State of Illinois
Department of Human Services
Office of the Inspector General

Abuse and Neglect of Adults With Disabilities

IDHS Office of the Inspector General
FY20 Annual Report

December 15, 2020

To Governor Pritzker and Members of the Illinois General Assembly:

Although 2020 was, to state the obvious, a trying year for the Illinois Department of Human Services ("IDHS" or the "Department") Office of the Inspector General ("OIG" or the "Office"), as it was for the entire State of Illinois, due to the dedication and flexibility of OIG's mission-driven staff, the office continued to function as an effective watchdog for individuals with developmental disabilities and individuals receiving mental health services at State-operated facilities or community agencies licensed, funded or certified by the Department. More specifically, despite facing unprecedented challenges, including having to conduct investigations entirely off-site and transitioning staff from in-office work to fully remote operation in a matter of days, OIG managed to reduce its caseload by over twenty percent, while also substantiating cases at an increased rate. In addition, OIG reduced by almost fifty percent the number of employees at State-operated facilities who were on paid administrative leave as a result of OIG investigations open for more than 60 days.

Aside from addressing the many logistical difficulties presented by COVID-19, OIG also made numerous modifications to its policies and procedures in FY20 to better comport with investigative best practices and to generally improve the quality and timeliness of OIG's investigations. Among other implementations, OIG: (1) in coordination with the State facilities, commenced a pilot complaint intake project designed to provide a timelier response to allegations and allow for the more efficient utilization of OIG resources; (2) created and implemented a conflict of interest policy for OIG staff to better ensure the credibility of OIG's investigations; and (3) revised the Office's substantiated report template to improve clarity and readability.

OIG understands though, that because it, like many government agencies, is asked to do a great deal with relatively modest resources, OIG must continue to identify operational efficiencies to improve the quality and timeliness of its investigations. As part of that process, OIG's primary focuses in FY21 will be to: (1) make internal and external policy changes to further reduce the number of State facility staff that are on paid administrative leave as a result of OIG investigations; and (2) ensure that OIG has the personnel and technology resources it needs to fully inhabit its role as an independent watchdog.

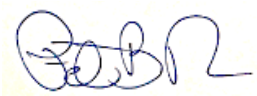
Finally, OIG notes that in an effort to better highlight the many facets of OIG's work, OIG's FY20 annual report, in addition to setting forth the usual metrics and data, also contains the following new sections:

- Deidentified narrative summaries of a small subset of the OIG investigative work that produced significant criminal or administrative consequences for the subjects of the investigation, *see infra* Chapter 6: Notable OIG Investigations;
- Capsule summaries of the most significant internal OIG policy changes and developments, *see infra* Chapter 4: New Initiatives;
- Identification of certain structural challenges OIG faces, *see infra* Chapter 7(A); and
- My vision, as Acting Inspector General, for the future of the Office, *see infra* Chapter 7(B).

Going forward, OIG will continue to place an increased emphasis on outcome-based reporting—including creating and implementing new data tracking methods—to more accurately measure OIG's performance and better illustrate OIG's importance to the State of Illinois.

Thank you for your interest in IDHS OIG and its important mission.

Sincerely,



Peter B. Neumer
Acting Inspector General

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Chapter 1: Summary of OIG's FY20

A. COVID-19's Impact on OIG

The COVID-19 pandemic significantly altered how OIG carries out its mission of detecting abuse and neglect at State facilities and community agencies licensed, funded or certified by the Department. Most notably, after State facilities and community agencies restricted access to their sites, OIG began conducting its investigations remotely—conducting interviews via phone or video conference and acquiring documents exclusively through secure electronic means or via mail—and quickly implemented new protocols to ensure that its remote investigations remained thorough and credible. In addition, OIG faced the logistical challenge of transitioning its workforce, who worked entirely in office settings, to remote work in a matter of days. Compounding the difficulty of this task was OIG's general lack of in-house technological resources. However, to its credit, OIG's staff, as evidenced by the data set forth in this report, was able to maintain its productivity.

OIG, where appropriate, also worked in collaboration with IDHS and community agencies during the early stages of COVID-19 to address the unprecedented logistical challenges presented by the pandemic. For example, OIG assisted IDHS in drafting Executive Order 2020-24 (the "EO"), which was designed to help alleviate the staffing shortages the State-operated Mental Health (MH) and Development Disability (DD) facilities faced as a result of COVID-19. The EO allowed OIG to more quickly return State facility employees to work in situations where OIG's investigation had established that the allegations against the employees would not be substantiated. As a result, OIG was able to protect individuals while also addressing the operational concerns of the facilities. OIG subsequently proposed legislation which would codify these common-sense reforms and likely produce fiscal benefits for the State of Illinois and hopes to see that legislation enacted.

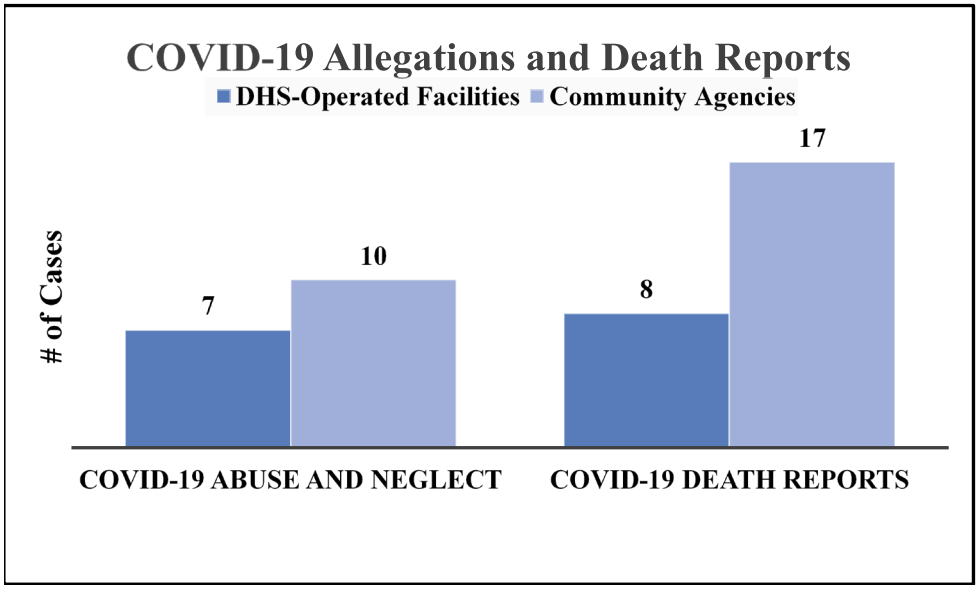
In addition, during the early stages of the pandemic, when facilities and agencies were facing unprecedented staffing and logistical challenges, OIG briefly suspended its compliance review program, to lessen the operational burden on facilities and agencies. As part of that compliance review process, OIG reviews at least ten percent of the written responses it receives from State facilities or agencies regarding OIG's recommendations and findings to ensure the facilities or agencies actually took the action they said they did. *See infra* Chapter 2(F). OIG communicated with the Office of the Executive Inspector General (OEIG) and IDHS prior to suspending the review program to ensure full transparency regarding the nature of that suspension. Once the staffing shortages and logistical challenges at the facilities and agencies abated, OIG promptly resumed its reviews.

Unfortunately, due to the pandemic and the closing of State facilities to non-essential personnel, OIG was only able to complete site visits at 7 of the 14 State-operated facilities prior to the end of the fiscal year. As in-person site visits continue to pose safety risks for staff and individuals, OIG will be conducting its site visits remotely in FY21, through interviews, document requests and questionnaires. Although OIG is confident these remote site visits will produce actionable insights, the Office looks forward to a return to its usual, in-person site visits in FY22.

OIG notes that from the start of the pandemic in March 2020 to the end of FY20 in June 2020, OIG experienced an approximately 40 percent decline in complaints that resulted in the opening of an OIG investigation, when compared to the same period in FY19. OIG determined that part of that decline was likely due to the temporary closure of day programs, but OIG is still working to determine the other causes of the decline, which occurred throughout OIG's five investigative bureaus and at both MH and DD divisions as well.

With respect to OIG's COVID-19 related investigations, from March 2020 until the end of the fiscal year, OIG received 17 allegations of abuse or neglect related to COVID-19. As of December 2020, OIG had completed all 17 of those investigations and substantiated neglect in one of those investigations. OIG identified other issues that required a written response from the agency or facility in 7 of those 17 cases.

OIG also received 25 reports of COVID-19 related deaths in FY20.[1] As of December 2020, OIG completed reviews of 23 of those deaths and subsequently opened full abuse or neglect investigations in two of those cases, based on a finding that there was a suspicion of abuse or neglect related to those deaths. OIG substantiated neglect in one of those two cases. OIG also identified other issues that required a written response from the agency or facility in 3 of those 23 cases.



With respect to OIG's substantiation of 2 of the 19 FY20 abuse and neglect COVID-19 investigations OIG has completed—a substantiation rate that is almost identical to OIG's overall substantiation rate—OIG notes that while many individuals have tested positive for COVID-19 at facilities and agencies, OIG did not and does not view a positive COVID-19 test as *per se* evidence of neglect. Rather, with respect to its COVID-19 investigations, OIG focused on whether the facilities and agencies were competently following the policies and directives set forth by IDHS, as it is possible for a facility to follow all the rules and guidelines and still have an individual test positive for COVID-19. In addition, pursuant to the Illinois Administrative Code's definition of

[1] OIG conducts death reviews with respect to all reportable deaths to determine whether there was any suspicion of abuse or neglect in connection with the death. If there is a suspicion of abuse or neglect, OIG opens the case for a full investigation. If there is no suspicion of neglect, the death review is closed.

"neglect," in order to make a substantiated neglect finding, OIG must establish by a preponderance of the evidence that there was a failure to provide adequate care and that that failure resulted in the deterioration of an individual's physical condition or placed an individual's health at substantial risk of harm or death. Thus, under the applicable rules, a failure to follow COVID-19 protocols will not result in a neglect finding unless it also placed an individual at substantial risk of harm or death.

Finally, with respect to a return to on-site investigative work, OIG, as of the drafting of this Annual Report, remains in communication with DD and MH regarding when it will be safe and prudent to engage in such work on a regular basis. Although OIG believes strongly in the value of on-site investigations, OIG's highest priority has been and always will be the safety and well-being of the individuals under its jurisdiction and OIG will continue to perform investigations remotely until it believes that it can do so without endangering individuals. As to when such a return will be appropriate, there are multiple factors to consider, including positivity rates throughout the State, the presence of a reliable vaccine, and the COVID-19 infection rates at facilities and agencies. Ultimately, OIG, DD and MH will continue to take a prudent, holistic, and cautious approach on this subject.

B. Notable FY20 Data

The FY20 data demonstrates that OIG, in spite of the many challenges posed by the pandemic, made some significant improvements in terms of its productivity and timeliness. Most notably, OIG:

- Reduced its overall caseload from 1,869 to 1,392, a reduction of 25.5 percent;
- Reduced the number of OIG investigations that have been open more than 60 days from 1,181 to 1,032, a reduction of 13 percent;
- Increased the percentage of cases completed within 60 days from 39 percent in FY19 to 47 percent in FY20;
- Helped reduce the number of facility employees on paid administrative leave due to OIG investigations that extend beyond 60 days by almost 50 percent. *See infra* Chapter 1(C) for additional information regarding OIG and paid administrative leave.

For a more complete detailing of OIG's FY20 metrics, *see infra* Chapter 2 & 3.

C. OIG's Efforts to Reduce the Number of IDHS Employees on Paid Administrative Leave

In FY20, one of OIG's priorities was to reduce the number of facility employees that were on paid administrative leave as a result of OIG investigations. As background, a 2001 memorandum of understanding between IDHS and AFSCME provides that employees who are the subject of a complaint alleging abuse or neglect will be placed on paid administrative leave if OIG's investigation of the allegation extends beyond 60 days. When a facility has a significant number of employees on paid administrative leave, it can create staffing challenges for the Facility, resulting in increased overtime and extended shifts for other employees. Thus, whenever possible, OIG attempts to complete its investigations within 60 days to ensure optimal facility staffing and the most efficient use of the State's fiscal resources.

Notably, facility employees are also placed on paid administrative leave when they are the subjects of criminal law enforcement investigations that extend beyond 60 days. As OIG must suspend its administration investigation until the criminal investigation and any ensuing proceedings are complete, OIG has minimal ability to reduce the number of facility employees who are on paid administrative leave due to criminal investigations, which often can take over a year to complete. Accordingly, with respect to the below metrics, the figure that is most reflective of OIG's performance in this area is the number of facility employees who are on paid administrative leave as a result of OIG administrative investigations.

