still included in the OIG's Directives.

Timeliness of investigations has been an issue in all of the 11 previous OIG audits. For FY10, 69 percent of cases were completed within 60 calendar days with an average calendar days to complete an investigation of 57 days. For FY17, only 37% of cases were completed within 60 calendar days with an average calendar days to complete of 152 days.

CALENDAR DAYS TO COMPLETE
ABUSE AND NEGLECT INVESTIGATIONS
FY10, FY16, and FY17

Days to Complete Cases	FY10 % of Cases	FY16 % of Cases	FY17 % of Cases
0-60 days	**69%**	**32%**	**37%**
61-90 days	17%	11%	13%
91-120 days	8%	10%	10%
121-180 days	4%	17%	12%
181-200 days	0%	3%	3%
>200 days	2%	27%	25%
Percent > 60 days	**31%**	**68%**	**63%**
Total Cases Closed	**2,150**	**3,226**	**3,589**

Source: OAG analysis of OIG data.

According to the OIG, there are several causes of the decrease in timeliness including:

- Increased allegations;
- An increase in the number of CILAs across the State (OIG is responsible for more sites, and they are more spread out);

- Shortage of staff; and
- A longer time for new investigators to learn the job and be self-sufficient in the duties, due to the hiring and evaluation process.

The number of OIG investigations taking more than 200 calendar days to complete increased significantly for FY17 compared to the previous audit. In FY10 there were a total of 51 closed investigations that took more than 200 days to complete, of which 38 (75%) were death cases. For FY16, this increased to 888 cases with the majority of those cases being for physical abuse and neglect. For FY17 there were a total of 920 cases closed that took more than 200 days to complete.

The OIG's Clinical Coordinators become involved in investigations for cases that involve medical issues, as well as death cases. As of June 30, 2016, the OIG had four Clinical Coordinators (two full-time and two contractual staff).

During FY16, the Clinical Bureau closed a total of 223 cases, taking an average of 142 calendar days to complete. The Clinical Bureau primarily handles death cases. During FY17, the Clinical Bureau closed 173 cases, with an average of 73 calendar days to complete. This is a significant improvement over the 166 average days to complete a case in FY10.

The Department of Human Services Act requires the Inspector General to review all reportable deaths including those for which there is no allegation of abuse or neglect. Reportable deaths are required to be reported within 24 hours after initial discovery by phone to the Office of the Inspector General 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 facility;
(ii) Any death of an individual occurring within 24 hours after deflection from a residential program or facility; and
(iii) Any other death of an individual occurring at an agency or facility or at any Department funded site.

The 236 death reviews and investigations closed in FY16 took on average 143 calendar days (97 working days) to complete. Of these 236 death cases, 17 were substantiated neglect. Substantiated cases took an average of 693 calendar days (472 working days) to complete.

The 196 death reviews and investigations closed in FY17 took on average 112 calendar days (76 working days) to complete. Of these 196 death cases, 11 were substantiated neglect. Substantiated cases took an average of 468 calendar days (318 working days) to complete. According to OIG officials, death cases can take longer to complete because it is a serious event: records from hospitals and medical examiners often take a long time to obtain, and additional consultation may be needed.

For the FY17 cases sampled by auditors where there was a victim identified, it took an average of 26 days from the reporting of an incident for the victim to have a statement taken or interviews to be performed. Within the sample there were two cases which impacted the average time significantly. In one case it took 466 days to interview or obtain a written statement from the alleged victim and another which took 568 days. If these two cases are excluded the average time is reduced to 16 days. The FY10 audit found that it took an average of 9 days to obtain a statement or interview from the alleged victim.

For FY17 cases sampled, it took an average of 45 days from the reporting of an incident for the alleged perpetrator to be interviewed or a statement to be taken. Within the sample, there were 4 cases that took over 200 days to interview the alleged perpetrator, which impacted the average time significantly. For one case it took 540 days from the reporting of the incident for the first interview or statement from the alleged perpetrator to be taken and for another it took 626 days. If these four cases are excluded, the average time is reduced to 28 days. The FY10 audit found that it took an average of 17 days to obtain a statement or interview from the alleged perpetrator.

OIG Response: Agree. As noted in the Audit report, the number of investigations opened continues to increase year after year which, with staff shortages, has impacted OIG's overall timeliness in completing interviews with the victim and accused. From FY16 to FY17, OIG completed more investigations in less time and we plan on continuing this trend going forward as our staffing issues have improved and we have increased case management oversight.

