LEGISLATIVE AUDIT COMMISSION

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

December 2010

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

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RECOMMENDATIONS – 9
Repeated – 5

Accepted – 4
Implemented – 4
Partially Accepted - 1

Background

The Program Audit of the Office of the Inspector General, Department of Human Services was conducted by the Office of the Auditor General pursuant to the Human Services Act. 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 facility or agency. The Inspector General is appointed by the Governor and confirmed by the Senate for a four-year term. The current Inspector General is Dr. William Davis, and he has served as Inspector General since February 2006.

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

Effective August 28, 2007, Public Act 95-545 amended the Department of Human Services Act and the Abused and Neglected Long Term Care Facility Residents Reporting Act transferring all provisions concerning the Office of the Inspector General within the Department of Human Services from the Abused and Neglected Long Term Care Facility Residents Reporting Act to the Department of Human Services Act.

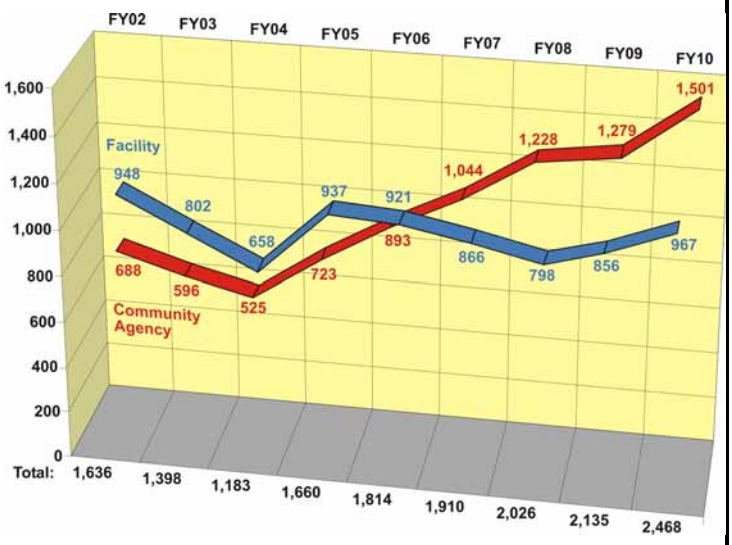
Effective August 13, 2009, Public Act 96-407 amended the Department of Human Services Act relating to the DHS Office of Inspector General. Some of the most significant changes made by Public Act 96-407 were to the definitions related to abuse and neglect and adding

a new category for "financial exploitation." Several of the changes made to the statutes addressed recommendations that have been made in prior OAG audits.

During FY10, the Department of Human Services operated 18 facilities statewide that served 12,722 individuals. Nine facilities served the developmentally disabled, and nine facilities served the mentally ill. In addition, DHS licenses, certifies, or provides funding for 376 community agencies operating 3,473 programs providing services to individuals with developmental disabilities or mental illness in community settings within Illinois. These community agency programs provide transportation services, workshops, or community living arrangements. In FY10, approximately 37,500 individuals with developmental disabilities and approximately 163,147 individuals with mental illness were served in community agencies required to report to the OIG.

Overall, allegations of abuse and neglect reported to the OIG have been increasing since FY04. In FY08, 2,026 allegations were reported (1,631 abuse and 395 neglect). This compares to 2,468 in FY10 (1,877 abuse and 591 neglect) or a 22 percent increase over the last two years.

Exhibit 1-3
TOTAL ABUSE OR NEGLECT ALLEGATIONS REPORTED TO OIG
Fiscal Years 2002 to 2010



Note: State facilities served 2,485 individuals with developmental disabilities and 10,237 individuals with mental illness in FY10. Community agencies served approximately 37,500 individuals with developmental disabilities and approximately 163,147 individuals with mental illness in FY10.

Source: OIG data summarized by OAG.

After decreasing for several years, the number of allegations reported at State facilities has also increased since the 2008 audit. Of the 2,026 allegations reported in FY08, 798 allegations were reported at State facilities and 1,228 allegations were reported at community agencies. For FY10, of the total of 2,468 allegations of abuse or neglect, 967 were from State facilities and 1,501 from community agencies.

Allegations of abuse reported to the OIG have continued to increase since the last audit. In FY08, there were 1,631 abuse allegations reported to the OIG. This compares to 1,877 in FY10 or a 15 percent increase since FY08. Allegations of neglect have increased 50 percent since FY08. In FY08, there were 395 neglect allegations reported to the OIG. This compares to 591 in FY10.