In FY20, OIG took several actions in an effort to reduce the number of facility employees that are placed on paid administrative leave as a result of an OIG investigations:

- As noted above, OIG helped draft an Executive Order that allowed for the quicker return to work for employees who were the subject of an unsubstantiated or unfounded report, *see supra* Chapter 1(A);
- OIG launched a pilot program that involves assigning an investigator specifically to the Ludeman facility, which investigator is responsible for handling investigations from the initial complaint through issuance of the final Investigative Report;
- OIG worked with its Bureau Chiefs to prioritize the completion of investigations that involved multiple facility employees who had been placed on paid administrative leave or reassignment.

Based on the figures provided by IDHS's Developmental Disability (DD) Division (as DD maintains the records and data regarding facility administrative leave), these efforts were a success as the number of facility employees on paid administrative leave due to OIG investigations (excluding the employees on paid administrative leave due to criminal investigations or proceedings), dropped from 108 on May 31, 2019 to 55 on June 11, 2020, a reduction of nearly fifty percent. With respect to the Ludeman facility, the number of employees on paid administrative leave due to OIG administrative investigations dropped from 35 to 27 employees, a reduction of 23%.

Looking forward to FY21, OIG has identified a common-sense statutory amendment that would effectively codify the reforms enacted through Executive Order and that OIG believes would allow for continued reductions in the number of employees on paid administrative leave. OIG will be working collaboratively with IDHS on this legislative proposal.

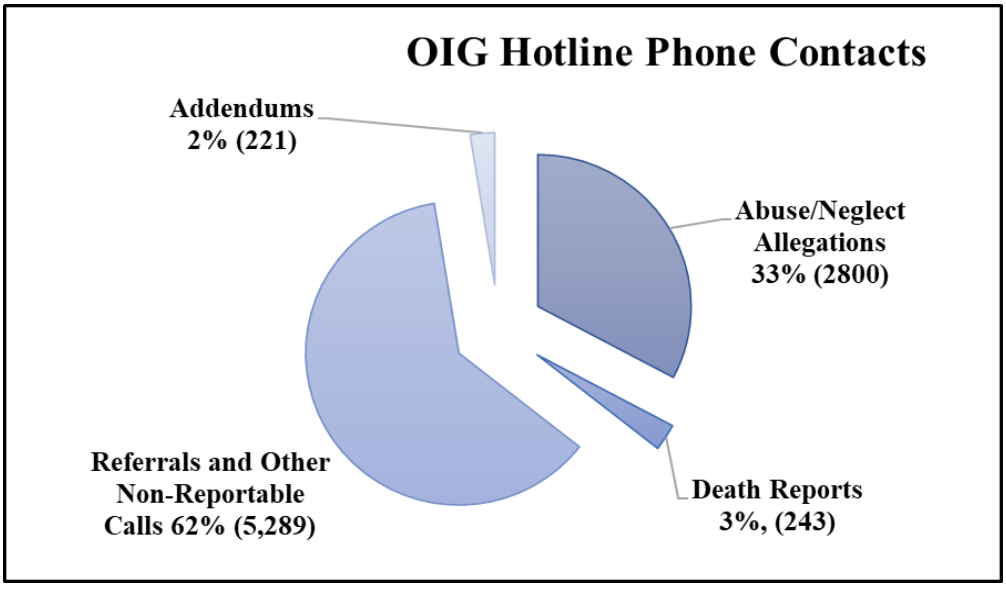
OIG is also collaborating with DD on the drafting of a directive for facilities that is designed to provide additional guidance as to when facility employees are to be placed on administrative leave. In addition, OIG is working with the Department and DD to ensure OIG has the most up-to-date data regarding administrative leave, as absent such data, OIG's ability to properly prioritize its resources to focus on administrative reassignment investigations is somewhat curtailed. Through these efforts, OIG believes it will be able to continue to reduce the number of employees on paid administrative leave as a result of OIG investigations.

Chapter 2: OIG's FY20 in Numbers

A. OIG Hotline Calls and Referrals

During FY20, the OIG's Intake Bureau processed 8,558 calls, as reflected in the below table. As background, OIG's Intake Bureau is staffed by a Bureau Chief, six Intake Investigators who answer calls during business hours, and a contracted answering service that answers calls during the evening and overnight hours. OIG management is available for after-hour calls regarding reports of deaths or serious incidents or coming from anonymous callers.

OIG receives complaints alleging abuse (physical abuse, sexual abuse, mental abuse, and financial exploitation), neglect (neglect and egregious neglect), as well as death reports (reports of death where abuse and neglect is not suspected).[2] OIG's Complaint Intake Bureau also receives numerous non-reportable calls, which include complaints that do not fall under the abuse or neglect definitions of "Rule 50" (Title 59, Chapter I, Part 50, Section 50 of the Illinois Administrative Code) or other reporting requirements.



For non-reportable calls, the Intake investigator may either refer the caller to a more appropriate reporting entity or directly transfer the caller to that entity. In FY20, OIG had 5,289 non-reportable calls. No action was needed on 86 or 1.6% of the calls OIG received. The following table reflects

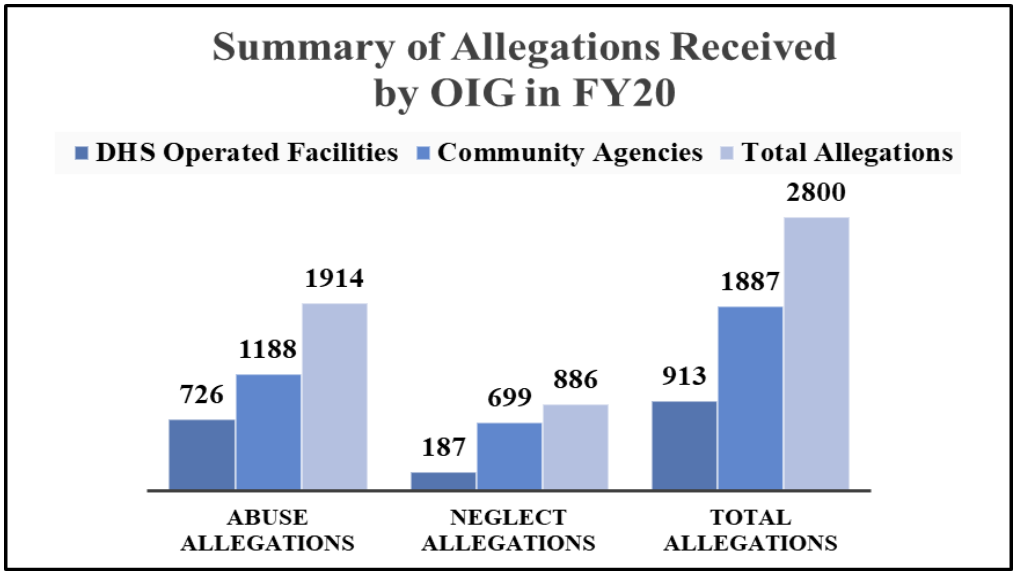
[2] *See* Appendix B: Rule 50 Definitions of Abuse and Neglect.

the recipients of OIG's FY20 referrals:

Referral Recipient	Number of Complaints Referred
Department of Children and Family Services	37
Department of Health and Family Services	58
Department on Aging	132
DHS BALC/OCAPS	47
DHS Division of Developmental Disabilities	143
DHS Division of Mental Health	25
DHS Division of Rehabilitation Services	17
Illinois Department of Public Health	262
Local Community Agency or Facility	3855
Law Enforcement	51
Other	576
Total Referred	**5289**

B. Allegations of Abuse and Neglect Received

During FY20, OIG received a total of 2,800 allegations of abuse or neglect, 778 fewer than in FY19. The following tables provide a detailed breakdown of the allegations OIG received in FY20, by type and location.

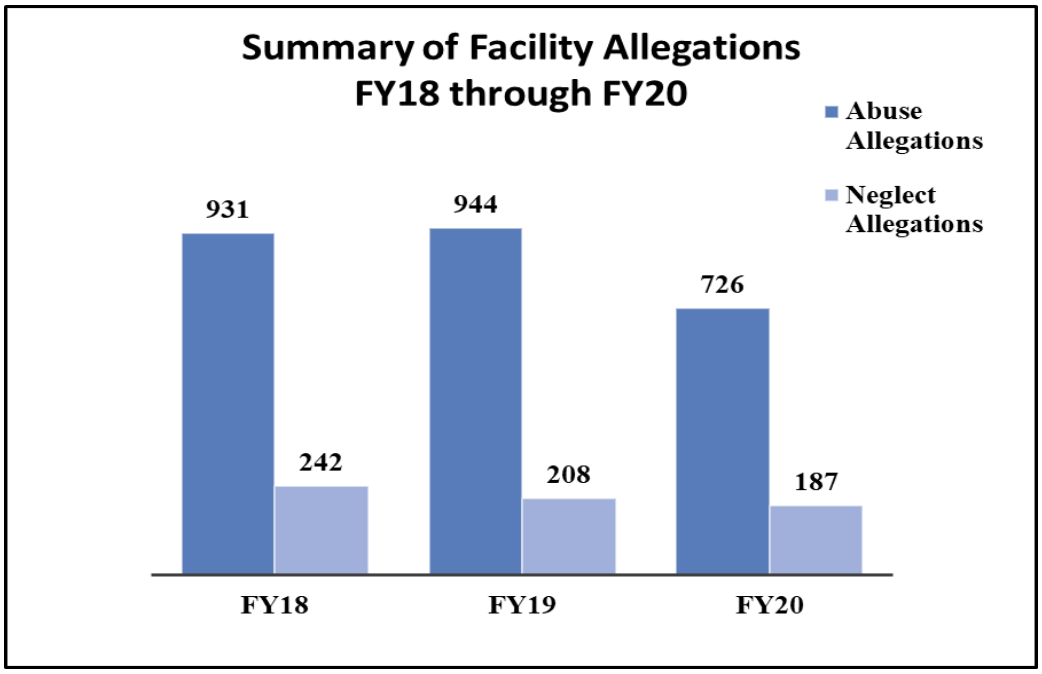


Total abuse allegations in IDHS-operated facilities and community agencies decreased from 2425 in FY19 to 1914 in FY20. Allegations of financial exploitation (a subset of abuse) also decreased by 23.8% from FY19 to FY20. Similarly, neglect allegations in IDHS-operated facilities and community agencies decreased by 23.1% from FY19 to FY20.

Facilities

During FY20, OIG received 913 allegations of abuse and neglect at the IDHS-operated facilities, a 20.7% decrease from FY19. 726 of the 913 facility allegations were allegations of abuse (which abuse allegations included 28 allegations of financial exploitation). Abuse allegations accounted for 79.5% of the total allegations at facilities, a slight decrease from FY19.

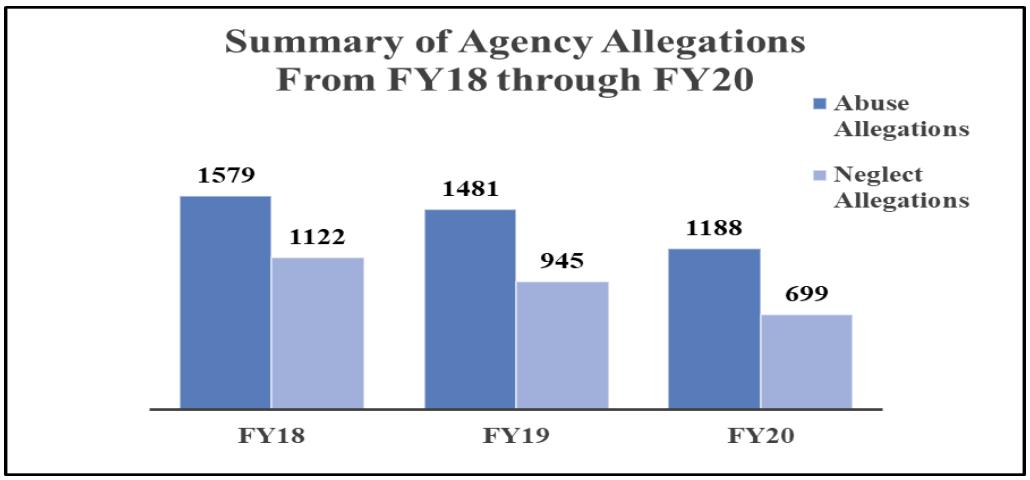
187 of the 913 facility allegations OIG received in FY20 were allegations of neglect. The number of FY20 neglect allegations decreased by 10% from FY19.