OIG Updated Response: Implemented.

- DHS-OIG sent a memorandum to staff regarding the importance of timely completing investigations and completing interviews of the victim and accused. The OIG will also highlight requirements of appropriate case actions into the database regarding these interviews to be tracked and monitored.
- DHS has revised the ISI2 job description to a new Option A requiring more investigative experience. DHS is working to fill vacancies with better qualified candidates. In addition, an office wide refresher training will be provided in the Fall of 2018. These action plans are anticipated to improve timeliness.

5. The Office of the Inspector General should ensure that investigations are reviewed by the Investigative Team Leader or Bureau Chief within seven working days of receipt, absent extenuating circumstances, as is required by OIG directives. (Repeated-2010)

Finding: The timeliness of case file reviews has declined since the FY10 audit. This is especially true for substantiated cases.

OIG directives require the Investigative Team Leader (ITL) or Bureau Chief to review cases within seven working days of receipt absent extenuating circumstances. For cases

closed in FY17, 55% (2,079 of 3,797) were approved within 7 working days of submission. If the case is substantiated physical abuse, sexual abuse or egregious neglect, the case is reviewed by the Inspector General or his designee.

The average days to review for substantiated cases have risen from an average of 27 days to review and approve in FY10 to 88 days in FY17. For the South Bureau, the average days to review for substantiated cases has risen from 21 days on average to 187 days. As of June 30, 2017, the South Bureau did not have a Bureau Chief or ITL. An Internal Security Investigator (ISI II) has been serving as Acting Bureau Chief.

OIG Response: Agree. Timely review of investigations is critical in completing timely, thorough investigations. The timeliness of review is determined by numerous factors including the number of investigations opened, the complexity of the investigation and the skill level of the assigned investigator. The seven day timeframe that is required in current directives has been in place for a number of years and will be re- evaluated in light of the circumstances OIG works under today. We will review the required case review timeframes to ensure the appropriate amount of time is given based on the needs of that investigation to ensure a thorough and quality investigation is completed and revise the directives accordingly.

OIG Updated Response: Accepted (In Progress).

- DHS-OIG has revised OIG Directive INV-018 regarding Case Review of OIG Investigations to set timeframes more consistent with circumstances OIG currently operates under.
- DHS-OIG is currently working with DoIT to either redevelop the current OIG database or purchase a new database system. DHS-OIG is also working with budget, HFS OIG and DoIT on system requirements and budget issues to determine which route will be selected. This is an ongoing process. Database revisions will include ensuring the case review form will have a comment section for each level of review to detail any delays in review. In addition, an automatic email will be generated and sent to the reviewer when the review has not been completed within 3 days of required review timeframe.

6. The Office of the Inspector General should improve the collection of investigation documentation including photographs of injuries, injury reports/medical examinations, and statements or interviews with the alleged victim and alleged perpetrator.

Finding: OIG case reports were generally comprehensive and addressed the allegation. However, in the sample of investigations, auditors found that injury reports were not in the case file for 5 of 32 (16%) investigations sampled where there was an allegation of an injury being sustained. Photographs were not in the case file for 10 of 30 (33%) investigations sampled. Medical records, treatment plans, or progress notes were also missing in 4 of 130 investigations sampled (3%).

Of the 130 cases reviewed to determine whether there was a statement or interview with the alleged victim or perpetrator, of the 130 cases, 4 cases involved an alleged victim who was verbal and the case file did not contain a written statement or interview with the alleged victim. Six cases (5%) did not contain documentation of a written statement or interview with the alleged perpetrator.

Evidence for OIG investigations includes items such as signed statements, interview summaries, documents, photographs, and other physical evidence. Prior to May 26, 2017, OIG administrative rules required that the case files contain all investigatory materials, including physical and documentary evidence, such as photographs, interview statements and records. Effective May 26, 2017, the OIG's administrative rules were amended and all case file requirements were deleted.

OIG Response: Agree. OIG will provide further training to investigative staff to ensure all appropriate documentation is collected based on the needs of the investigation and to better document when and why certain documentation could not be collected or certain interviews could not be completed.

OIG Updated Response: Implemented.

- DHS-OIG sent a memorandum to staff reminding them of the importance of gathering all needed documentation for the specific allegation under investigation and to appropriately document the information obtained in the case file and case actions when a necessary action could not be completed.
- DHS has revised the ISI2 job description to a new Option A requiring more investigative experience. DHS is working to fill vacancies with better qualified candidates. In addition, an office wide refresher training will be provided in the Fall of 2018. These action plans are anticipated to improve timeliness.