Report Conclusions

This is the Office of the Auditor General's eleventh audit of the Department of Human Services' Office of the Inspector General. The audit reports the following:

- Total allegations of abuse and neglect reported to the OIG increased 22% over the last two years. In FY10, 2,468 allegations were reported compared to 2,026 in FY08.
- The timeliness of OIG investigations continued to improve since the last audit. In FY10, 69% of investigations were completed within 60 calendar days. 85% were completed within 60 working days, the OIG's standard of timeliness.
- Although there has been continued improvement in the overall timeliness of investigations, the timeliness of cases assigned to clinical coordinators (involving death or other medical issues) continues to be a problem. Of the 327 cases closed in FY10 that took more than 60 working days to complete, 98 were clinical.
- The timeliness of reporting allegations of abuse and neglect by community agencies improved substantially. For FY10, 13% of allegations were not reported within the required four hours, as compared to 25% in FY08. In FY10, 10% of State-operated facility incidents were not reported within the four-hour time requirement.
- In 18% (5 of 28) of the cases sampled, more than six months passed from the date the case was completed to the date when a written response delineating the corrective actions taken was submitted by the State facility or community agency and approved by DHS.
- Two facilities remained decertified from participation in Medicare and Medicaid—Howe and Tinley Park. The U.S. Department of Justice released reports in 2009 with serious concerns about two facilities—Howe and Choate. Howe closed effective June 21, 2010.
- The Quality Care Board did not maintain the seven members that are required by statute. From November 2009 to May 2010, all of the members of the Board were serving on expired terms.

RECOMMENDATIONS

1. The Office of the Inspector General should continue to consider adding serious injuries to its investigative database that would allow it to look for and identify patterns and trends in serious injuries, which may be an indicator of staff neglect or other problems which need to be addressed. (Repeated)

Findings: Beginning in December 2006, OIG started entering non-reportable allegations into its incident database and also included a list of non-reportable complaints on subsequent calls so that a more complete past history is displayed. However, the OIG continued to consider serious injuries without an allegation of abuse or neglect to be not

reportable. Until FY03, these cases were reported and were investigated by the OIG even though there was no allegation of abuse or neglect. The legal interpretation OIG was given by the DHS Office of General Counsel was that OIG is not required to investigate these serious injury cases and has taken the necessary steps to ensure that these cases are no longer reported or investigated. Auditors concluded that it should be up to the OIG to determine if an injury was caused by abuse or neglect, and not up to the facility or community agency.

In the 2004, 2006 and 2008 audits, auditors recommended that the OIG capture data for all allegations of serious injuries in its database. In 2008 the OIG responded that requiring agencies and facilities to report even accidental serious injuries to OIG would require a change in the statute.

According to OIG officials, the OIG considered adding serious injuries to its database but chose instead to revise the law to clarify that serious injuries are reportable to OIG only if abuse and neglect by staff is alleged or suspected, including injuries caused by an employee directing an individual to injure another.

The auditors still conclude that it should be up to the OIG to determine if an injury was caused by abuse or neglect, and not up to the facility or community agency. Serious injuries caused by neglect may not have a specific allegation associated with them, such as incidents involving resident on resident injuries. Resident on resident incidents may be a result of neglect by staff and may be identifiable if an examination of patterns and trends of serious injuries is conducted.

OIG Response: Partially agree. OIG cannot effectively review every injury report from the thousands of community agency sites and facilities.

OIG Updated Response: Corrective Action Implemented as of 3/31/11:

Partially accepted. OIG has implemented the recommendation to the extent allowed by law. OIG continues to add serious injuries to OIG's investigative database when reported. OIG investigates when those serious injuries are alleged or suspected to result from abuse or neglect by staff. When they are not, they are outside OIG's statutory jurisdiction; they are still retained in the database for later reference but are listed as "not reportable" and referred back to the facility or community agency for review and action.

2. The Office of the Inspector General should update its interagency agreements with other State agencies that have investigatory powers.

Findings: While the Department of Human Services 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 and 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.

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(a) of the Act) unless another State agency has requested that OIG participate in the investigation (such as the Departments of State Police, Children and Family Services, or Public Health)."* Although the Inspector General has clarified the investigatory role of each agency through signed interagency agreements, several of the agreements now contain outdated statutory cites and definitions that need updated.