Community Agencies

During FY20, OIG received 1,887 allegations of abuse and neglect at community agencies, a 22.2% decrease from FY19. Of the 1,887 community agency allegations, there were 1,188 allegations of abuse, including 106 allegations of financial exploitation. In FY20, 63% of the community agency allegations OIG received were abuse allegations, compared with 61% in FY19, and 58.5% in FY18. OIG received 699 allegations of neglect at community agencies in FY20, a 26% decrease from the 945 neglect allegations OIG received in FY19.

In FY20, allegations at community agencies accounted for 67.4% of all allegations OIG received, roughly the same as in FY19. This number is generally reflective of the fact that significantly more individuals receive MH/DD services at community agencies than at State-operated Facilities.



Allegation Type

The following tables show the allegations of abuse and neglect and death reports that OIG received during FY20, categorized by the type of allegation and program location. In addition to the above-described abuse and neglect allegations that OIG received, during FY20, OIG received death reports regarding 243 individuals who were or had been receiving MH/DD services in facility or community agency programs.

FY20 Allegations and Death Reports Received by Mental Health Locations

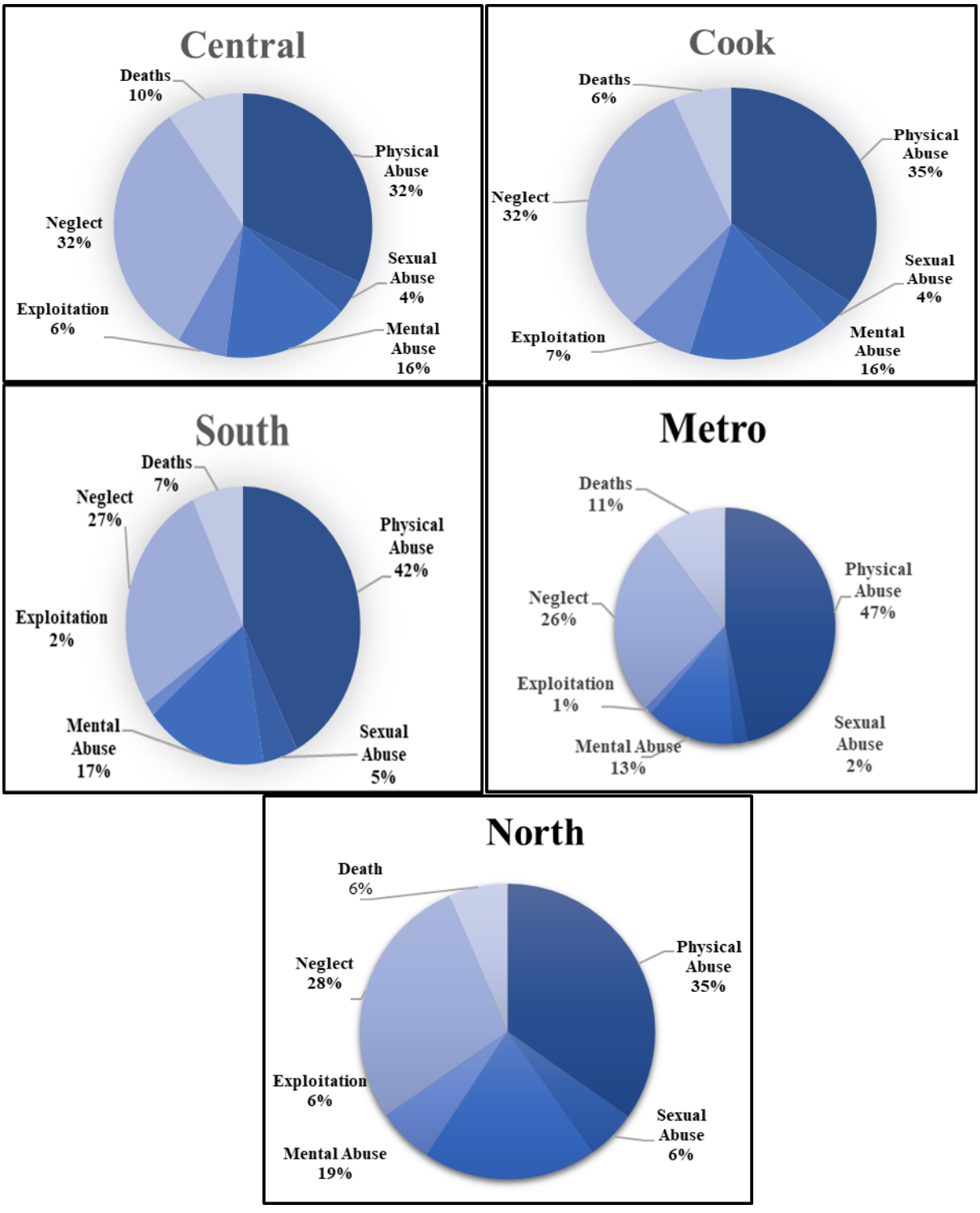
Location	Allegations Received						
	Physical Abuse	Sexual Abuse	Mental Abuse	Financial Exploitation	Neglect	Total	Death Reports
Mental Health Centers							
Alton	32	6	16	6	14	138	0
Chester	68	11	32	3	24	138	0
Chicago-Read	20	5	6	3	16	50	3
Choate	17	4	5	1	1	28	1
Elgin	61	19	47	8	35	170	3
Madden	14	3	9	1	7	34	1
McFarland	16	2	10	4	15	47	1
Facility Totals	228	50	125	26	112	541	9

Community Agencies:							
Residential	8	5	17	10	17	57	16
Non-Residential	6	14	17	22	5	64	7
Agency Totals	14	19	34	32	22	121	23
Total Allegations and Reports	242	69	159	58	134	662	32

FY20 Allegations and Death Reports Received by Developmental Center Locations

Location	Allegations Received						Death Reports
	Physical Abuse	Sexual Abuse	Mental Abuse	Financial Exploitation	Neglect	Total	
Developmental Centers:							
Choate	71	5	21	1	13	111	2
Fox	0	0	0	0	6	6	5
Kiley	29	3	3	1	14	50	6
Ludeman	37	0	4	0	17	58	12
Mabley	18	0	0	0	7	25	4
Murray	40	0	3	0	13	56	6
Shapiro	48	1	12	0	5	66	12
Center Totals	243	9	43	2	75	372	47
Community Agencies:							
Residential	558	39	234	66	588	1485	157
Non-Residential	118	10	56	8	89	281	7
Agency Totals	676	49	290	74	677	1766	164
Total Allegations and Reports	919	558	333	76	752	2138	211

Allegations by Bureau



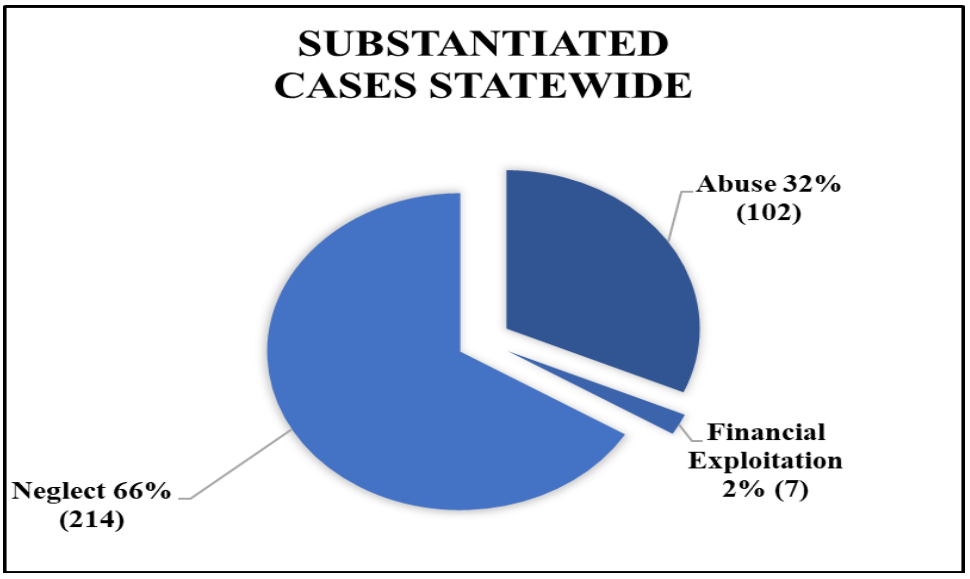
C. Findings

Pursuant to Illinois statute, OIG makes three types of findings in its investigative case reports:

Substantiated	• OIG determined that the preponderance of the evidence supports a finding of abuse or neglect.
Unsubstantiated	• OIG determined that there is credible evidence to support a finding of abuse or neglect, but not a preponderance of the evidence.
Unfounded	• OIG determined that no credible evidence exists to support the allegation of abuse or neglect.

OIG substantiated abuse or neglect in 323 of the 3,425 investigations it closed in FY20, including 214 substantiated neglect cases, 102 substantiated abuse cases, and 7 financial exploitation cases. The below tables reflect: (1) FY20 Substantiated Cases Statewide by Category; (2) Substantiated Abuse and Neglect Cases by MH Location; and (3) Substantiated Abuse and Neglect Cases by MH Location.

FY20 Substantiated Cases Statewide by Category



FY18 through FY20 Substantiated Case Trends

OIG's overall substantiation rate increased from 7.9% in FY19 to 9.4% in FY20. In FY20, OIG substantiated cases at a higher rate at both DD facilities and DD community agencies than in FY19.

OIG substantiated 20 more abuse cases at DD community agencies in FY20 than FY19, and 30 more neglect cases.

Substantiation Rate FY18 through FY20			
Location	**FY18**	**FY19**	**FY20**
MH State Facility	**1.8%**	**3.1%**	**2.9%**
DD State Facility	**6.0%**	**4.7%**	**3.6%**
MH Community Agency	**5.0%**	**5.4%**	**6.1%**
DD Community Agency	**14.4%**	**10.3%**	**12.5%**
Total	**10.6%**	**7.9%**	**9.4%**

FY20 Findings by Mental Health Locations					
Location	**Abuse Substantiated**	**Financial Exploitation Substantiated**	**Neglect Substantiated**	**Not Substantiated[3]**	**Finding Totals**
Mental Health Centers					
Alton	1	0	0	90	91
Chester	2	0	5	196	203
Chicago-Read	0	0	0	44	44
Choate	0	0	1	32	33
Elgin	3	0	0	171	174
Madden	2	0	0	23	25
McFarland	0	0	4	46	50
Center Totals	**8**	**0**	**10**	**602**	**620**
Community Agencies					
Residential	4	0	3	83	90
Non-Residential	0	0	0	71	74
Agency Totals	**7**	**0**	**3**	**154**	**164**
Finding Totals	**15**	**0**	**13**	**756**	**784**

[3] OIG made recommendations to the facility in 75 of the 756 MH cases that OIG did not substantiate.

FY20 Findings by Developmental Locations					
Location	**Abuse Substantiated**	**Financial Exploitation Substantiated**	**Neglect Substantiated**	**Not Substantiated[4]**	**Findings Totals**
Developmental Centers					
Choate	1	0	4	125	130
Fox	0	0	0	8	8
Kiley	2	0	4	82	88
Ludeman	0	0	2	71	73
Mabley	0	0	1	28	29
Murray	1	0	0	41	42
Shapiro	0	0	0	42	42
Center Totals	**4**	**0**	**11**	**397**	**412**
Community Agencies					
Residential	67	4	151	1581	1803
Non-Residential	16	3	39	377	435
Agency Totals	**83**	**7**	**190**	**1958**	**2238**
Total Findings	**87**	**7**	**201**	**2355**	**2650**

FY20 Substantiated Death Cases

OIG closed 188 death cases during FY20, a decrease from the 236 death cases OIG closed during FY19. Of the 188 closed death cases:

- OIG determined that there was no suspicion of abuse or neglect in 153 of the cases;
- With respect to the 35 death cases where OIG subsequently opened an abuse or neglect investigation, OIG substantiated 5 cases for neglect. As to the other 30 cases that OIG did not substantiate, OIG identified issues that required a written response from the agency or facility in 26 of those cases.