7. The Office of the Inspector General should ensure that all Case Tracking Forms and Case Routing and Approval Forms are completed. (Repeated-2010)

Finding: The OIG requires that case files contain case monitoring and review documentation. This documentation includes the Case Tracking Form and the Case Routing and Approval Form.

- **Case Tracking Form** - All case files in the sample contained a Case Tracking Form as required by OIG investigative directives. However, for 36 of 130 (28%) investigation files reviewed, the Case Tracking Form was not complete. The Case Tracking Form identifies information such as the case number, investigative agency, bureau, and allegation.
- **Case Routing and Approval Form** - All of the 130 cases reviewed contained a Case Routing and Approval Form. However, for 26 cases (20%) the form was incomplete.

OIG Updated Response: Implemented.

- A memorandum was sent to staff reminding them to ensure all required documentation is fully and accurately completed as required by directive, which would include Case Tracking Forms and Case Routing Forms. Also, the OIG will highlight the need to conduct appropriate quality assurance reviews of the forms.

8. The Department of Human Services should continue its efforts to ensure that written responses from facilities and community agencies are received and approved in a timely manner. (Repeated-2010)

Finding: The Department of Human Services Act requires that 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 must file a written response. The response includes the implementation and completion dates of the actions. The Secretary of DHS is required by the Act to accept or reject the 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.

For FY16, OIG received a total of 984 written responses approved by DHS. The OIG conducted reviews of 146 written responses (106 from community agencies and 40 from State facilities).

For FY17, OIG received a total of 986 written responses approved by DHS. For the same period, the OIG conducted reviews of 170 written responses (132 from community agencies and 38 from State facilities).

DHS, in some instances, still takes an extended amount of time to receive and approve the actions taken by the agency or facility. Overall there were 20 cases in the auditor's sample that required a written response. Of the 20 cases in the sample that required a written response, 1 of 20 took more than 6 months from the date the case was completed until the written response was approved by DHS. For 4 of 20 investigations sampled, auditors could not obtain an approved written response. These 4 investigations had been completed for an average of 180 days as of September 1, 2017. These investigations had a range of 106 days to 289 days since the case was completed.

OIG Response: The Department accepts the recommendation. The Department has worked with the facilities and community agencies to meet the 30 day response requirement. The Department will continue its efforts to ensure that written responses from facilities and community agencies are received and approved in a timely manner.

Updated OIG Response: Accepted (In Progress).

DDD

- Upon receipt of a case report from OIG, DDD Bureau of Quality Management (BQM), staff will contact the community agency to confirm receipt of the copy of the investigative report and provide a reminder of the due date for the written response. When needed, BQM will ensure missing reports are resent to the agency.
- During BQM calls to the agency, use of BQM's secure FAX number will be encouraged. This will alleviate any possibility of faxed responses being lost and also ensures HIPAA compliance.
- One week prior to the due date of written responses, BQM staff will contact the provider agency to provide reminders of the deadline.
- Past due written responses will be reviewed weekly with immediate follow up by BQM. In cases where the agency does not provide the required written response within three working days, notice of the failure to submit the written response will be provided the DDD Director with discussion about the need for additional administrative action.

DMH

- DMH will adjust its tracking system to improve receipt of responses by community providers. If a written response has not been received by DMH by the 21st day following the OIG provider notice, DMH will send a reminder alerting the provider of the 30-day deadline for delivery of their written response.

9. The Secretary of the Department of Human Services and the Inspector General should continue to work with the Governor's Office to appoint members to the Quality Care Board in order to fulfill statutory membership requirements.

Once members are appointed, the Quality Care Board should comply with the Department of Human Services Act and meet quarterly as required. (Repeated-2010)

Finding: The Quality Care Board (Board) did not have seven members during FY16 and FY17 as is required by statute. For FY16, the Board also did not meet quarterly as required by statute and did not always have a quorum at all the meetings that were held. As of October 2017, the OIG was unable to provide approved meeting minutes for scheduled meetings in February 2017 or May 2017 and, therefore, auditors could not determine whether these meetings were held or whether there was a quorum present to conduct business. In September 2017, a board member resigned leaving the Board with only three members. Four members are needed for a quorum. A lack of membership on the Board was also an issue in the previous audit released in 2010. Also, the statutory requirement for having two members of the Board be a person with a disability or the parent of someone with a disability was not being met.