Illinois State Police

The most recent agreement between the OIG and the Illinois State Police was signed in July 2005 prior to the OIG's investigative authority being moved to the Department of Human Services Act. Consequently, the statutory references are outdated in the agreement. More importantly, the definition for reporting to the State Police contained in the interagency agreement no longer matches the definition contained in the statutes. The interagency agreement still requires that the OIG shall within 24 hours after receiving a report of suspected abuse or neglect determine whether the evidence indicates that any possible criminal act has been committed and report it immediately. The statutes now 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 Department of State Police or other appropriate law enforcement authority, or ensure that such notification is made.

Department of Public Health

The Department of Public Health (DPH) conducts investigations at any long-term care institution participating in the Medicare or Medicaid programs, including facilities operated by DHS. The Act requires all persons who provide direct care services or have direct contact with residents to report all incidents of suspected abuse or neglect to Public Health immediately. The current interagency agreement between the OIG and Public Health was signed in January 2001 and contains outdated statutory references and language.

When DPH receives a complaint against a long-term care facility, an unannounced site visit is planned. DPH sends a copy of the complaint to the OIG because of the interagency agreement. DPH officials provided auditors with an example of a case in which OIG notified the facility that there would be a visit, which defeats the purpose of a surprise

investigation. According to DPH officials, OIG should not call or notify facilities and agencies about the complaint received by DPH before DPH is able to start its investigation. OIG should hold the complaint as confidential until the DPH investigation is completed.

When the OIG receives an allegation, its administrative rules require that officials contact the facility or agency to notify them of the allegation within three days unless the notification compromises the integrity of the investigation.

Department of Children and Family Services

An interagency agreement was executed by DCFS and the OIG on November 20, 2000, which 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. Like the agreements with ISP and DPH, the agreement with DCFS also contains outdated statutory cites.

OIG Updated Response: Corrective Action Implemented as of 3/31/11:

OIG chaired the HR 201 Workgroup on reporting of allegations in settings across State agencies; the final report was released in March 2011.

Corrective Action to be Completed:
In light of that report and the recent death of an individual in a community group home, the General Assembly is considering new legislation that could impact the inter-relationships of all four State agencies. Revising the interagency agreements will need to await those decisions.

3. The Office of the Inspector General should continue to work to improve the timeliness of investigations of abuse and neglect. The OIG should also work to improve the timeliness of investigations conducted by Clinical Coordinators, especially death investigations. (Repeated)

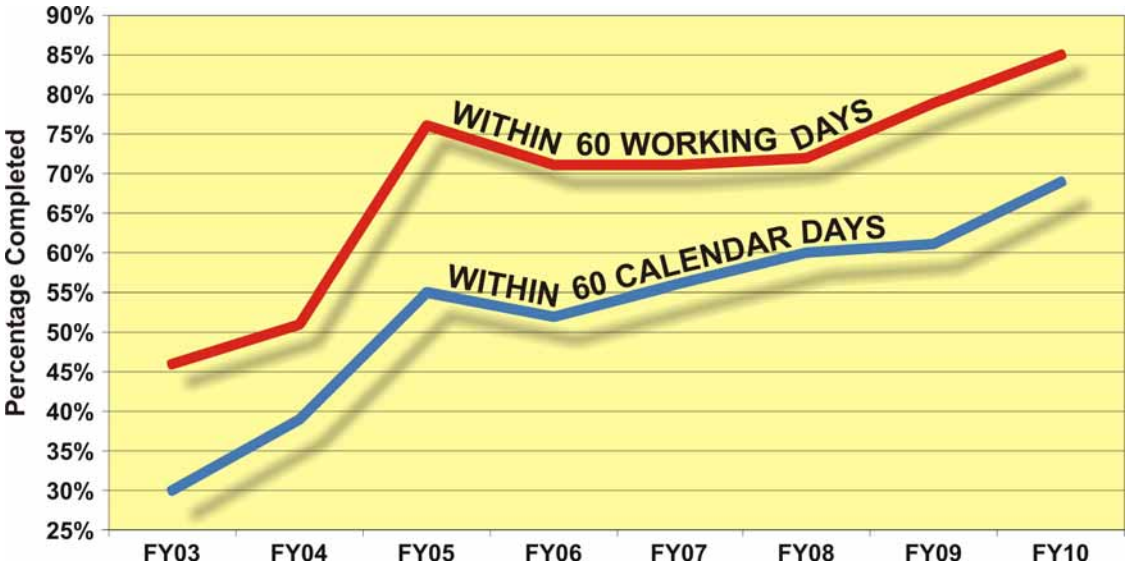
Findings: The effectiveness of an investigation is diminished if it is not conducted in a timely manner. In several prior OIG audits, auditors noted that timely completion of investigations is critical for an effective investigation, because as time passes, injuries heal, memories fade, or witnesses may not be located. The OIG changed the definition of days in its administrative rules in January 2002 to be **working** rather than **calendar** days. Sixty working days generally works out to over 80 calendar days.