D. Reconsiderations of OIG Findings

In FY20, OIG received and reviewed 127 requests for reconsideration of OIG's investigative findings or recommendations, in connection with 123 investigations (on occasion an investigation will have multiple requests for reconsideration). As background, pursuant to Illinois statutory law, facilities, agencies, victims, guardians, or subject employees can request that OIG reconsider the

[4] OIG made recommendations to the facility in 620 of the 2,355 DD cases that OIG did not substantiate.

findings or recommendations OIG made in its investigative report.[5] Upon receipt, OIG conducts a multi-layer review of the request, which review includes at least one OIG employee who did not participate in the investigation or approval of the investigative report at issue. OIG reviews the information provided in the reconsideration request and all evidence gathered during the original investigation. The Inspector General ultimately makes the final determination as to whether the request should be:

- Denied.
- Denied, with the issuance of an amended report to correct errors or address issues that OIG identified during its review.
- Granted, with an amended report to follow with no additional investigation; or
- Granted to re-open for further investigation.

The reconsideration process ensures that OIG's investigations are complete, thorough, and accurate and therefore serves an important quality assurance function.

Of the 127 reconsiderations OIG received in FY20, OIG denied 72% and granted 28%, as reflected in the below table.

Reconsideration Outcomes	Number of Cases
Denied	82
Denied, with the Issuance of an Amended Report	7
Granted, with the issuance of an Amended Report	26
Granted, and Reopened Investigation	8
Total Reconsiderations	**123**

E. Written Responses

When OIG makes a finding of abuse or neglect or a recommendation in an investigative report, the facility or agency must respond to the finding or recommendation in writing, setting forth the action(s) that the facility or agency has taken or will take to: (1) protect the individual from future occurrences of abuse or neglect; (2) prevent reoccurrences of the identified abuse or neglect generally; and (3) eliminate the problem(s) identified during the investigation.

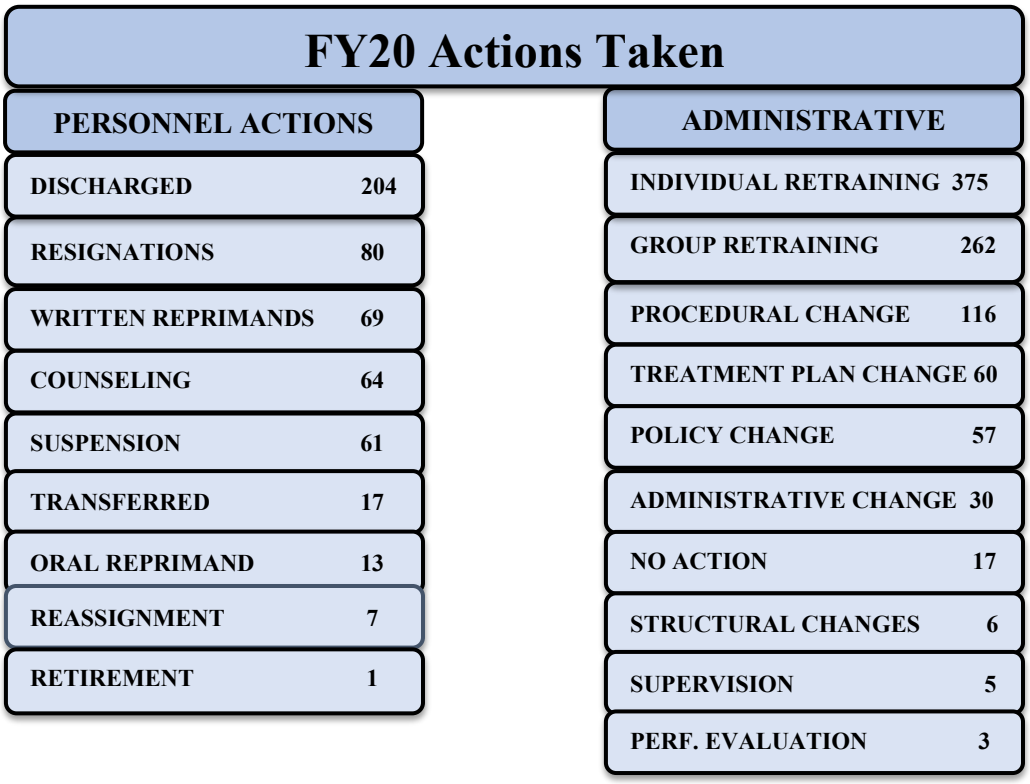
The facility or agency has 30 calendar days from the date it receives the investigative report to submit a written response to the appropriate IDHS program division (DD or MH). The program division then reviews and approves the written responses and sends the written response to OIG.

In FY20, OIG received 155 approved written responses from facilities and 779 from community agencies for a total of 934 written responses, regarding OIG's findings and recommendations.[6]

[5] *See* Department of Human Services Act, 20 ILCS1305/1-17(n).

[6] These numbers include approved written responses OIG received in FY20 regarding cases it completed in FY19.

With respect to the above-described written responses, facilities and agencies detailed the following actions related to OIG's findings and recommendations:



F. Compliance Reviews

Once IDHS' DD and MH Divisions approve the facilities' and agencies' written responses to OIG's findings and recommendations, OIG conducts compliance reviews to ensure that the facilities and agencies took action as set forth in those responses.[7] OIG selects a random sample of at least 10% of the written responses approved by the respective divisions during the prior month. OIG then requests documents/records or conducts telephone interviews to confirm that the facility or agency implemented or executed the detailed corrective action.

The table below reflects the percentage of compliance reviews OIG conducted in FY20 by location and program division:

[7] *See* Title 59, Chapter I, Part 50, Section 50.80(d) of the Illinois Administrative Code.

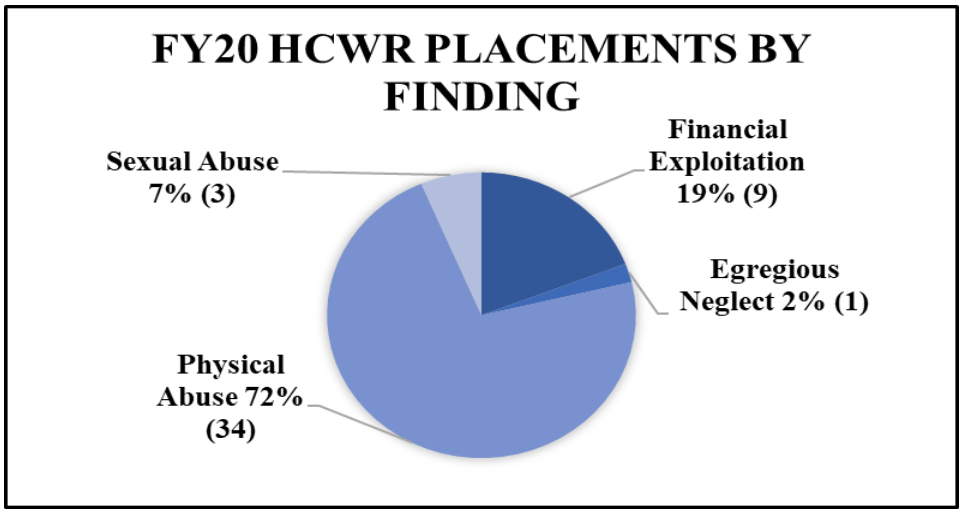
FY20 Percentage of Approved Written Responses for which OIG Completed Compliance Reviews						
	DD Programs			MH Programs		
	Written Responses	Compliance Reviews	%	Written Responses	Compliance Reviews	%
DHS Facilities	94	19	20%	61	8	13%
Community Agencies	740	97	13%	39	14	36%

With respect to these 138 compliance reviews, OIG issued two "Out of Compliance" letters to DD community agencies in FY20.[8]

G. Healthcare Worker Registry

Following the completion of an OIG investigative report that contains a substantiated finding of physical abuse, sexual abuse, financial exploitation, or egregious neglect against an employee, OIG, pursuant to Illinois statute, reports the name of the employee and the nature of OIG's finding to the Illinois Department of Public Health for placement on the Healthcare Worker Registry (HCWR). Following such a referral, the employee can request an administrative hearing to challenge their placement on the HCWR.

During FY20, 47 employees' names and findings[9] were placed on the registry as a result of OIG investigations.[10] For FY20, the HCWR placements by finding are reflected in the below table:



[8] OIG, in response to COVID-19, suspended compliance reviews from April to June 2020, after communicating with IDHS and OEIG, in order to reduce operational strain on facilities and agencies.

[9] There were 48 actual findings because one employee had two substantiated HCWR reportable cases.

[10] Notably, some of these placements resulted from investigations OIG completed in previous fiscal years.

During FY20, OIG closed 60 substantiated cases involving 59 employees who were eligible for placement on the HCWR (one employee was involved with two cases). Of these 59 employees, 35 have been placed on the HCWR.

Arbitrations

Following the completion and issuance of substantiated OIG investigative reports, four subject employees requested labor arbitrations in FY20, in which the employees challenged OIG's substantiated findings. The results of the labor arbitration requests—one hearing involved two employees—were as follows:

- Two of the matters were resolved prior to hearing. One resolution resulted in the staff person being offered to return to work with a voluntary reduction in pay and a position outside direct care, with no back pay. The second resolution resulted in full reinstatement of the employee to her prior position.
- One arbitration hearing resulted in the two subject employees being returned to their prior work status with full back pay.

HCWR Administrative Hearings

If an employee requests an administrative appeal of OIG's HCWR referral, IDHS has to prove by a preponderance of the evidence that OIG's finding of abuse or neglect warrants reporting to the HCWR. During FY20, 18 employees filed appeals challenging their names and findings being reported to the HCWR. 12 of those appeals remain pending, as HCWR hearings have been temporarily suspended due to COVID-19. The remaining six cases were decided as follows:

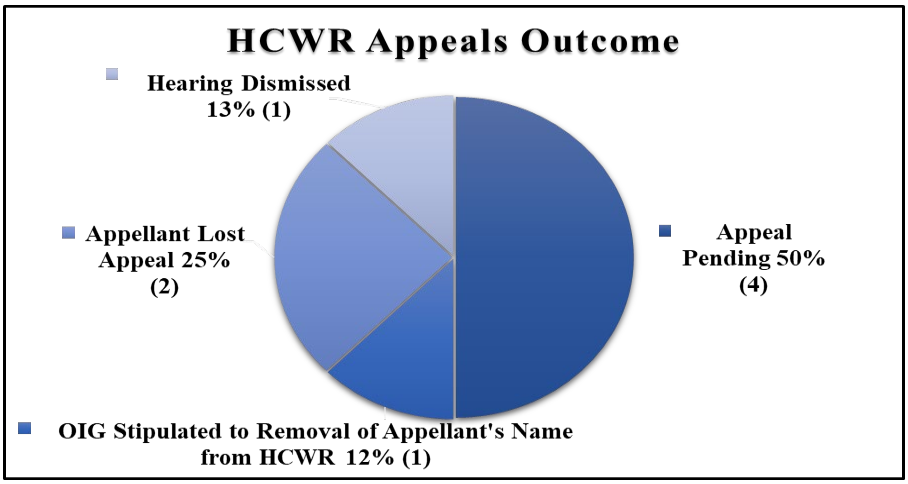
- 2 employees' names were placed on the HCWR, along with OIG's findings (1 employee lost at hearing and 1 had their case dismissed for failure to appear);
- 1 employee's name was not placed on HCWR because the employee's appeal was successful;
- OIG stipulated to three cases, meaning that OIG and IDHS agreed that OIG's findings did not warrant the placement of the employees' names on the HCWR.

HCWR Removal Hearings

An employee may petition IDHS to have his or her name and OIG's abuse or neglect finding removed from the HCWR. A petitioner has the burden to prove by a preponderance of the evidence that removal of the petitioner's name and finding from the HCWR is in the public interest. The hearing officer is to consider the following criteria when determining whether to remove the petitioner's name and finding from the HCWR:

Statement of the nature of the abuse or neglect for which the petitioner was placed on the HCWR.
Evidence that the petitioner is now rehabilitated, trained, or educated and able to perform duties in the public interest.
Evidence of the petitioner's conduct since his/her name was placed on the HCWR.
Evidence of the Petitioner's candor and forthrightness in presenting information in support of the decision.

During FY20, eight employees participated in hearings to have their names and findings removed from the HCWR. The following table shows the results of the hearings:



H. Site Visits

OIG conducts annual, unannounced site visits to the 14 IDHS developmental and mental health centers for the purpose of making recommendations regarding systematic issues related to the prevention, reporting, and investigation of abuse and neglect.[11] In connection with these site visits, OIG identifies systemic issues and concerns and makes recommendations to the facilities with the aim of reducing instances of abuse and neglect.

FY20 Issues

In FY20, OIG focused on the following topics (in addition to addressing the facilities' responses to OIG's FY19 recommendations):

[11] *See* Department of Human Services Act, 20 ILCS 1305/1-17(i).

Facility Response to Injuries and Injury Reporting to OIG

- Facility policies/procedures on reviewing injuries for underlying causes.
- Staff training on documenting and tracking injuries.
- Reporting injuries appropriately to OIG.