OIG Response: Agree. OIG will continue to work with the Secretary and the Governor's Office to appoint members as required. We will also work with the QCB Chairperson to help them schedule timely meetings each quarter.

OIG Updated Response: Accepted (In Progress).

- DHS-OIG is assisting the Secretary and the Governor's Office to appoint board members as required. Four new members have been appointed by the Governor's Office including a new Chairperson. Others are being considered to complete the Board appointments.
- A New QCB Chair has been appointed and DHS-OIG will work with him to ensure the scheduling of timely meetings each quarter.

10. The Office of the Inspector General should:

- **Ensure that training required per the OIG directives is available and provided to investigative staff; and**
- **Develop management reports to more effectively track training to ensure that each employee has received the required training.**

Finding: The OIG could not provide documentation to show that employees had received the required initial training courses delineated in OIG directives. Further, a number of classes that fall under required initial training for investigators are no longer available because of the discontinuation of the NetLearning system (a computer-based learning system).

OIG Response: Agree. OIG is meeting on a regular basis with other Inspector Generals to discuss common issues and needs, including pooling training resources in order to offer more opportunities to our investigators. The class records in the database will be condensed to eliminate multiple listings and bi-monthly reports will be added to the automated database to monitor staff training.

OIG Updated Response: Accepted (In Progress).

- DHS-OIG is in the process of reviewing the training information contained in the database and condensing class records to ensure uniformity.
- A bi-monthly report is sent to management to track staff training.
- DHS-OIG is currently working with DoIT to either redevelop the current OIG database or purchase a new database system. DHS-OIG is also working with budget, HFS OIG and DoIT on system requirements and budget issues to determine which route will be selected. This is an ongoing process.

11. The Department of Human Services should ensure that all employees at State-operated facilities and community agencies receive training in prevention and reporting as is required by law.

Finding: According to Rule 50, DHS should ensure that all employees at State-operated facilities and community agencies receive training in prevention and reporting of abuse and neglect. Training information provided by the DHS Division of Mental Health and the Division of Developmental Disabilities showed that some employees at facilities operated by the State were not receiving Rule 50 training. Although provider agreements require community agencies to ensure that staff are provided training in Rule 50, DHS does not maintain information regarding community agency employees and Rule 50 training.

DHS RULE 50 TRAINING BY FACILITY

Facility	% of Staff Trained in Rule 50	
MH Facilities	**FY16**	**FY17**
Alton	100%	100%
Chester	83%	93%
Chicago-Read	62%	93%
Choate	98%	98%
Elgin	100%	92%
Madden	99%	99%
McFarland	100%	100%
DD Facilities	**FY16**	**FY17**
Ann Kiley	100%	93%
Fox	100%	100%
Ludeman	99%	86%
Murray	95%	82%
Shapiro	100%	100%
Choate	90%	97%
Mabley	98%	99%

Source: DHS Division of Mental Health and Division of Developmental Disabilities (unaudited).

OIG Response: The Department accepts the recommendation. The Department is complying with the required training and will continue its efforts to ensure that all employees at State-operated facilities and community agencies receive training in prevention and reporting as is required by the Act.

OIG Updated Response: Accepted (In Progress).

- Each State Operated Facility is working to achieve compliance with OIG Rule 50 training.

12. The Office of the Inspector General should ensure that all unannounced site visits are completed annually as required by the Department of Human Services Act. (Repeated-2010)

Finding: The Department of Human Services Act requires the Inspector General to conduct unannounced site visits to each facility at least annually for the purpose of reviewing and making recommendations on systematic 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.

FY16 and FY17 site visit information provided by the OIG showed a reduction in time spent on site, number of areas reviewed, and findings. In FY15, all 14 unannounced site visits

were conducted over a two-day period. In FY16, 5 of the 14 visits were conducted over a two-day period. In FY17, 5 of the 14 were two-day visits. The FY15 unannounced site visits covered four different areas, two of which were medically related, and resulted in 51 findings. In FY16, two areas were examined, neither was medically related, and the site visits resulted in 15 findings. For FY17, three areas were examined resulting in a total of seven findings.

According to documents provided by the OIG, site visit protocol changed in FY15. The OIG FY15 Annual Report states that this was done because of many factors including additional responsibilities, as well as contractual and staffing constraints. According to the FY15 Annual Report, these changes would make more efficient use of existing staff resources, as well as add a fresh approach to OIG's statutory responsibilities. Although the protocol was changed, the OIG directives for site visits were not changed until FY17 (February 27, 2017).