Timeliness of investigations has been an issue in all of the ten previous OIG audits. Exhibit 2-1 shows that since FY03 the OIG has made significant improvements to the timeliness of investigations; however, caseloads have doubled for three of the four

investigative bureaus since 2008. During this audit period, the OIG again made improvements in its timeliness for completing investigations. In FY08, 60% of OIG investigations were completed in 60 calendar days. For FY10, 69% of cases were completed within 60 calendar days.

In FY06, the average was 69 calendar days and the median was 57 calendar days. In FY08, the average was 63 calendar days and the median was 43 calendar days. For FY10, the average calendar days to complete an investigation was 57 days and the median was 42 days.

Exhibit 2-1
ABUSE AND NEGLECT INVESTIGATION TIMELINESS TRENDS
Fiscal Years 2003 to 2010



Source: OAG analysis of OIG data.

Since the OIG changed the definition of days from calendar to the more lenient working days in Rule 50 in January 2002, auditors also looked at the percent of cases completed within 60 working days. With the more lenient working day standard, the OIG completed 71% of its FY07 cases and 72% of its FY08 cases within 60 working days. For FY09 and FY10, this improved to 79% and 85% of cases, respectively, when using the 60 working day standard.

Exhibit 2-3 shows that the Central and North Bureaus had the smallest percentages of cases taking longer than 60 working days, with 8% and 4% respectively. For the South Bureau, cases taking longer than 60 working days were 11% of total cases. The Metro Bureau cases taking longer than 60 working days were 24% of total cases. Even through

the Metro Bureau had the highest percentage of cases taking more than 60 working days, the 24% for FY10 is a substantial improvement over the 64% that were not completed within 60 working days for FY08.

The OIG has taken steps to address these timeliness problems by utilizing other bureaus to help complete cases. This includes assigning cases to be completed by the Bureau of Domestic Abuse (DAP), Bureau of Hotline and Intake, and the Bureau of Compliance and Evaluation (BCE). For the 2,150 cases closed in FY10, 242 cases were completed by other bureaus. For FY08, 219 cases were completed by other bureaus. The 242 cases completed by other bureaus during FY10 included 149 assigned to Clinical Coordinators which include death cases and cases that involve a medical issue. About two-thirds (98 of149) of the cases assigned to Clinical Coordinators took longer than 60 working days to complete. Of the remaining cases, 68 were assigned to intake investigators, 10 were assigned to DAP, and 15 were assigned to BCE.

Exhibit 2-3
CASES WITH INVESTIGATIONS GREATER THAN 60 WORKING DAYS
Cases Closed During Fiscal Year 2010

OIG Bureaus	**Number of Cases Greater Than 60 Working Days**	**Total Cases Closed**	Percent Greater Than 60 Working Days
North	20	510	4%
Metro	115	471	24%
Central	48	565	8%
South	39	362	11%
Other [1]	105	242	43%
Total	**327**	**2,150**	**15%**

Note:

[1] Other includes cases assigned to the Bureau of Compliance and Evaluation, Bureau of Domestic Abuse, Bureau of Hotline and Intake, or Clinical Coordinators. Of the 105 cases completed by other bureaus, 98 were clinical.

Source: OIG data summarized by OAG.

Cases Over 200 Days

The number of OIG investigations taking more than 200 calendar days to complete increased from 38 in FY06 to 40 in FY08 to 51 in FY10. The primary reason is the number of allegations over 200 days involving deaths investigations increased considerably in FY09 and FY10.