Parent/Guardian Notification of OIG Allegations

- Facility policies/procedures on notifying parent/guardians upon becoming aware of an OIG allegation.
- Staff training on notifying parent/guardians about OIG allegations.
- Appropriate tracking of parent/guardian notifications.

Staffing

- Facility policies/procedures on ensuring adequate supervision in cases of staff shortages, i.e., call-offs, illness, etc.
- Protocol for ensuring adequate staffing when employees are temporarily assigned to other positions.
- Staff training on special observation and special precautions.
- Documentation of special observation/1:1 supervision.

DHS Facilities Visited

OIG conducted site visits at the following seven facilities during FY20:[12]

Chicago-Read Mental Health Center	October 8 & 9, 2019
Choate Developmental Center	February 19-26, 2020
Choate Mental Health Center	February 19-26, 2020
Kiley Developmental Center	October 23-29, 2010
Madden Mental Health Center	September 26 & 27, 2019
McFarland Mental Health Center	December 4 & 5, 2019
Shapiro Developmental Center	November 6 & 7, 2019

Each site visit began with a request for documents, which OIG made at least one month prior to the on-site portion of the visit. OIG then had an entrance conference with administrative staff upon arriving at the facility. The OIG site-visit team then reviewed the relevant documentation and interviewed appropriate personnel to discuss the topics of review and observe processes. Each site visit ended with an exit conference, where OIG presented its findings to the facility. OIG ultimately provided each facility with a formal report within sixty working days of the completion of its site

[12] OIG, due to COVID-19 and the facilities' prohibition on the admission of non-essential parties, was not able to complete in-person site visits at all 14 facilities in FY20. OIG communicated with the OEIG and IDHS in the Spring of 2020 to provide full transparency regarding its inability to complete these in-person site visits.

visit follow-up. In response to OIG's report, each facility submitted a written plan to address the report's recommendations within sixty days of the site visit's completion.

Summary of Recommendations

In FY20, OIG made the below recommendations or findings in its site visit reports.

Facility Response to Injuries/Injury Reporting to OIG

- One DD center should provide additional training to its staff on its Injury Reporting Policy.
- One DD center and one MH facility did not appropriately report injuries to the OIG Hotline.
- One DD center should better demonstrate compliance with Behavior Intervention Programs when significant injuries occurred to individuals with a history of Self Injurious Behaviors or aggression toward others.
- One MH facility should more accurately and thoroughly track injuries.

Parent/Guardian Notification of OIG Allegations

- One MH center did not adequately notify all parents and guardians of all allegations of abuse and neglect.
- Two DD centers did not notify guardians per guardian notification preferences indicated in the individual's file.

Chapter 3: Additional FY20 Data

A. Reporting Allegations to OIG in a Timely Manner

Any employee of a State-operated facility or community agency that falls under OIG's jurisdiction is considered to be a required reporter and must report an abuse or neglect allegation to OIG's Hotline within four hours of their initial discovery of the allegation.[13] OIG refers to these types of reports as "self-reports." Allegations reported by anyone who is not a required reporter are called "complaints." Facilities and agencies generally train their staff on the "four hours" timeliness reporting requirement.

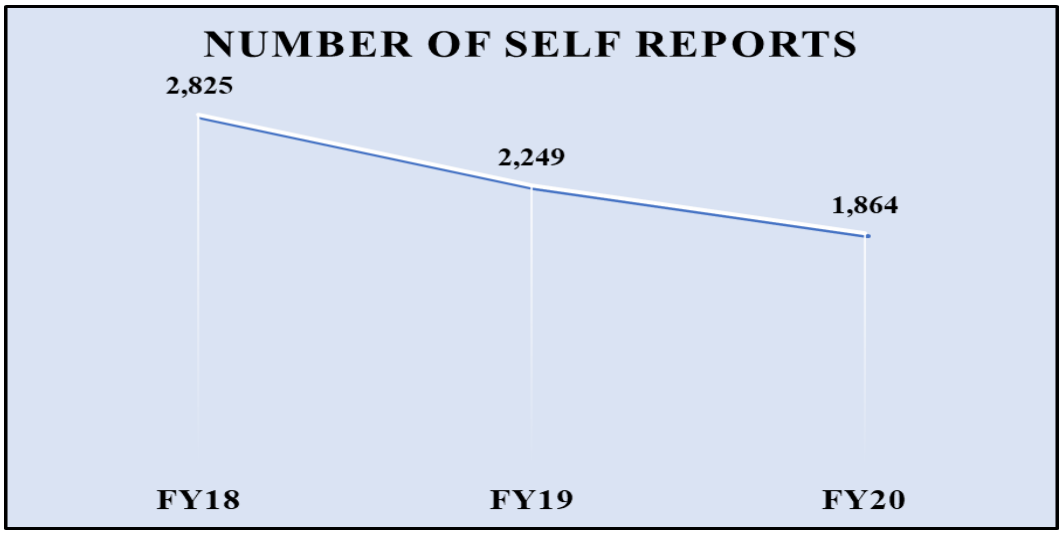
OIG's Intake Reports indicate if a self-reported allegation was not called into OIG in a timely manner (i.e. more than four hours after it was discovered). As part of the overall investigation, the assigned OIG investigator investigates whether and why the report was not made in a timely fashion. At the conclusion of the investigation, if OIG determines that the agency or facility did not timely report the allegation, OIG makes a recommendation to the agency/facility to address the late reporting and requires the agency or facility to state in writing what corrective action it will take.

[13] *See* Department of Human Services Act, 20 ILCS1305/1-17(k).

Self-Reports

Each month, OIG sends the IDHS program divisions a report of the untimely "self-reports" OIG received in the previous month. The report identifies each late report and states the number of days each report was late, and the overall percentage of reports that were late.

In FY20, OIG received 1,864 self-reported allegations of abuse and neglect, a 17.1% decline from FY19. OIG believes that this decline in self-reports is partly due to COVID-19. *See supra* Chapter 1(A)(detailing the general drop in complaints during the COVID-19 pandemic).



Late-Reporting

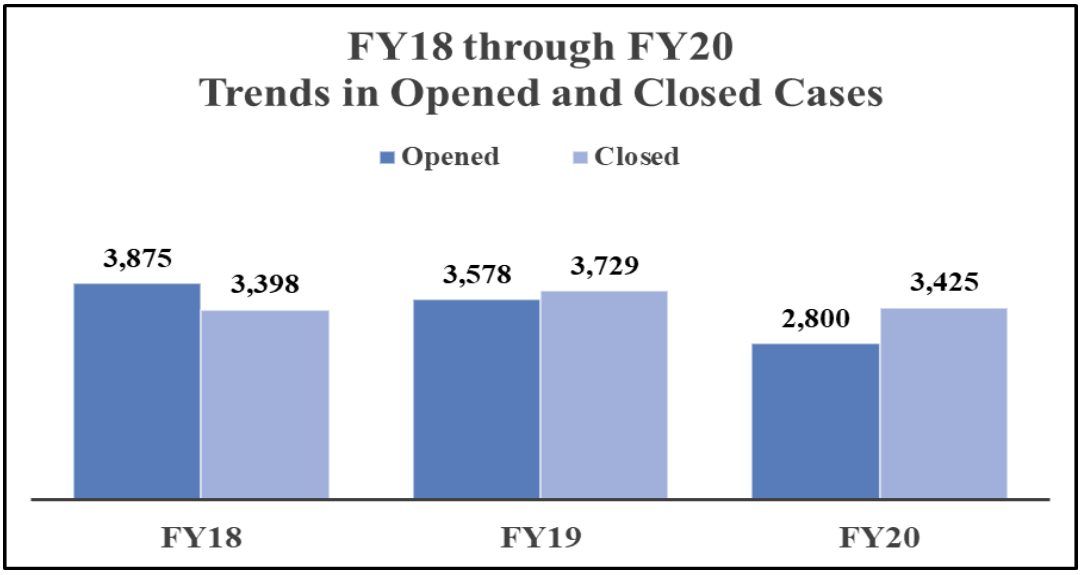
The percentage of late self-reports (i.e. reports of abuse or neglect from facility or community agency employees) increased slightly in FY20 to 11.1% from 10.1% in FY19.

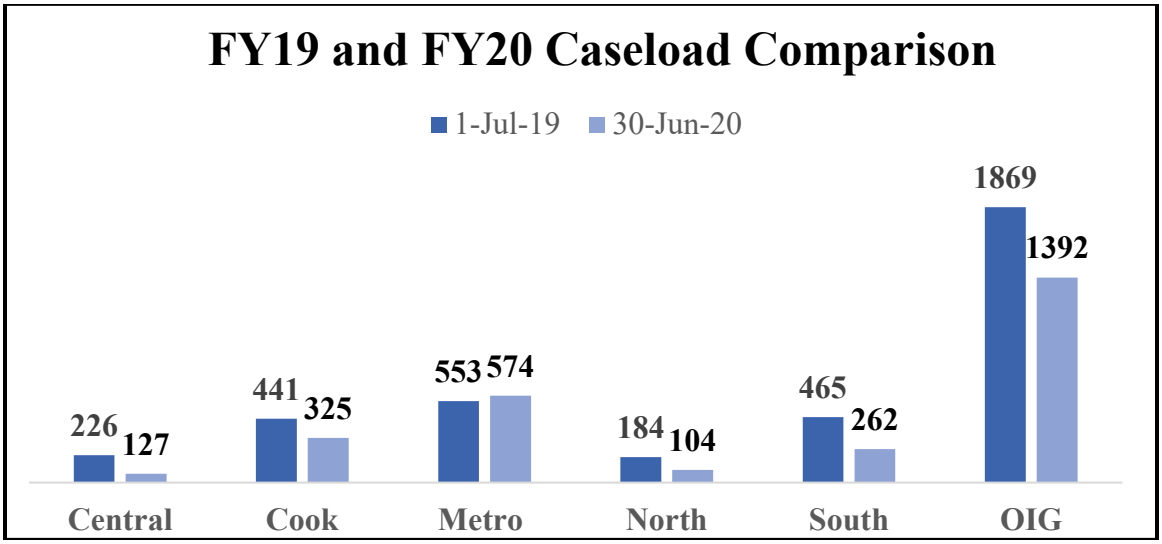
FY18-FY20 Late Reporting by Program and Disability Type						
Fiscal Year	Late from Agencies		Late from Facilities		Total Late	Percent Late
	DD	MH	DD	MH		
FY18	189	28	222	20	259	9.2 %
FY19	170	21	31	18	140	10.1 %
FY20	163	14	17	12	206	11.1 %

B. Reduction in OIG Caseloads

For the second fiscal year in a row, OIG closed more cases than it opened. More specifically, OIG opened 2800 cases in FY20 and closed 3,425, and reduced its overall caseload from 1,869 cases to 1,392 cases, a 25.5% reduction. In addition, OIG reduced the number of cases that had been open

over 60 days, from 1,181 to 1,032, or 12.6%. The below tables reflects the number of cases OIG opened and closed from FY18 through FY20.





With respect to OIG's Metro Bureau, OIG recognized, even prior to FY20, that additional resources would be helpful to reduce the Bureau's caseload. Accordingly, as noted above, OIG launched a pilot program that involved hiring an investigator who is assigned specifically to the Ludeman facility, which facility Metro Bureau is responsible for investigating. That investigator began working in January 2020. In addition, in FY2020, OIG began the hiring process for a second Investigative Team Leader for the Metro Bureau. OIG finalized that hiring process in FY21. OIG expects that with that additional personnel, Metro Bureau will be able to decrease its caseload in FY21.

C. Timeliness of OIG's Investigations

OIG's directives provide that investigators are to submit investigative case reports within sixty working days of their assignment. However, for a variety of reasons, it is not uncommon for OIG

investigations to extend beyond sixty days. Most notably, some cases are complex and require the issuance of subpoenas, the review of thousands of documents or, for cases where medical expertise is necessary, a clinical consultation. To complete these sorts of complex cases thoroughly and professionally within 60 days is a difficult task. In addition, although OIG has reduced its overload caseload in the last two years, investigative caseloads (cases per investigator) are still higher than OIG would like. Obviously, there is an inverse relationship between the number of cases an investigator has and the timeliness of their completion of those investigations. In addition, as investigations become older, they become more difficult to complete as witnesses change jobs, video is no longer retained, and records are more difficult to locate. Thus, for multiple reasons, as caseloads increase, it becomes increasingly difficult to complete investigations within 60 days. This is one of the reasons that OIG implemented its complaint intake pilot project, *see infra* Chapter 4(B): to reduce investigator caseloads and improve OIG's metrics with respect to the timely completion of investigations, while maintaining the health and well-being of vulnerable individuals as OIG's number one priority.