The FY16 and FY17 site visit information provided by the OIG shows a reduction in time spent, number of areas reviewed, and findings. Many site visits for FY16 and FY17 were performed over one day rather than two. In FY15, all 14 unannounced site visits were conducted over a two-day period. In FY16, 5 of the 14 visits were conducted over a two-day period. In FY17, 5 of the 14 were two-day visits (see Exhibit 5-4). Spending less time at the facilities may impact the depth of the review that can be conducted.

The timing of some unannounced site visits reviewed did not follow OIG directives during FY16 and FY17 because they were conducted in the same month as those visits conducted in the two preceding years. The OIG deleted this requirement from its directives effective February 27, 2017.

For 12 of 14 unannounced site visits conducted in FY16, a Clinical Coordinator was not present as was required by the OIG directives. For FY17, a Clinical Coordinator did not attend any of the visits. The OIG deleted the requirements that Clinical Coordinators are to attend unannounced site visits from its directives effective February 27, 2017. The absence of a medical professional from planning and attending site visits impacts the types of areas that can be examined. Reducing the number and types of areas examined during site visits decreases the depth of the reviews conducted and may increase the risk that some areas may be overlooked or not included for review for a substantial amount of time.

The number of areas examined during site visits has decreased and the number of recommendations made has decreased substantially. In addition, the types of areas examined (non-medical vs. medical) and the specificity of the areas examined have changed. During site visits in FY10-FY14, at least six areas were examined each year, three of which were medically related. The FY15 unannounced site visits covered four different areas, two of which were medically related, and resulted in 51 findings. In FY16, only two areas were examined (neither was medically related) and resulted in 15 findings. For FY17, each facility had 3 total areas examined with only 7 total findings in 14 unannounced site visits.

One FY16 unannounced site visit was not completed in a timely manner. The OIG did not complete the FY16 unannounced site visit of Murray Developmental Center until FY17.

OIG Response: Agree - As noted in the Audit report, only one unannounced site visit was completed outside the timeframes of the statute. This was due to a unique set of circumstances present at that facility at that time which required OIG to take longer to fully review and make appropriate recommendations prior to closing the site visit. OIG will monitor the site visit protocol to make sure all site visits are completed per directive.

OIG Updated Response: Implemented.

- DHS-OIG has reviewed Site Visit Protocol for any needed updates to ensure all site visits are completed timely each year as required. In addition, completion date deadlines have been set for each facility to ensure reports are issued as soon as possible.

13. The Office of the Inspector General should work to improve the quality and accuracy of the information contained in the OIG investigative database.

Finding: The OIG was able to provide auditors with downloads from its investigations database for FY16 and FY17. Although the data provided by the OIG was generally complete and reliable enough for analysis and sample selection for testing, auditors identified several instances in which the OIG could improve the quality of its data:

- The discovery date and time in the OIG database is not always specific/accurate. In some cases the date and time were recorded in the wrong field, while in others a range of time or an estimate time ("around") is given. In a few cases it appears the date recorded is the date the incident occurred and not when it was discovered. This could lead to the appearance that reporting is not timely in some cases in which it may actually be timely.
- There are cases in the database in which the incident was reported to local law enforcement or Illinois State Police (ISP), but a date was not included in the OIG database regarding when the case was reported to the local law enforcement agency or ISP.
- There were 116 investigations closed in FY17 that were substantiated in which the recommendation was "No Action" in the database. For substantiated investigations there should, with few exceptions, be an associated recommended action.

OIG Response: Agree. OIG is in the process of hiring new staff to monitor the database and develop procedures to do trend analysis on data entry. Current QA procedures will be revised and others added to monitor quality on a weekly/monthly basis as necessary. OIG will also reinforce with all staff the importance of accurate entry of all data into the database.

OIG Updated Response: Accepted and Partially Implemented.

Corrective Action Implemented:

- A memorandum was sent to staff reminding them of the importance of full and accurate entry of needed information into the database on March 20, 2018.

Corrective Action In Progress:

- DHS-OIG is currently working with DoIT to either redevelop the current OIG database or purchase a new database system. DHS-OIG is also working with budget, HFS OIG and DoIT on system requirements and budget issues to determine which route will be selected. This is an ongoing process.