For FY09, there were 82 investigations that took more than 200 days to complete. Of these 82 investigations, 50 involved a death. For FY10 there were 51 cases that took more than 200 days to complete. Of these 51, 38 involved a death. These cases are not assigned to a specific bureau but instead are assigned to a Clinical Coordinator. According to OIG officials, death cases 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 consults may be needed.

Of the 51 cases that took more than 200 days to complete for FY10, 17 of 51 (33%) were State-operated facilities, while 34 (67%) were investigations of allegations at community agencies.

Clinical Coordinators

The OIG's Clinical Coordinators handle cases that involve medical issues as well as death cases. The Coordinators work and consult with Clinical Services at DHS. During the majority of FY08, OIG had only one Clinical Coordinator to cover the entire state. As of June 30, 2010, the OIG had four Clinical Coordinators (two full-time staff and two contract staff). One of these coordinators also conducts annual site visits to State-operated facilities.

The time to conduct investigations assigned to a Clinical Coordinator increased significantly from FY06 to FY10. In FY06, the average completion time for cases referred to the Clinical Coordinator was 66 days. For FY08, the average completion time for cases referred to the Coordinators was 119 days. For FY10 the average completion time for cases assigned to Clinical Coordinators was 166 days. During FY07-08, Clinical Coordinators completed 231 cases and were secondary investigators in 51 other cases. During FY09-10, Clinical Coordinators completed 302 cases and were secondary investigators in 145 other cases, nearly three times as many. The OIG hired another registered nurse on contract in FY09 to help reduce the time required for completing death cases, as well as conducting investigations involving clinical issues.

OIG Updated Response: Corrective Action Implemented as of 3/31/11:

Implemented. OIG continues to work to improve timeliness in the face of ongoing increases in the number of allegations received: a 16% increase in one year, FY2009 to FY2010, alone. The importance of timely investigations was reiterated to the investigative bureau chiefs during an OIG Leadership Team meeting on February 9, 2011, and in an email dated March 2, 2011. OIG has also begun utilizing its contractual nurse surveyor to assist in clinical consultations and seeks to re-bid the current contractual investigative nurse position, which is expiring in June 2011.

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

Findings: The OIG needs to improve the timeliness of investigator assignment and completion of investigative plans. OIG directives require that investigations be assigned to an investigator within one working day of the OIG assuming responsibility for the investigation. For cases in which auditors could determine an assignment date, 80% (99 of 123) reviewed were assigned within one working day. However for 24 of the 123 cases sampled, the assignment was not made within one working day. The time to assign for these cases ranged from 2 days to 23 days. An assignment date could not determine for 5 cases.

OIG directives also require assigned investigators to complete an investigative plan within three working days of assignment, except if the case is closed at intake or is a death investigation. For 10 of the 128 cases sampled, an investigative plan was not required because the case involved a recanted allegation, a death, or was a State Police investigation. For 9 additional cases it could not determine whether the plan was completed in a timely manner. For the remaining 109 cases sampled for which an investigative plan was required and the days from assignment to approval could be calculated, 6 (6%) were not completed and approved within the required three working days.

OIG Updated Response: Corrective Action Implemented as of 3/31/11:

Implemented. The requirements to assign all investigations within one working day and to complete all investigative plans within three working days, as required, were reiterated to the investigative bureau chiefs during an OIG Leadership Team meeting on February 9, 2011, and in an email dated March 2, 2011.

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

Findings: Alleged incidents of abuse and neglect are not being reported by facilities and community agencies in the time frames required by statutes and the OIG's administrative rules. The Department of Human Services Act requires that allegations be reported to the OIG hotline within four hours of initial discovery of the incident of alleged abuse or neglect.

Reporting allegations of abuse and neglect by community agencies improved over the past two years. For FY10, the percent of allegations not reported within the required four hours was 13 percent or nearly half of what it was two years ago. State facilities, however, saw an increase in the percent of cases that were not reported within the required four hours. Exhibit 2-10 shows allegations of abuse and neglect not reported within four hours of discovery for State facilities and community agencies from FY07 through FY10.

Exhibit 2-10
ALLEGATIONS OF ABUSE AND NEGLECT NOT REPORTED WITHIN FOUR HOURS OF DISCOVERY

Fiscal Year	Facility	Community Agency
FY07	5%	21%
FY08	7%	25%
FY09	9%	19%
FY10	10%	13%

Source: OAG analysis of OIG data.