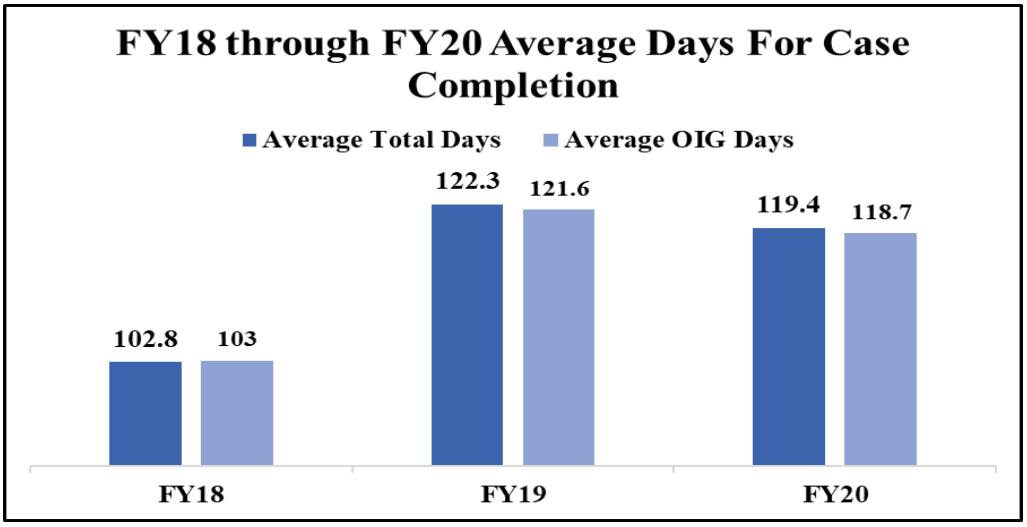
As noted above, due to OIG's focus over the last two years on completing its oldest cases, OIG has significantly reduced the number of OIG cases that are over 60 days old. In addition, OIG increased the percentage of cases it completed within 60 days from 39 percent in FY19 to 47 percent in FY20.

Cases Completed Within and Over 60 Days FY19 through FY20

Fiscal Year	Cases Closed Within 60 Days	Cases Closed Over 60 Days
FY19	39% (1,487)	61% (2,371)
FY20	47% (1,618)	53% (1,847)

As the below table reflects, though, for the past three years OIG's average time to complete an investigation has remained above sixty days. OIG expects that as the office continues to reduce the number of cases overall, and in particular the number of older cases, the percentage of cases completed within 60 days will begin to rise again. OIG further notes that the Office did slightly reduce the average time it takes to complete a case from 121.6 days to 118.7 days.[14]

[14] When the Illinois State Police (ISP) or local law enforcement (LLE) accepts a case for criminal investigation, OIG, by agreement, suspends its administrative investigation until ISP/LLE has completed its investigation. Accordingly, when calculating data regarding the timeliness of OIG's investigations, OIG excludes the time during which its investigations are suspended pending the completion of criminal investigations. For this reason, OIG counts "total time" and "OIG time" separately.



D. Facility Staffing Ratios

By law, OIG's annual report must include facility census figures which include counts of the number of individuals receiving services in each facility and the ratios of individuals to direct care staff. OIG calculates those ratios as of June 30, the last day of the fiscal year.

Below are the census figures and staffing ratios for each type of facility for FY20. The tables present census figures three ways:

- Counting every individual only once, regardless of the number of times he or she is admitted during the year, which gives an "unduplicated count." This count is presented in the first column.
- The second method is to count every day that individuals are in the facility or on temporary transfer to another location ("person-days" or "on-books bed-days"). This count is presented in the second column.
- The third column reflects the census taken on June 30, 2020, which details the number of individuals in the facility on that day.

OIG also uses the June 30, 2020 census figure to calculate the direct care staff to patient ratios. The number of direct care staff is counted in Full-Time Equivalents, which counts part-time staff as only a fraction. That count, again as of June 30, 2020, is reflected in the fourth column of the tables.

OIG divides the June 30, 2020 direct care staff figures by the June 30, 2020 census figures to calculate the direct care staff to patient ratios, which are reflected in the fifth column.

DHS State-Operated Facilities Census and Staffing Ratios (as of June 30, 2020)					
Facility	**Unduplicated Count of individuals Served**	**Person-Days**	**Inpatient Census on June 30**	**Direct Care Staff (Full-Time Equivalent)**	**Direct Care to Individual Ratio**
Alton MHC	**210.00**	**36,985.00**	**85.00**	**161.90**	**1.9**
Chester MHC	**471.00**	**96,648.00**	**254.00**	**344.40**	**1.36**
Chicago Read MHC	**261.00**	**48,934.00**	**130.00**	**180.40**	**1.39**
Choate MH&DC Total	**344.00**	**89,687.00**	**256.00**	**466.10**	**1.82**
Elgin MHC	**968.00**	**132,627.00**	**326.00**	**424.30**	**1.3**
Fox DC	**86.00**	**29,934.00**	**80.00**	**130.00**	**1.63**
Kiley DC	**214.00**	**72,493.00**	**194.00**	**306.10**	**1.58**
Ludeman DC	**368.00**	**128,174.00**	**334.00**	**636.50**	**1.91**
Mabley DC	**119.00**	**40,646.00**	**109.00**	**174.50**	**1.6**
Madden MHC	**1,657.00**	**34,675.00**	**74.00**	**133.10**	**1.8**
McFarland MHC	**296.00**	**49,183.00**	**123.00**	**156.75**	**1.27**
Murray DC	**256.00**	**88,274.00**	**245.00**	**387.82**	**1.58**
Shapiro DC	**504.00**	**173,503.00**	**468.00**	**891.07**	**1.9**
Total DD Facilities	**1,891.00**	**622,711.00**	**1,686.00**	**2,992.09**	**1.77**
Total MH Facilities	**3,863.00**	**399,052.00**	**992.00**	**1,400.85**	**1.41**

E. Quality Care Board

The purpose of the Quality Care Board ("QCB" or the "Board"), which was authorized in 1992, is to "monitor and oversee [OIG's] operations, policies and procedures." *See* 20 ILCS 1305/1-17. The Board is empowered to provide consultation on OIG practices, review regulations, advise on training, and recommend policies to improve intergovernmental relations.

The law provides for the QCB to have seven members, each appointed by the Governor with consent of the State Senate. However, "[f]our members shall constitute a quorum allowing the Board to conduct its business." 20 ILCS 1305/1-17. The members must be qualified by professional knowledge or experience in law, investigatory techniques, or the care of people who have mental illness or developmental disabilities. At least two members must either have a disability themselves or have a child with a disability. The members are not paid, but OIG may reimburse them for any costs related to travel.

The Quality Care Board members for FY20 were:

Brian Dunn, Chairperson
Jae Jin Pak
Shirley Perez
Angela Hearts-Glass
Megan Norlin

The QCB held five meetings in FY20. The meeting dates were as follows:

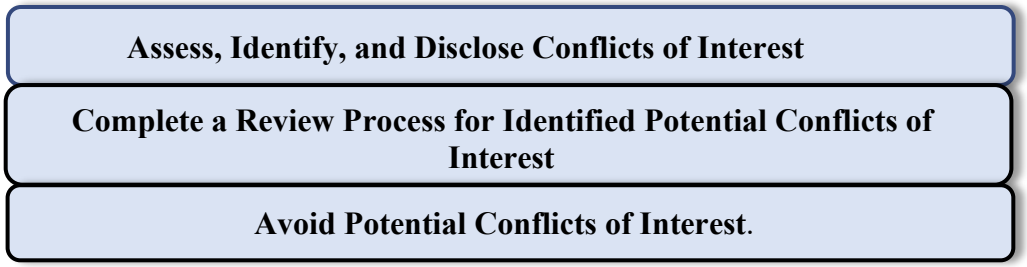
January 14, 2020	(Chicago OIG office and teleconference)
February 4, 2020	(Chicago OIG office and teleconference)
March 10, 2020	(teleconference)
April 14, 2020	(teleconference)
May 12, 2020	(teleconference)

Chapter 4: New Initiatives

During FY20, OIG made numerous modifications to its policies and procedures to better comport with the Association of Inspectors General Quality Standards for Offices of Inspector General and Quality Standards for Investigations and to generally improve the quality and timeliness of OIG's investigations.[15]

A. Conflict of Interest Directive

In FY20, OIG drafted and implemented a Conflict of Interest directive that requires OIG employees to be free from real and apparent conflicts of interest so that OIG's findings and recommendations will be impartial and be viewed by others as independent and objective. In particular, the directive instructs employees how to:



In situations where the Inspector General determines a conflict of interest exists, the conflicted employee will be recused from the case and possibly future cases, if appropriate.

[15] *See* Principles and Standards for Offices of Inspector General*, available at*: http://inspectorsgeneral.org/files/2014/11/AIG-Principles-and-Standards-May-2014-Revision-2.pdf

B. Complaint Intake Pilot Project

In order to ensure that OIG's uses its limited investigatory resources in the most efficient and effective manner possible, OIG initiated a pilot project in FY20 – developed in conjunction with DD, MH, and several advocacy organizations – wherein OIG's Intake Bureau, with Inspector General approval, refers certain cases to the State-operated facilities to address. Under the pilot project, an allegation may be appropriate for referral, where:

The Allegation, if True, Would Likely Not Result in a Report to the HCWR

Another Entity is Better Positioned to Immediately Address the Situation

The Reporting Entity or Person has Already Identified the Primary Facts Relevant to the Allegation, Meaning Additional Investigative Work Would be of Minimal Value

Notably, OIG has not and will not refer allegations if they: (i) present an emergency situation; (ii) indicate that an individual is in imminent danger; or (iii) would likely result in an employee's placement on the HCWR.

OIG's expectation is that the referral of these above-described cases, which OIG estimates will amount to approximately 3 to 5% of OIG's cases, will allow for individuals' concerns to be addressed more quickly, while also allowing OIG to complete its cases in a more timely fashion. *See supra* Chapter 3(C) Timeliness of OIG Investigations.

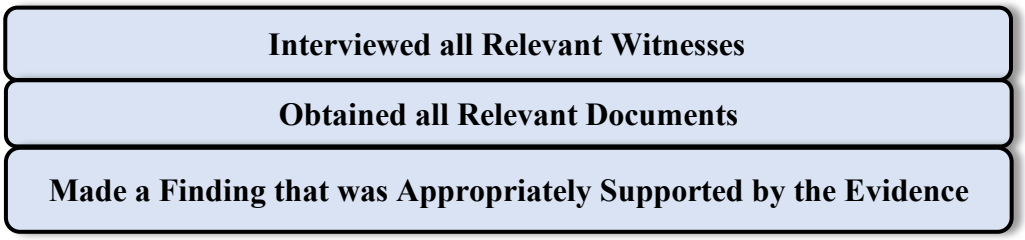
Importantly, to ensure that facilities are responding appropriately to the referrals, OIG will conduct compliance reviews of a sample of their responses—much like OIG conducts compliance reviews of facility and agency responses to OIG's findings and recommendations—to assess whether the facilities have appropriately addressed the underlying allegations. Thus, OIG has an important quality assurance plan in place for the work the facilities are doing pursuant to this project. Finally, OIG notes that facilities already conduct their own inquiries into abuse and neglect allegations—separate and apart from OIG's investigations—in order to comply with IDPH and federal regulations. Thus, OIG is not asking facilities to engage in activities for which they are ill-prepared.

If the pilot project ultimately proves successful, OIG will expand the program to all the SODCs. However, presently, only Shapiro, Kiley, and Choate are currently participating in the project on the DD side, with Elgin and McFarland participating on the MH side. Going forward, OIG is considering the roll-out of a similar pilot project with community agencies as well.