- **Facility** – 10% of facility incidents were not reported within the four-hour time requirement in FY10 compared to 7% in FY08.

- **Community Agency** – 13% of community agency incidents were not reported within the four-hour time requirement in FY10 compared to 25% in FY08.

Effective June 13, 2006, Public Act 94-853 added a provision that states that a required reporter who willfully fails to comply with the reporting requirements is guilty of a Class A misdemeanor. The OIG continues to cite late reporting in its investigations when it occurs. OIG officials cited late reporting in 34 cases in FY06, 68 cases in FY07, and 175 cases in FY08. The FY09 OIG annual report shows that the OIG cited late reporting in 305 cases in FY09. For FY10, the OIG cited late reporting in 190 cases.

OIG Response: Agree. OIG has proposed a revision to the DHS program directive on reporting of abuse or neglect, clarifying and strengthening the requirements for reporting. OIG continues to flag late reporting on initial intakes, to identify late reporting to the divisions every month, to cite late reporting in investigative case reports, and to provide an electronic Rule 50 training for the facilities and agencies to use for internal training on reporting.

DHS Updated Response: Corrective Action Implemented as of 3/31/11:

Implemented. The new DHS program directive was promulgated in December 2010, strengthening the requirements for reporting and for cooperating with investigations. OIG continues to flag and to cite late reporting, to identify late reported incidents to the divisions each month, and to provide a computer-based Rule 50 training for the newly required biennial training on reporting.

6. The Office of the Inspector General should ensure that all routing and approval forms are completed and signed off on by the Bureau Chief.

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

- **Case Tracking Form** - All case files in the sample contained a Case Tracking Form as required by investigative directives. The Case Tracking Form identifies information such as the case number, investigative agency, bureau, and allegation. This form's main purpose is to track OIG's actions throughout the investigation. Dates for when the investigative report was received, when it was reviewed, and when it was closed are all tracked on this form. It is also used to document the case finding and recommendations for action.

- **Case Routing/Approval Form** - After a case is submitted for review, the review progress is documented through the Case Routing/Approval Form. After each level of review, the reviewer signs and dates the form to indicate that the review has taken place and sends the case to the next level of review. On these forms, the reviewer can note when the case was sent to special review, clinical, legal, a consultant, or another office. All of the 128 cases tested contained a Case Routing/Approval Form. However, for three cases there was no review or approval by the Bureau Chief or anyone else for that matter on the case routing and approval form. The OIG's directives require that the Bureau Chief sign off on the Case Routing/Approval Form. All three of these cases were in the South Bureau where the Bureau Chief for the South Bureau retired effective November 30, 2009. As of June 30, 2010, the Bureau Chief for the OIG's Central Bureau was also filling in as the acting Bureau Chief for the South Bureau.

OIG Updated Response: Corrective Action Implemented as of 3/31/11:

Implemented. The requirement for signing the final routing and approval form was reiterated to the investigative bureau chiefs during an OIG Leadership Team meeting on February 9, 2011, and in an email dated March 2, 2011.

7. 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)

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

In a review of 128 case files, auditors identified 11 files that did not contain the required

written response. Even though the written responses were not contained in the case file, auditors were able to obtain copies of the written response from the OIG for 10 of the 11 files.

In a review of written responses, auditors found that DHS, in some cases, still takes an excessive amount of time to receive and approve the actions taken by the agency or facility. Overall there were 28 cases in the sample that required a written response. Of the 28 cases in the sample, 5 of 28 took more than six months from the date the case was completed until the written response was approved by DHS. If DHS does not approve written responses in a timely manner, the OIG cannot effectively monitor the implementation of actions by State-operated facilities and community agencies. In addition, not ensuring that appropriate actions are taken may put client safety at risk.

DHS Updated Response: Corrective Action Implemented as of 3/31/11:

MENTAL HEALTH:

- OIG Late Reporting data has been added to each hospital's FY11 Performance Indicators (measures). Threshold will be set Zero (0). For those hospitals that exceed the threshold, will review with the Associate Director and discuss corrective action plan.

DEVELOPMENTAL DISABILITIES:

- The Bureau of Quality Management's curriculum has been developed. First training for community agencies was offered prior to or on 3/31/11.
- Two additional training sessions for community agencies were conducted via webinar (4/6 and 4/8/11).
- At least 125 different registrants participated on these two days; although multiple persons may have participated at a computer log-in site without knowledge of the presenter. Seventy-nine (79) different community agencies were represented.