C. Unsubstantiated and Unfounded Closed Case Review Directive

In FY20, OIG developed a quality-assurance Closed Case Review Process directive to ensure that OIG's work adheres to established policies and procedures, meets established standards of

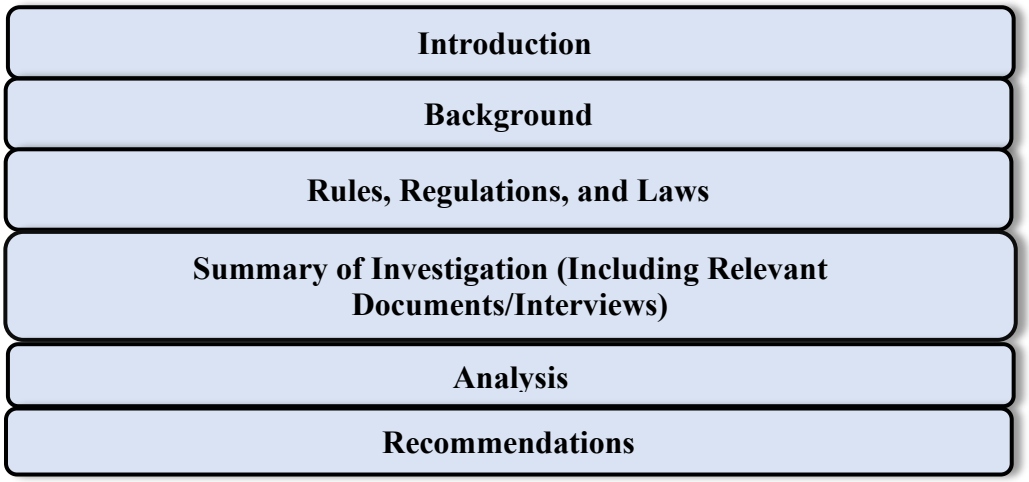
performance, and is carried out economically, efficiently, and effectively. Pursuant to the directive, OIG will review a random sample of unsubstantiated and unfounded cases from each OIG Investigative Bureau every six months. As part of the review, OIG will assess, among other topics, whether the investigative team for each investigation:



OIG will then produce an annual report for distribution to the Investigative Bureau Chiefs, the Deputy Inspector General, and Inspector General, which report is to include findings and recommendations regarding each Bureau's performance. Thus, the case review process will help OIG identify areas where its investigative quality needs to improve and allow OIG to allocate resources accordingly.

D. New OIG Substantiated Report Template

To present its substantiated findings in a more comprehensible and readable manner, OIG developed and implemented a new substantiated report format which includes the following sections:



Whereas, previously, OIG's reports often alternated between interview and document summaries, the new format ensures that these subject matters are treated separately. As a result, the reports are easier to write, more conducive to quick and efficient internal review, and more comprehensible for external readers.

Chapter 5: Training and Certification Updates

A. Staff Training

The State of Illinois, IDHS, and OIG require OIG staff to take certain training courses. Specifically, OIG's investigative staff receive ongoing training in Title 59, Chapter I, Part 50, Sections 50, 115, 116 and 119 of the Illinois Administrative Code, concerning, respectively, OIG investigations of alleged abuse or neglect in State-operated facility and community agencies, standards and licensure requirements for community integrated living arrangements, administration of medication in community settings, minimum standards for certification of developmental training programs, which are directly related to OIG's work and mission. OIG's directives also require that staff take a minimum of three training courses in investigative skills, computer skills and personal/professional growth. In FY20, OIG staff completed 1,319 training courses to meet these requirements.

In addition, each of the six Internal Security Investigators (ISIs) and two contractual investigators OIG hired in FY20 received OIG's classroom training, which includes instruction in the following areas:

OIG HISTORY	**APPLICABLE DIRECTIVES, RULES, STATUTES**	**INVESTIGATIVE SKILLS AND INTERVIEWING**	**REPORT WRITING**
APPEALS RIGHT AND TESTIFYING	**OIG DATABASE**	**ROLE OF CLINICAL COORDINATORS**	**PERSON CENTERED PLANNING**

In addition to the classroom training, as part of the field training program, the new ISIs were assigned a Field Training Investigator (FTI), who assists new ISIs in implementing their classroom training in the field. More senior and experienced ISIs, under close supervision of their Bureau Chief and Investigative Team Leader, also participate in mentoring newly hired ISIs.

OIG conducts weekly evaluations and written assessments to ensure the new probationary ISIs become permanent hires. Of the six ISIs OIG hired in FY20, all six completed their classroom and field training to become certified ISIs.

B. Association of Inspectors General Certifications

Three OIG staff attended a five-day Inspector General Institute training program to become certified Association of Inspectors General (AIG) Inspector/Evaluators. Instruction included the professional standards for conducting inspections/evaluations, evidence collection, analysis, documentation, and ethics. After participating in the Institute and passing an examination, all three participating OIG staff became Certified Evaluators. These OIG staff are now using their training to revise OIG's site visit protocols to ensure they better comport with national best practices for

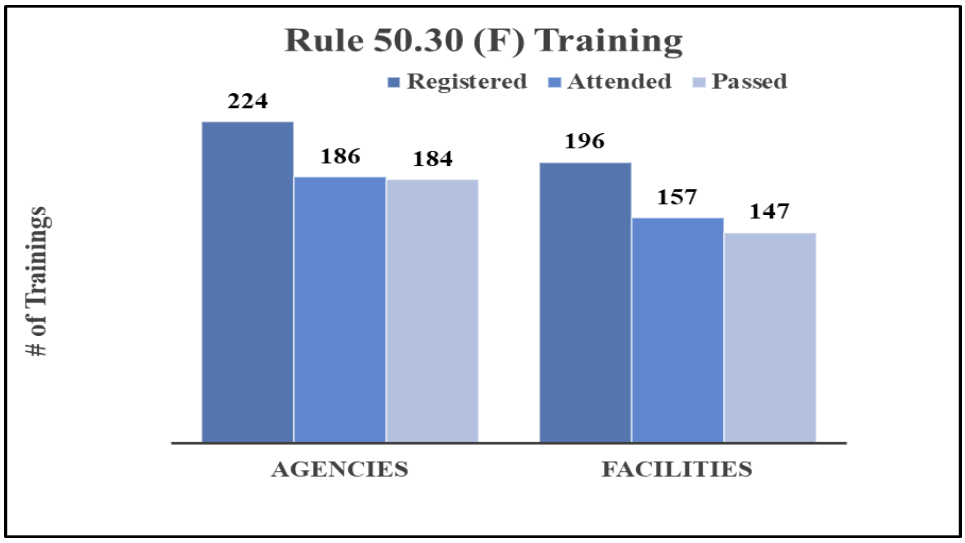
inspections and evaluations.

C. Training for Agencies and Facilities

50.30(f) Initial Incident Response

Section 50.30(f) of Rule 50[16] requires agencies and facilities to take initial steps to respond to an allegation of abuse or neglect. These steps include ensuring the health and safety of individuals and staff, ensuring OIG is notified of the allegation in a timely manner, gathering initial statements from principles involved in the incident, and gathering basic documentation related to the incident.

OIG provides online training to help agencies and facilities carry out this important function. In FY20, 420 agency and facility staff registered for and completed OIG's online 50.30(f) training. To complete the training, the staff have to score 70% or better on a test. 99% of agency staff and 94% of facility staff who took the training passed the test. The numbers of agency and facility staff that registered, attended, and passed the training are reflected in the table below.



OIG Investigative Steps

OIG also provides an online "Investigative Steps" training for employees at IDHS' Developmental and Mental Health Centers that provides instruction on interviewing and document/evidence collection. For a Facility employee to become a Facility investigator (which allows them to play a more significant role in the initial response to an allegation - including conducting interviews instead of gathering statements), they must take the Investigative Steps training. During FY20, 58 facility staff registered for the training and 49 staff completed the training.

[16] Title 59, Chapter I, Part 50, Section 50.30(f) of the Illinois Administrative Code.

Chapter 6: Notable OIG Investigations

OIG's work often results in significant criminal or administrative consequences for employees who engage in abuse, neglect, or financial exploitation. Below are deidentified, narrative summaries of a small sample of the 323 cases OIG substantiated in FY20, reflecting some of the most egregious employee conduct.

Case # 1619-0223: OIG substantiated a finding of physical abuse where its investigation established that an employee slapped an individual with an open hand to the face resulting in swelling underneath the individual's eye. As a result of OIG's investigation, the worker's name was placed on the HCWR.

Case # 1619-0486: OIG substantiated a finding of financial exploitation where its investigation established that an employee took unjust advantage of multiple individuals by driving the individuals to his former and current residences to help him move his personal belongings. As a result of the investigation, the employee's name was placed on the HCWR.

Case # 5917-0169 and Case # 5918-0047: OIG substantiated findings of sexual abuse where its investigations established an employee had sexual relationships with two different individuals. Following OIG's referral of the matter to law enforcement and the subsequent criminal investigation, the employee ultimately pled guilty to one count of Sexual Misconduct with a Person with a Disability, a felony, and was required to register on the Illinois Sex Offender Registry as a sexual predator. In addition, the Illinois Department of Financial and Professional Regulation (IDFPR) permanently revoked the worker's Clinical Social Worker License in 2019. Following the completion of OIG's administrative investigation, the worker's name was placed on the HCWR.

Case # 1020-0065: OIG substantiated a finding of physical abuse after its investigation established that an employee kicked an individual, slid the individual across the floor, and pinned the individual against the wall for a short period of time. Following OIG's referral of the matter to law enforcement, and the subsequent criminal investigation, the employee was charged with Aggravated Battery to a Person with a Disability, a felony. With respect to the administrative process, after OIG completed its investigation, the employee filed an appeal regarding their potential placement on the HCWR and that appeal is pending.

Case # 1116-0055: OIG substantiated a finding of egregious neglect where its investigation established that an employee failed to administer evening medication to an individual, failed to ensure the individual was placed in bed properly, failed to perform scheduled nighttime checks, and slept while on duty. These failures resulted in the individual's death by asphyxia by hanging. Following the referral of the matter to law enforcement, and the subsequent criminal investigation, the employee pled guilty to one misdemeanor count of Reckless Conduct. After OIG completed its administrative investigation, the worker's name was placed on the HCWR.

Case # 1117-0469: OIG substantiated a finding of physical abuse where its investigation established that an employee punched an individual with a closed fist. Following the referral of the matter to law enforcement, and the subsequent criminal investigation, the employee pled guilty to one Felony count of Aggravated Battery to a Pregnant or Handicapped Person. After OIG

completed its administrative investigation, the worker's name was placed on the HCWR.

Case # 1219-0228: OIG substantiated a finding of physical abuse where its investigation established that an employee pulled an individual backwards with his arm around the individual's neck, and repeatedly pinched the individual, leaving bruises on the individual's body. Following the completion of OIG's investigation, the worker's name was placed on the HCWR.

Case # 1220-0006: OIG substantiated a finding of sexual abuse where its investigation established that an employee had an ongoing sexual relationship with an individual to whom she was providing counseling in a non-residential setting. Following the completion of OIG's investigation, the worker's name was placed on the HCWR.

Case # 1218-0673: OIG substantiated a finding of physical abuse where its investigation established that an employee slapped an individual across his right cheek. After OIG completed its administrative investigation, the worker' name and finding was placed on the HCWR. In addition, following a criminal investigation, the employee pled guilty to aggravated battery, a felony.

Case # 1319-0223: OIG substantiated a finding of financial exploitation where its investigation established that an employee removed money from individuals' accounts and used the money to purchase gas and groceries, among other items. Following the referral of the matter to law enforcement, and the subsequent criminal investigation, the employee was charged with misdemeanor theft and those charges remain pending. After OIG completed its administrative investigation, the worker's name was placed on the HCWR.

Case # 1318-0009: OIG substantiated a finding of physical abuse where its investigation established that an employee, while cutting an individual's hair and shaving the individual's face, tied a trash bag and a bed pad around the individual's neck tightly with a rubber band, grabbed the individual's hand and bent it down with force multiple times, struck the individual with a shaving cream can multiple times, and pulled the individual's ear. The employee then picked the individual up by the items tied around his neck and threw the individual into a wheelchair and then pushed the individual onto the individual's bed. OIG's investigation further established that the employee mentally abused the individual by calling the individual derogatory names during the incident. After the completion of OIG's administrative investigation, the employee's name was placed on the HCWR. In addition, following a criminal investigation, the employee pled guilty to Aggravated Battery, a felony.

Case # 1318-0234: OIG substantiated two findings of physical abuse where its investigation established that two employees pushed an individual's head backwards while the individual was in a chair; and either kicked or pushed the individual's chair in an attempt to get the individual out of the chair when the individual was non-responsive after taking medication. In addition, the employees both forcefully pulled the individual out of a chair by the individual's arms. OIG also substantiated a finding of mental abuse as its investigation established that one of the employees took the individual's videos and pretended to throw them away. As a result of OIG's investigation, the two employees' names were placed on the HCWR.