Corrective action to be completed:
DEVELOPMENTAL DISABILITIES:

- The Bureau of Quality Management will develop and present training to community agencies regarding steps to take when an investigative report from OIG substantiates a finding of abuse, neglect or exploitation and/or OIG makes recommendations to the community agency. A substantial portion of the curriculum will focus on how to correctly prepare a timely written response. On-going training will be presented at least once each fiscal year.
- Two additional training sessions will be conducted 4/15 and 4/18/11.

DIVISION of DEVELOPMENTAL DISABILITIES OPERATIONS UNIT:

- The DD Operations Unit will create a spreadsheet to track written responses of State Operated Developmental Centers (SODCs).
- A ticker file will be established to alert Operations staff of the due dates of all written responses. If written responses are not received on the scheduled due date, facility

directors will be called and instructed to send in their responses by close of business.

8. **The Office of the Inspector General should use the annual site visit process to target and examine areas at individual facilities where other investigations and/or reports have identified systemic resident safety concerns, such as the underreporting of abuse and neglect. Furthermore, if State facilities repeatedly fail to take corrective action on matters raised by OIG site visits or arising out of other investigations, the Inspector General should also consider making recommendations, up to and including sanctions, to ensure the safety of State-operated facility residents.**

Findings: During FY09 and FY10, the OIG conducted annual unannounced site visits at each of the mental health and developmental facilities as required by statute. In addition, during both fiscal years, the OIG met its established timeline for submitting site visit reports to facility directors or hospital administrators within 60 days after completion of the site visit. The goal of these visits is to review systemic issues that may be related to the prevention of abuse or neglect of individuals receiving services in the facilities. OIG staff from the Bureau of Compliance and Evaluation (Compliance Reviewer) and a Clinical Coordinator (Registered Nurse) were responsible for conducting site visits.

During FY09, site visitors followed up on prior recommendations and reviewed the actions taken by the facility to address the recommendations. They also looked at issues concerning the patient's habilitation/treatment planning, quality assurance reviews, facility investigative protocol, and employee return from administrative leave.

As part of the site visit procedures for FY10 for DHS facilities, site visitors reviewed the facility's process for preventing and responding to outbreaks of common or serious infectious disease and several medication related issues. They reviewed how each facility scheduled staffing levels and the facility's practices regarding reassignment. Site visitors also reviewed the facility's incidents related to peer to peer aggression and/or aggressive individuals for possible staff involvement. Recommendations made as part of the FY10 site visits included: adopting policies regarding medication errors, better documenting administrative reassignments, reviewing peer to peer aggression for possible staff involvement, and documenting follow up for OIG non-reportable complaints.

During FY10, site visitors continued to follow up on prior recommendations to check for compliance. Site visitors also conducted focused reviews of new issues. These issues pertained to infectious disease, medication errors, outdated medications, staffing levels, administrative reassignment, and peer aggression.

OIG Updated Response: **Corrective Action Implemented as of 3/31/11:**

Separately, OIG has reiterated its commitment to using the statutory authority to recommend sanctions.

Corrective Action to be implemented:
OIG's annual site visit planning meeting is scheduled for April 27, 2011. Recent investigations, written responses, surveys, and prior recommendations will again be used to target and examine systemic issues related to abuse/neglect.

9. The Secretary of the Department of Human Services and the Inspector General should continue to work with the Governor's Office to get members appointed to the Board as promptly as possible, in order to fulfill statutory membership requirements to the Quality Care Board. Staggering the terms of members should be used in order to ensure membership.

Findings: The Department of Human Services Act established a Quality Care Board within the Department of Human Services' Office of the Inspector General 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.

One of the requirements of the Board is to meet quarterly; and four Board members constitute a quorum to conduct business. The Board is comprised of seven members, appointed by the Governor with the advice and consent of the Senate. During FY09 and FY10, the Board met five times in each fiscal year. The July 2008 and October 2009 Board meetings failed to have quorums.

The Board continues to have problems maintaining seven members as required by statute. During FY09, the Board had six members. During FY10, one Board member resigned in July 2009, and another member resigned in October 2009. This left the Board with only four members. One of the four members indicated in March 2010 that he would not seek renewal of his membership, but agreed to stay on the Board until the end of the calendar year. According to DHS officials, Board members continue to serve until the next appointment is made by the Governor.