Chapter 7: IG's Closing Remarks

A. Structural Challenges at OIG

Prior to becoming IDHS OIG Inspector General, I spent almost a decade on the legal staff at the City of Chicago Office of Inspector General (the "Chicago OIG"). The Chicago OIG is generally regarded as one of the preeminent OIGs in the country and I, wherever appropriate, have attempted to implement at IDHS OIG the policies and protocols that I saw work well at the Chicago OIG. In particular, our pilot complaint intake project, conflict of interest policy, and new substantiated report template all derive from policies that are in place at the Chicago OIG. *See infra* Chapter 4.

However, one area where IDHS OIG has not yet met the standard of the Chicago OIG is independence. *See* 20 ILCS 1305/1-17(d) (stating that IDHS OIG "shall function independently within the Department with respect to the operations of the Office, including the performance of investigations and issuance of findings and recommendations"); *see also* Association of Inspectors General "Principles and Standards for Offices of Inspector General," *available at*: http://inspectorsgeneral.org/files/2014/11/AIG-Principles-and-Standards-May-2014-Revision-2.pdf (last visited December 8, 2020) (stating that an OIG "should be placed in the governmental structure to maximize independence from operations, programs, policies, and procedures over which the OIG has authority" and "should be funded through a mechanism that will provide adequate funding to perform its mission without subjecting it to internal or external impairments on its independence").

IDHS OIG falls short of these standards in several ways: (a) OIG must often rely on IDHS, the Department it is supposed to oversee, for legal, administrative, and budgetary support due to a lack of appropriate staff at OIG; (b) OIG does not have full and complete control over its budget, but must rather, on occasion, engage with IDHS prior to making any new expenditures (such as buying new computers for staff); (c) OIG does not have final authority over who is hired or promoted at OIG[17]; and (d) OIG does not have a statutory budgetary floor, meaning OIG could potentially be starved, in the General Assembly's and Governor's budget process, of necessary resources for any reason or no reason. *See*, in contrast, Municipal Code of Chicago § 2-56-010 (stating that "[t]he appropriations available to pay for the expenses of the [City of Chicago] office of inspector general during each fiscal year shall be not less than fourteen hundredths of one percent (0.14%) of the annual appropriation of all funds contained in the annual appropriation ordinance, as adjusted"); *see also* Toll Highway Act, 605 ILCS 10/8.5(h) (stating that "the Authority shall not reduce the budget of the Office of the Toll Highway Inspector General by more than 10 percent (i) within any fiscal year or (ii) over the five-year term of each Toll Highway Inspector General").

With respect to staffing, as of the end of FY20, IDHS OIG simply did not have the same executive management resources as other similar-sized OIGs. For example, the executive management structure at Chicago OIG includes four deputies (including a Deputy of Operations), a General Counsel, an Assistant General Counsel, a Chief Technology Officer, and a Chief Forensic Data

[17] More specifically, OIG's personnel hires are subject to oversight and approval from the Department of Central Management Services. The *Rutan* interview process can also constrain and limit OIG's ability to participate in the selection of candidates.

Analyst. *See* Chicago OIG Website, *available at*: https://igchicago.org/wp-content/uploads/2017/02/OIG-Functional-Org-Chart.pdf. Similarly, the Illinois Office of Executive Inspector General (OEIG), another State-wide OIG, has three deputies, a General Counsel, and a Chief Administrative Officer. *See* OEIG Website, *available at*: https://www2.illinois.gov/oeig/about/Pages/Staff.aspx; *see also* IHFS OIG Website https://www.illinois.gov/hfs/oig/Pages/Welcome.aspx (detailing that HFS OIG has two deputy positions and a deputy chief counsel). In contrast, IDHS OIG, a State-wide office with a staff headcount of 81 has one Deputy. IDHS does not have a Chief Administrative Officer, a General Counsel, nor any staff position that requires a legal background.

OIG acknowledges that the above-described OIGs have disparate missions and powers, making for a somewhat imperfect comparison with IDHS OIG. However, there is little doubt that OIG's present lack of executive staff limits IDHS OIG's independence, as described above and also hurts the Office's operational effectiveness. OIG's case reviews (i.e., file review, report editing, etc.) take longer, as we have less staff to conduct such reviews, policy innovations take longer to develop and implement, and there is less time to think strategically about the function and performance of the Office, as supervisors are focused almost exclusively on ensuring that OIG is thoroughly investigating the thousands of complaints we receive each year. In addition, OIG's current lack of a Chief Administrative Officer means we are: (1) not able to respond to technology challenges as quickly as we would like, which can cause delays in the completion of investigations, particularly during a period of remote work; and (2) are possibly failing to identify (or even be aware of) technological advances that could streamline our investigative processes.

Finally, OIG does not, at the present time, have any in-house staff who have expertise or specific training in budgetary matters or whose position is devoted to the strategic assessment of OIG's financial resources.

To be clear, IDHS is not the cause of, and has minimal ability to remedy, certain of the structural challenges identified above, including OIG's almost complete lack of authority over personnel decisions. In addition, OIG notes that Secretary Hou has been extremely supportive of OIG's attempts to staff its office in a manner commensurate with similarly-sized governmental investigative agencies and OIG has engaged in continuing discussions with IDHS regarding the optimal restructuring of OIG's organizational chart. I further believe Secretary Hou and her team are as strong of advocates for good governance as one will find. Secretary Hou understands and appreciates the mission of OIGs and the importance of independence for a successful OIG. As a result, OIG is optimistic that it will have positive news to report on this front in FY21.

B. Inspector General's Vision for the Future

In the short-term, OIG absolutely must continue making progress in terms of reducing its caseload and completing its investigations in a more-timely fashion. Improving investigative performance will always be a priority for OIG However, there is no easy, quick-fix available to the Office on that front. Rather, to reach its goals, OIG must continue to work hard, maintain a culture of accountability, and be innovative in many different ways. OIG is confident, though, that with the dedicated staff it possesses, it will continue to make progress with respect to the quality and timeliness of OIG's investigative work.

Longer term, though, OIG would like to devote more of its resources to analyzing and assessing

the root causes of abuse and neglect. Although it can be difficult to identify and address structural issues through individual investigations, OIG also has an inspections component of its operations that conducts statutorily-mandated site visits at IDHS'14 developmental centers and mental health facilities "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)(1).

As noted above, in an effort to bolster OIG's program review capabilities, in February 2020, OIG sent three staff members to receive their certification in inspections and evaluations from the AIG, the premier training and accreditation organization for OIGs. This week-long training provided instruction in seven core competency areas, including professional standards for conducting inspections/evaluations, types of inspections/evaluations, and evidence collection, analysis, and documentation. OIG believes that this training will allow for the Office to more fully inhabit its role as a program reviewer and also identify additional opportunities for structural review that extend beyond facility site visits.

OIG further notes that the Office had engaged AIG to perform the first peer review of OIG in May 2020, which review would have assessed OIG's performance in achieving the investigative standards set forth by AIG. However, due to COVID-19, that peer review has been indefinitely postponed. As soon as it is feasible, though, OIG will reschedule that peer review in order to identify additional areas of improvement.

OIG has also been in communication with external academic and non-profit consulting entities about potential collaborative projects that would involve data analysis and root-cause analysis. Although OIG has not finalized these partnerships, OIG expects to report on further developments on this subject next fiscal year.

More structurally, as alluded to above, *see supra* Chapter 7(A), OIG will continue to attempt to create an organizational chart befitting an investigative organization of OIG's size. If successful in creating positions to oversee OIG's budgetary, personnel and technology functions, OIG believes it will be able to use its budget and technological resources more strategically, thus likely providing fiscal benefits to the State. Such staffing will also provide OIG with added independence from IDHS, as OIG will no longer be as reliant on IDHS for resources.

OIG understands that the various reforms it is looking to make may take several years to achieve. However, OIG is committed to making those changes so that the Office can effectively function as an independent, credible watchdog, today, tomorrow and for the years to come.

APPENDIX A – Relevant Illinois Statutes

Healthcare Worker Background Check Act

225 ILCS 46.15

"Health care employer" means:

(1) the owner or licensee of any of the following:

(i) a community living facility, as defined in the Community Living Facilities

(ii) a life care facility, as defined in the Life Care Facilities Act;

(iii) a long-term care facility;

(iv) a home health agency, home services agency, or home nursing agency as defined in the Home Health, Home Services, and Home Nursing Agency Licensing Act;

(v) a hospice care program or volunteer hospice program, as defined in the Hospice Program Licensing Act;

(vi) a hospital, as defined in the Hospital Licensing Act;

(vii) (blank);

(viii) a nurse agency, as defined in the Nurse Agency Licensing Act;

(ix) a respite care provider, as defined in the Respite Program Act;

(ix-a) an establishment licensed under the Assisted Living and Shared Housing Act;

(x) a supportive living program, as defined in the Illinois Public Aid Code;

(xi) early childhood intervention programs as described in 59 Ill. Adm. Code 121;

(xii) the University of Illinois Hospital, Chicago;

(xiii) programs funded by the Department on Aging through the Community Care Program;

(xiv) programs certified to participate in the Supportive Living Program authorized pursuant to Section 5-5.01a of the Illinois Public Aid Code;

(xv) programs listed by the Emergency Medical Services (EMS) Systems Act as Freestanding Emergency Centers;

(xvi) locations licensed under the Alternative Health Care Delivery Act;

(2) a day training program certified by the Department of Human Services;

(3) a community integrated living arrangement operated by a community mental health and developmental service agency, as defined in the Community-Integrated Living Arrangements Licensing and Certification Act; or

(4) the State Long Term Care Ombudsman Program, including any regional long term care ombudsman programs under Section 4.04 of the Illinois Act on the Aging, only for the purpose of securing background checks.

Mental Health and Developmental Disabilities Administrative Act

20 ILCS 1705/7.3

Sec. 7.3. Health Care Worker Registry; finding of abuse or neglect. The Department shall require that no facility, service agency, or support agency providing mental health or developmental disability services that is licensed, certified, operated, or funded by the Department shall employ a person, in any capacity, who is identified by the Health Care Worker Registry as having been subject of a substantiated finding of abuse or neglect of a service recipient. Any owner or operator of a community agency who is identified by the Health Care Worker Registry as having been the subject of a substantiated finding of abuse or neglect of a service recipient is prohibited from any involvement in any capacity with the provision of Department funded mental health or developmental disability services. The Department shall establish and maintain the rules that are necessary or appropriate to effectuate the intent of this Section. The provisions of this Section shall not apply to any facility, service agency, or support agency licensed or certified by a State agency other than the Department, unless operated by the Department of Human Services.

(Source: P.A. 100-432, eff. 8-25-17.)

APPENDIX B – Rule 50 Definitions of Abuse and Neglect

Chapter I, Part 50, Section 50.10 of the Illinois Administrative Code provides the following OIG Definitions:

Abuse

Physical Abuse
"[a]n employee's non-accidental and inappropriate contact with an individual that causes bodily harm." Section 50.10 further defines "bodily harm" as "[a]ny injury, damage or impairment to an individual's physical condition, or making physical contact of an insulting or provoking nature with an individual."

Sexual Abuse
"[a]ny sexual contact or intimate physical contact between an employee and an individual, including an employee's coercion or encouragement of an individual to engage in sexual behavior that results in sexual contact, intimate physical contact, sexual behavior, or intimate physical behavior." Sexual abuse also includes "employee's actions that result in the sending or showing of sexually explicit images to an individual via computer, cellular phone, electronic mail, portable electronic device, or other media, with or without contact with the individual."

Sexually Explicit Images
"any material that depicts nudity, sexual conduct, or sadomasochistic abuse, or that contains explicit and detailed verbal descriptions or narrative accounts of sexual excitement, sexual conduct, or sadomasochistic abuse." Images contained in sex education materials used by employees to educate individuals are not considered sexually explicit images."

Financial Exploitation
"[t]aking unjust advantage of an individual's assets, property or financial resources through deception, intimidation or conversion for the employee's, facility's, or agency's own advantage or benefit."

Mental Abuse
"[t]he use of demeaning, intimidating or threatening words, signs, gestures or other actions by an employee about an individual and in the presence of an individual or individuals that results in emotional distress or maladaptive behavior, or could have resulted in emotional distress or maladaptive behavior, for any individual present."

Neglect

Neglect
"[a]n employee's, agency's or facility's failure to provide adequate medical care, personal care or maintenance," which "causes an individual pain, injury or emotional distress, results in either an individual's maladaptive behavior or the deterioration of an individual's physical condition or mental condition, or places an individual's health or safety at substantial risk of possible injury,

harm or death."

Egregious Neglect

"A finding of neglect as determined by the Inspector General that represents a gross failure to adequately provide for, or a callous indifference to, the health, safety or medical needs of an individual and results in an individual's death or other serious deterioration of an individual's physical condition or mental condition."