From November 2009 to May 2010, all of the remaining member's of the Board were serving under terms that had expired. The Governor temporarily appointed two Board members in May 2010. This extended one Board members term date to November 2011, and another Board member's term date to November 2013. As of June 30, 2010, the Board only had two members serving under appointments that had not expired. After the audit period, another Board member was temporarily reappointed and a new applicant received a temporary appointment to serve on the Board.

Initial appointments to the Board should be made so that four members are appointed to a four-year term and three members are appointed to a two-year term, thus avoiding the

situation that occurred between November 2009 and May 2010 in which all the members' terms had expired.

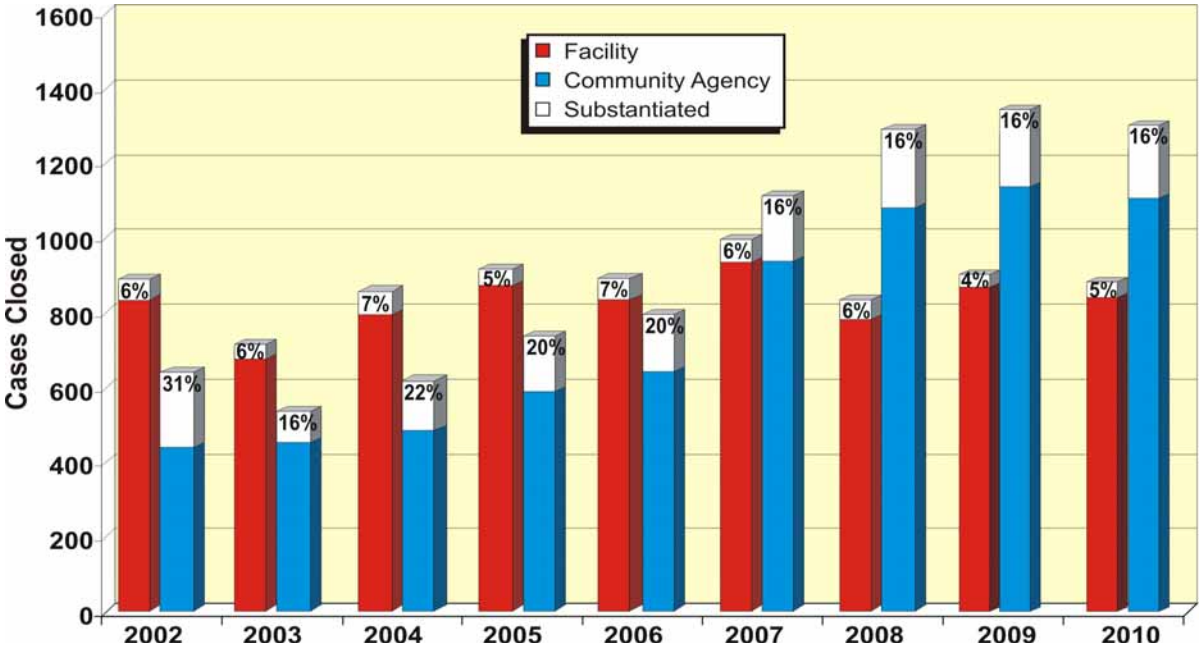
DHS & OIG Updated Response: **Corrective Action Implemented as of 3/31/11:**

Implemented. OIG has continued to work with the Governor's office on appointments to the OIG Quality Care Board. Terms are being staggered as specified in statute.

SUBSTANTIATED ABUSE AND NEGLECT CASES

In FY10, the OIG closed a total of 2,162 investigations of allegations of abuse or neglect. The OIG substantiated 258 cases of the abuse or neglect allegations, resulting in a 12% substantiation rate. These numbers and percentages include substantiated cases that were classified as abuse or neglect at intake.

Exhibit 4-2
ABUSE AND NEGLECT CASES CLOSED AND SUBSTANTIATED FOR STATE FACILITIES AND COMMUNITY AGENCIES
(Allegations Categorized as Abuse or Neglect at Intake)
Fiscal Years 2002 to 2010



Note: State facilities served 2,485 individuals with developmental disabilities and 10,237individuals with mental illness in FY10. Community agencies served approximately 37,500 individuals with developmental disabilities and approximately 163,147 individuals with mental illness in FY10.

Source: OIG information summarized by OAG.